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INVESTIGATION OF HEW

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HEARINGS

BEFORE THE

SPECIAL SUBCOMMITTEE ON INVESTIGATION OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

EIGHTY-NINTH CONGRESS

SECOND SESSION

ON

ORGANIZATION OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

APRIL 18, 19, 20, 21, 22; MAY 27; JUNE 20, 1966

Serial No. 89–42

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INVESTIGATION OF HEW

MONDAY, APRIL 18, 1966

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON HEW
INVESTIGATION OF THE COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. ROGERS of Florida. The committee will please come to order.

This morning the Special HEW Investigation Subcommittee is beginning hearings on the organizational structure of the Department of Health, Education, and Welfare as it pertains to the public health programs of the Department.

Congressman Oren Harris, the former chairman of the House Committee on Interstate and Foreign Commerce, ordered this study just a year ago this month. Since then the staff has been engaged in a detailed analysis of the huge, expanding and farflung operations of the Department and of the governmental machinery and procedures used to coordinate the health programs, both within the Department and with agencies outside the Department having substantial health responsibilities.

Chairman Staggers, who took over the chairmanship of the committee in January of this year, has reemphasized the need for this study. There is growing concern in Congress over the rapid expansion of the size of the Department of Health, Education, and Welfare. In 1956, for example, the Department had 56,000 employees, whereas next year it is expected to have over 118,000, more than double the 1956 number.

The Department's budget, not including trust funds, has jumped from $2.1 billion in 1956 to an expected $11.7 billion for the coming fiscal year, more than a fivefold increase. In this same period the budgets of two of the major health agencies of the Department, the Public Health Service (which includes the National Institutes of Health) and the Food and Drug Administration, have expanded by a proportionately even greater amount.

In conducting these hearings, the chairman and all the members of this subcommittee are very mindful of their responsibilities. Above all, we want to be constructive and we hope that this investigation will serve to strengthen the administration of all of the Department's health programs. There has been substantial criticism, both within the Congress and outside of the Congress, with regard to the manner in

which some of these programs have been administered. We want to go into some of these criticisms in a constructive way.

This morning we are commencing a short series of public hearings on a very important subject. Our President has committed this Nation to the highest possible health care for all of our citizens. Our goal is good health for every citizen to the limit of our country's capacity to provide it. During the 89th Congress there has been unprecedented activity in the field of health. The medicare program, which on July 1 will make health benefits available to more than 19 million older Americans, is but one example.

The Federal health programs and activities, of course, do not function in isolation from State and local programs. We will be attempting, during the coming week, to gather some information on the present status and workings of the Federal, State, and local health partnership. It is only through a coordinated effort in which the energies of all levels of government are pooled toward the desired goals that we can make the greatest progress in our national health effort. Lack of communication, overlapping of responsibility, interagency rivalry, and lack of coordination among Federal, State, and local health authorities will only dilute our energies and hamper our efforts to achieve better health for all of our citizens.

During the first 3 days of our hearings we will have the benefit of testimony from representatives of many levels of State and local governments and of the academic world. On Thursday and Friday of this week we will hold a roundtable panel discussion to further develop this area of inquiry. The participants will include Federal, State, and city level officers.

At the present time new leadership in the Department of HEW is considering far-reaching organizational changes in the Department to improve the Federal effort in public health. This seems a particularly opportune time, therefore, in which to explore the relationship among all levels of government. We have been extremely fortunate in obtaining the testimony of the distinguished witnesses who will appear before the subcommittee this week, beginning with the distinguished Governor present this morning in the hearing room.

We hope that our inquiry will be fruitful and constructive and be of benefit both to the Congress, to the Department of HEW, and to private and public organizations which depend on and are effected by the health programs administered by the Department. The objective of all of these programs is improving the health of the American people, and this is our ultimate objective too.

It is a pleasure and an honor to have as our first witness this morning the Honorable John Chafee, Governor of the great State of Rhode Island.

Governor Chafee.

STATEMENT OF HON. JOHN H. CHAFEE, GOVERNOR OF THE STATE OF RHODE ISLAND; ACCOMPANIED BY DR. JOSEPH E. CANNON, DIRECTOR, DEPARTMENT OF HEALTH, STATE OF RHODE ISLAND

Governor CHAFEE. Thank you very much.

Mr. Chairman, Mr. Younger, and other distinguished members of the subcommittee, first, I wish to thank you very much for giving me the kind opportunity to speak briefly with you this morning on the subject of the effectiveness of the present organizational structure and health programs of the Department of Health, Education, and Welfare as seen from the State's point of view and we wish to extend to you our gratitude for undertaking this task of looking into how the effectiveness of this Department might be improved, because it certainly is an extremely important one as far as each of our States is concerned.

The department in my State's government which is charged with the responsibility of providing the best possible health services to all the people of our State is our department of health, headed by its director, Dr. Joseph E. Cannon, who is here with me today, and with whom I work closely.

This department is not a mere conduit of Federal funds. It actively initiates and carries out programs, many of which have no Federal financial support. For instance, in 1963 the department, in cooperation with our State's medical society, sponsored an end polio campaign that resulted in the mass immunization of 80 percent of our State's population, thus making Rhode Island the first State in the Nation to complete such a program.

In 1965, again in conjunction with the State's medical society, our department of health conducted a mass immunization against measles which reached 70 percent of our children between 1 and 12, which is, of course, the susceptible group. This past fall we conducted a statewide immunization against rabies. We had one case of rabies which turned up in our State which alarmed us a great deal and we embarked on this program wherein all dogs in the State were eligible for free rabies shots. Starting July 1 of this year, our State health department will take over all local health services now being provided by the different cities and towns in the State. No longer will there be any local health departments. It will all be centralized within our State department of health. The State will have the only health department in Rhode Island. This will increase the State's expenditures for public health 65 percent over the present fiscal year.

I cite these accomplishments, of which we are naturally proud, only to show you that the local effort we are making is substantial.

In reviewing Federal-State relations, it is my belief that present arrangements do not permit the full exploitation of current knowledge, nor the delivery to the people of my State the latest develop-

ments in public health. The factors which seem to interfere with this objective are: One, the dispersion of health services; and, two, restrictive Federal financing.

DISPERSION OF HEALTH SERVICES

On both the State and Federal level, health services are scattered through a variety of different departments or divisions. As far as possible certainly the States should put their own houses in order, but in so doing there is the risk of tearing up well-developed relationships with the Federal counterpart and in some instances the existing arrangement is actually required, or has been required, by Federal law.

For example, our State's division of vocational rehabilitation, which is ever increasing in size, because of existing Federal legislation, is located within our department of education. This department has no medical orientation and does not seek any, while, of course, vocational rehabilitation has primarily medical responsibilities and should be in our health department. Interdepartmental cooperation on the State level can reduce the possible confusion in this area but an outright transferral would be superior.

Another example: Water pollution control is a duty of our health department and we seek assistance from four different Federal departments: Health, Education, and Welfare; Housing and Urban Development; Commerce; and Agriculture. A specific project can be financed by one or all of these departments.

Let us take mental retardation. For assistance on this we seek assistance from both the Maternal and Child Health Division and the Crippled Children's Division of the Children's Bureau, and also from the Public Health Service, where we look in one section to the Chronic Disease Branch. We look to another branch for comprehensive State planning funds and to a third for construction money.

For a regular medical problem, there are a variety of Federal programs that we might use. For instance, let us take the case of a 15-year-old boy on aid to dependent children who has a hearing problem that can be corrected. My natural response, as I am sure yours is too, would be "Correct his hearing." However, confusion arises when one considers whether he should be referred to the public assistance medical care program administered by the Department of Social Welfare, the Division of Vocational Rehabilitation administered by the Department of Education, or to the crippled children's program administered by the Department of Health.

Under such conditions, there is the temptation—and I might say this is a very real one—to refer such a patient not to the program which is best organized to meet his particular need, but to the program in which the State obtains the best financial advantage. The Federal Government will pay 50 percent of the cost when the care is provided by the Crippled Children's Division; it will pay 56 percent under title XIX since he is on aid to dependent children and, if he is cared for by vocational rehabilitation, the Federal Government will soon pay 75 percent of the bill. Each of these programs have some variations in standards for eligibility, but nonetheless the differences in the Federal reimbursement seem extremely puzzling.

I would like to cite another example where we have some confusions coming up. There is talk now that the war on poverty, the OEO, is going to set up clinics and home nurse visiting groups instead of using official public agency nursing services that presently exist.

It is my belief that the States should rightfully look for overall nationwide leadership in the consolidation and integration of health efforts through a reorganization and realinement of health services on the Federal level, resulting in the creation of a strong, centralized Federal health agency. This does not necessarily mean a new and separate department. It could be a strong division within the present Department of HEW.

There is little question that the organizational pattern developed at the State level is in a large measure influenced by the Federal structure, again going back to this relationship that I mentioned earlier. Effective leadership demonstrated at the Federal level would surely be emulated at the State level.

The second point where we feel that Federal programs can be improved is in the field of restrictive financing which presently exists.

RESTRICTIVE FINANCING

The primary sources of Federal funds provided to the Rhode Island Department of Health are the U.S. Public Health Service and the U.S. Children's Bureau. These Federal agencies make assistance available to the State department primarily by two methods: the categorical formula grant method and the special project grant method.

The categorical formula grant represents funds made available for control of a specific disease, based on a formula. The actual amount allocated to each State is determined on the basis of population, extent of the health problem, and per capita income. States must match the Federal grant usually dollar for dollar and must submit and obtain approval of a State plan.

The current formula grants administered by the Rhode Island Department of Health include cancer control, heart disease control, chronic illness and care of aged, maternal and child health, crippled children, tuberculosis control, hospital and medical facilities planning and construction, radiological health, dental health, water pollution control, and general health.

With the exception of the modest general health grant, the moneys made available must be used specifically and solely for the purposes designated by the title of the grant. This is where the difficulty arises. Because of this, health departments are inevitably driven into the development of programs not because these are needs which are most urgent, but because these are the funds that are available.

In order to control a particular disease, the need must be identified, priorities must be established, and adequate resources must be available. The current Federal approach assumes that all States have identical needs, identical priorities, and equal resources. This, of course, fails to recognize individual differences in 50 State jurisdictions. My own State receives more than three times as much money for heart disease control than it receives for cancer control. Yet, at the moment, conditions are ideal for more effective programing in cancer control activities than they are in heart disease control activities

because of community interest and professional capabilities. This does not mean that heart disease money is not used wisely, but if heart disease control funds, cancer control funds, and chronic disease funds were combined, my department of health would have much more latitude in programing, and it would be more beneficial to the citizens of our State. It would result in meeting true local needs rather than theoretical Federal needs.

The restrictive nature of the various grants forces States to fractionalize staff and to hire accountants instead of nurses. Once hired, the nurse spends a great part of her time documenting her activities for the accountant so the proper program can be charged, rather than providing services to the patient.

I want to make it clear that States are appreciative of the Federal funds provided, and we look for additional support, but we need greater latitude in terms of program operation. We ask that Congress have confidence that we will use these funds in the areas of greatest need, which I am sure is what you want us to do. The needs of Rhode Island are not the same as those of Alaska, or Florida or North Dakota.

It is particularly depressing to witness the decreasing proportion of one of the smaller categorical grants—general health. Because this does not have the glamour of heart disease or cancer, it receives little money. Yet this grant is used to finance the basic functions of health departments, what we call the bread and butter programs, to which the other programs financed by specialized formula grants have been welded, over-welded, and cross-welded. The basic services it supports, so necessary to the specialized programs, are: local health services, general sanitation, laboratories, communicable diseases control, vital statistics, and health education.

The members of the committee, I am sure, are well aware of the financial difficulties experienced by State governments. Adequate financing of services poses the most serious problem a Governor faces. Additional Federal funds are helpful but not as helpful as they could be when such funds are segregated and restricted by outdated fiscal patterns.

On the Federal level over the past several years special project grants have become an increasingly popular method of initiating new health services. The special project grants differ from the categorical in that they are not distributed on population or need, but, rather, on the basis of an approved application. The projects are funded for a limited period and usually do not require matching.

There is no question the special project grant has served, and will continue to serve, a useful function in establishing the need for new services or for services in particular problem areas. However, so much has already been learned from these projects and other research activities that I believe we should sincerely consider providing more funds to translate what has been learned to action programs at the community level. In other words, we ask for more unrestricted grants.

In conclusion I would plea that there be greater flexibility in the rules and regulations drawn by HEW for its programs. Again the difficulty arises from attempting to draw tight rules which have to be applied in 50 different States where the situations vary so dramatically.

Let me illustrate: The Public Health Service requires that, to receive money as a community mental health center, the catchment

area—that is a term they use—must have a population between 75,000 and 200,000 people. It so happens that Rhode Island's Institute of Mental Health, which is State supported, serves our entire State of 900,000. Since we serve too large an area we cannot qualify, yet this is the very facility that should receive the money to upgrade itself.

I do hope that from your deliberations will emerge the decision to give the States far greater flexibility in spending Federal health moneys than presently exists.

I appreciate this opportunity to appear before you and thank you for the courtesies which you have extended to me.

Thank you, sir.

Mr. ROGERS of Florida. Thank you very much, Governor Chafee. This is an excellent statement and certainly points up the problems of actual experience that we are very much interested in hearing.

Congressman Younger?

Mr. YOUNGER. Thank you, Mr. Chairman. Governor Chafee, you say a few things about State and Federal relationship. One is the grants which require matching funds. Do you feel, as the Governor of Florida expressed one day, that for heaven's sake, this continuing of these grants is breaking us?

Governor CHAFEE. That is certainly a problem that comes up and I must say in fairness, not just with health grants, but with lots of other grants. We are enticed into the 50-cent or 25-cent dollars.

Mr. YOUNGER. Yes.

Governor CHAFEE. And you can't pass it up because you will be criticized, but if we had a choice we would say this is not our top order of priority. It may not be cancer control for our State. It may be heart diseases. Let us have some flexibility, but we don't dare pass up the money and, as you say, it is not quite breaking us, but it is putting us along the road.

Mr. YOUNGER. Do you feel it would be better, from both the State and the Federal Government standpoint, instead of making all of these various grants, that we return to the State a certain percentage of the income tax without limitation and let the State government apply that money wherever it was needed and give them that latitude?

Governor CHAFEE. I certainly do. This, of course, strikes home with a Governor because in so many programs the Federal money again, as I say, puts us into areas that aren't the top priority with us, and if we were given the money, I don't think the Federal Government has to be worried that we are just going to all run around and cut our taxes. I think they should have confidence that the people now are demanding the services and we have to give them the services and that we would give them these services in the areas that are of greatest importance to our people, but now the money is so restricted that we don't think it is being used as effectively as it might be, and, as I say, this isn't just in HEW; it is in the poverty programs; it is in the school assistance programs.

I think those are probably the best examples.

Mr. YOUNGER. That seems to be the difficulty. I know the difficulty in our own State of California. As you point out, with these specific grants, tuberculosis may be the top problem in one State, but the next State may not have priority on tuberculosis at all. It may be something else. As you point out, it isn't the heart trouble that you have.

It is the problem of cancer and that situation would need more of the money.

It seems to me that, with all of the grants and difficulties that we have, we could reduce the Federal situation from the standpoint of employment and everything else if we simply grant to the State on some kind of a basis—I think there is some proposal that a certain percentage of the taxes be refunded, half of it on the basis of the taxes paid and the other half on some formula so that under that formula the poorer States would get, probably, a little more than the larger States with heavy taxes. Then let the State work out where they can use the money to best advantage.

Governor CHAFEE. Yes, sir; I am very excited to hear you say that because, of course, this is something we are terribly interested in from the States' point of view and we feel that the people would be getting better services for less money if the States could administer it.

Mr. YOUNGER. Have you discussed that at all at your Governors' conferences?

Governor CHAFEE. Yes, they have. We have discussed it. It is often referred to there as the so-called Heller plan, and the difficulty comes in working out the formula, but frankly I wouldn't quibble too much over a formula if the principle could be established. I am speaking now for myself, and I think many of them feel the same way, but it has been discussed. It was discussed at considerable length in Minneapolis last summer.

Mr. YOUNGER. Thank you very much, Governor.

Governor CHAFEE. Thank you, sir.

Mr. ROGERS of Florida. Governor, I am very much interested in your testimony showing that a State has to deal with so many agencies within the Department on various programs covering the same health problem—for example, a child who may have a hearing difficulty. The State is then tempted to shop around, to find the aid program offering the greatest financial advantage to the State, even though it may not necessarily be the one geared to provide the best care for the child. In your example of a child with a hearing defect you say that the Federal Government contributes 50 percent of the cost under the crippled children's program, 56 percent under title 19, aid to dependent children, and 75 percent under vocational rehabilitation.

I would think this would be confusing for the State. How do you operate this way? How can you tell where the people will come for their aid? Do your State people try to guide them to those areas where the most Federal funds are, or how does this function? Maybe you would like Dr. Cannon to comment.

Governor CHAFEE. Yes, Dr. Cannon is with me and perhaps could help on that.

Dr. CANNON. Yes, sir; this does get quite confusing not only to State government, but also to the doctor who is taking care of the case and the family that case is a part of. Some mechanisms have been tried like an information and referral service, which is relatively successful.

However, basically, I think we find that usually they will call the health department. The doctor will call the health department or the parent will call the health department. We look at the case and it takes considerable time, which we are happy to do, but we find often

we then refer them to a program outside the health department, usually because of the financial situation.

There may be instances where they are not eligible for vocational rehabilitation because they would not be employable at a later date. We might pick up that case just because it has a potential for some type of rehabilitation, rehabilitation not for employability, but rehabilitation so they can lead a more satisfactory life.

There are other examples of the same thing. We have some clinics for the mentally retarded in Rhode Island and these are supported in large part by Federal funds so far. May I take this opportunity to say that over a period of many years I have worked very closely with the people in the Public Health Service and the Children's Bureau. They are always helpful within the limitations of what they can do and are competent, dedicated people. So, certainly we are not criticizing them.

We have set up an office of mental retardation in Rhode Island which the Governor has chosen to put in the health department. This is supposed to develop interdepartmental relationships and we are to try to pull the various programs together, whether they be in education or elsewhere. As we look at this and try to establish as a part of this program a handicapped children's center we find that we may be dealing with the Public Health Service, the Children's Bureau, the National Institute of Mental Health, vocational rehabilitation, labor, and utilize all of the various funding mechanisms. When you try to develop such a center and take the patients that come in and fund them through all these little chopped up pieces, it gets very, very difficult.

I don't know whether I have answered your question.

Mr. ROGERS of Florida. Yes, thank you. You have. I notice, too, along the same line, Governor, you pointed out in your statement that you almost have to hire accountants rather than nurses now to get the help, because there is so much redtape and so much fractionalization in your health programs. Maybe Dr. Cannon could comment on that for us, too.

Dr. CANNON. Again, sir, we are a small State and again I am not being critical. I work for a government and if I have certain rules to go by, I go by them, but since we are small the radiological health grant, as an example, is a very small grant compared to yours, sir, in California.

As I recall, for Rhode Island it was somewhere around $14,000. Well, again, we have many priorities in Rhode Island and Governors have many priorities and so do legislators. Sometimes when the Federal money is available the cash isn't available from the State to match it, because you have a budgetary process in the State. But we do want to try to do something about radiological health, so we will try to take part of the time of our occupational health personnel, perhaps add another person to the staff. Then in the area of radiological health and occupational health we may have three people. They then have to keep time sheets of what they did every 15 minutes in order to justify the utilization and expenditure of the Federal money.

This is all right. We have to do this, but with all the brains that there are here in Washington, with all the administrative ability that there is here, there may well be some mechanism that could be devel-

oped, that could be looked at to see how we could make this a little simpler and a little broader.

Mr. ROGERS of Florida. It is my understanding that a public health nurse often may go to a home to treat, say, a TB patient, because there are funds for this. She may find a child there that needs some other treatment, but since she is only funded from TB she may not be able to treat the child, and therefore you have to send out another nurse funded from another program. Would this be true?

Dr. CANNON. This is exactly right, sir. May I say that I think the good public health nurse is perhaps the greatest case finder of diseases in any given community, if she goes in with the family-centered approach and not with a categorical disease approach. She not only looks at the child, but at grandpa and grandma, and the rest of the family.

This is a good generalized public health nursing service, but if our funds are so established for maternal child health, tuberculosis, that we just go in with a tuberculosis nurse and don't look at anybody else, this is a serious mistake.

However, this is what you have to do unless again she keeps a time sheet on all those factors. So in any local health department you keep the time steet and you balance them all, in the long run. This takes a lot of time from a nurse who is a nurse and ought not to be bothered with the bookkeeping. However, she must be bothered with bookkeeping because this is the process.

Mr. ROGERS of Florida. This points up then the problem that you have stated of the Federal Government giving the funds, channeling the funds, for categorical diseases, rather than funding general health programs and letting the State place the money where it would do the most good in that particular State.

Dr. CANNON. This is my feeling, sir; yes, sir.

Mr. ROGERS of Florida. I would share that feeling. I think this is of great concern that health programs are getting to involve so much redtape and that this results, I would think, in a grossly improper use of manpower where you may have to send two or three nurses out to the same home or else make them do so much paperwork that the nurses cannot operate efficiently.

Dr. CANNON. When the amount is small it is hardly worth the time and effort to document it. Occasionally, we do not use the funds because of that reason.

Mr. ROGERS of Florida. Let me ask you one other question. I was very much interested, Governor, on page 2, where you say: "Starting July 1 of this year, our State health department will take over all local health services now being provided by the different cities and towns in the State. The State will have the only health department in Rhode Island."

Could you comment just a little bit about how this was brought about and the reasons and the results that you expect to obtain?

Governor CHAFEE. This was brought about through legislation and the feeling that ours being such a small State, with only, as I say, about 900,000 people and about 1,000 square miles, that instead of having the proliferation of a variety of health departments and some of the towns not having any health departments, it would be best for the whole thing to be run by the State. We can travel from

one end of our State to another in an hour and a half so that the travel isn't a problem. The communications are not a problem.

The financing, I will admit, will be a problem for the State, so that as of July 1, all the State health facilities will be concentrated in the State health department. The local communities will keep some functions such as nuisances, but I believe that is about all they will keep. All the health functions, the nursing service, and so forth, will be in the State health department. I am sure this is the only State in the Nation where that will be true.

Mr. ROGERS of Florida. Did you have any comment that you might like to make on that?

Dr. CANNON. No, sir. In general, we would prefer to have had regional or metropolitan counties get together or cities get together, but this has not worked. To get the job done we can get it done no other way. We hope that the cities and towns will take care of the dead cat in the alley and things like that.

Mr. ROGERS of Florida. Let me ask you this: How do you keep up with what agency you go to in the Federal Government to get funds? Do you have anybody in your department that devotes time to this?

Dr. CANNON. No, sir. We have a small department. In some departments we have people that concentrate on this, but we are small and try to do it within our own framework by whoever is responsible for a particular program. The Federal agencies are most helpful in telling us what is available, how it might be used, and encouraging us to get into some programs.

Mr. ROGERS of Florida. I appreciated your letter that was sent to me, Dr. Cannon, as chairman of the subcommittee, on the Governor's statement already made, and without objection, I will make this a part of the record. Thank you very much.

(The document follows:)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
DEPARTMENT OF HEALTH,
Providence, April 15, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: As you know, my Governor, John H. Chafee, will appear before your committee on Monday, April 18, 1966 at 10 a.m. to present a statement with which I am in complete accord.

The statement will not include the following personal opinions of mine:

1. I believe that the State mental health activities of the National Institute of Mental Health should be transferred to the Bureau of State Services.
2. I do not believe that the National Institute of Health should be withdrawn from the Public Health Service.
3. I do not believe that the Department of Health, Education, and Welfare should have a centralized Bureau of Grants for all health activities.

I hope to be present with Governor Chafee at the hearing on April 18, 1966.

Very truly yours,

JOSEPH E. CANNON, M.D., M.P.H.

Mr. YOUNGER. On that same subject, Mr. Chairman, evidently you do not have your county welfare organization as we do in California, and because of the booming economy that we are supposed to have and very little unemployment, I thought the welfare rolls would

be down, and I wrote to Dr. Choate, our welfare director, and was surprised to find that in every category the welfare rolls were going up. In other words, higher than they were a year ago, except in one category, and that was the category in which there were no Federal funds.

It was all funded by the county. In that category they had gone down. Do you think that there is a tendency on the part of the States to try and classify these cases where they can get the Federal funds available instead of funds locally?

Governor CHAFEE. Yes, sir; there is no question about that. If there is a program available where there is 100-percent Federal financing or partial Federal financing, we shift them over, provided they are eligible, and there is no secret about this. We feel that it is advantageous to our citizens, and if the money is there and the Federal Government has provided this program, we do the shifting.

Mr. YOUNGER. Kind of a care proposition.

Governor CHAFEE. Yes. Just as I mentioned in my testimony, you head toward where there is the maximum Federal financing.

Mr. YOUNGER. One other question to the doctor. Undoubtedly, on July 1, we are going to be rather hard pressed for hospital facilities. I know your State is quite progressive. How do you feel when this medicare program starts? Are you going to have sufficient hospital facilities?

Dr. CANNON. I don't think so, but I think it won't take too long before they are developed with some, again, Federal assistance in the proper areas. I think my biggest concern in Rhode Island is in the area of the home nursing services and in the area of the extended care facilities. We will be in much better shape as far as hospitals, general hospitals, are concerned than we will be for home health services and for extended care facilities.

Mr. YOUNGER. I was gone for a week, but this morning one of the girls in the office who lives in Virginia said there was quite an article in the paper that the President had asked the State not to expand either their colleges or their hospitals. Have you had any such request?

Governor CHAFEE. I received a request from Governor Bryant's office requesting us to keep capital construction at a minimum in line with the President's request due to the inflation situation. As I recall, it did not specifically mention hospitals or universities.

Mr. YOUNGER. That seems to be this story. I haven't read it yet, but one of the girls that lives in Virginia was calling it to my attention and I certainly can't see any occasion for it because if we do not expand our hospital facilities we are going to be in a dire need, as well as in the nursing expansion.

Governor CHAFEE. We feel in our State that trend is going to be toward using the hospitals much more for intensive care and then moving them either within the hospital to more limited facilities or out to the nursing homes faster so we feel with the growth of the nursing homes in our State that that will relieve much of the strain on the hospitals. The nursing homes will have to be upgraded, but we think

that the demand for the intensive care rooms will not be so great if we can get the physicians and the hospitals accustomed to moving them on.

Mr. YOUNGER. But there will have to be an expansion in that field, will there not?

Governor CHAFEE. Yes, sir.

Mr. ROGERS of Florida. Congressman Gilligan.

Mr. GILLIGAN. Thank you, Mr. Chairman. Governor or Doctor, would you say that you presently experience in your State any shortage of nurses, doctors, dentists, and other professionally trained people in the field of health care?

Dr. CANNON. Our physician population is quite good, not quite as much perhaps as we would like, and certainly not as many graduates of American schools as we would like to see. Our nursing situation is more critical. We do need more nurses. We are shorthanded, although I think in comparison with many States we are quite well off.

Mr. GILLIGAN. Have you any opinion on the legislation recently adopted by Congress in an effort to increase the supply of professionally trained medical people?

Dr. CANNON. Yes, sir.

Mr. GILLIGAN. Has it had any discernible effect in your State, or do you see in the future any beneficial effect?

Dr. CANNON. Yes, sir; I do. We are already seeing some of this in the lower echelons of professional personnel and I am sure it will go on into the rest.

Mr. GILLIGAN. Governor, one other question that I have, which is a rather theoretic one, if you will. Your statement was directed to the matter of health services, direct health services, to patients and so forth in your State and of the problems involved with your State facilities attempting to work under programs laid down by the Federal Government in these fields. One of the other great fields that the Public Health Service presently has control of through its Bureau of State Services is one that I am quite interested in: the field of research and study of things like environmental health.

These programs have been carried on for a long time by the Public Health Service at the Federal level. There are some proposed changes in this setup today within the Department of Health, Education, and Welfare and within the Public Health Service; for instance, the removal of the water pollution control operations from the Public Health Service now, indeed from HEW, into the Department of the Interior. Would you have any comment generally on the programs carried on in the field of environmental health by the Public Health Service presently, and specifically any comment about the effects, beneficial or otherwise, which you might see in the transfer of the water pollution control activity into the Department of the Interior from the Public Health Service?

As I say, that is a pretty theoretic question.

Governor CHAFEE. I will let Dr. Cannon answer that.

Dr. CANNON. No; I don't feel that this is advantageous at all to transfer the water pollution agency out of the Public Health Service. It has had a long and good record, and things could be done if they were given to them to do with greater opportunity.

I read something in the Washington paper about the school department in Washington. What they do in the school department in Washington is none of my business, so I am only going to say this: That they say that the school department program should be transferred out of the Department of Health in the District of Columbia and transferred to the school department. I can't see that this does any good at all because if you are going to have this same type of family centered service that we talked about, it is only another step toward fragmentation. The complaint was that they had to wait too long for examination. This is primarily a question of funding and personnel, not where it is located. I think this same principle applies as far as I am concerned—this is a personal opinion—about transferring the water pollution agency out of the Public Health Service.

Mr. GILLIGAN. Thank you, Doctor and Governor.

Dr. CANNON. They have had excellent environmental health training programs for us and they have done a lot of good research besides.

Mr. GILLIGAN. Thank you, sir.

No more questions.

Mr. Rogers of Florida.

Mr. Nelsen?

Mr. NELSEN. I note in your statement that you are suggesting greater flexibility in the use of funds that are allocated to the various States by the Federal Government. I would agree that there seems to be that need, and as I recall a presentation by HEW at a White House meeting one evening that it is the intention of HEW to use a rule of greater flexibility as far as the various States are concerned. As I recall, the only specific identification was for mental health and mental retardation. Beyond the amount that would be used for that activity the rest of it would be used in a manner that would fit the circumstances within the State itself.

I would gather from your statement, which I quickly glanced through, that that would be your feeling, that this would make a better program. Is that not true?

Governor CHAFEE. Yes, sir, that is correct, and even in mental health and mental retardation we are planning to set up a diagnostic clinic to which the child would come and we will look at the whole child, not just from a mental health or mental retardation standpoint. We will look at him from a crippled children's point and everything.

If we again have to charge so much time for mental health, and so much time for mental retardation, and so much time for crippled children, it gets complicated.

Mr. NELSEN. There is another point that I would like to mention. It seems to me that now with medicare, and with the proposed International Health Education Act, with our activities in mental health, and the many other programs which have been established, the big problem seems to be that of providing personnel who are trained to handle the job that has been laid out for them.

Do you find in your State a shortage of professional people that are trained in all these health services. Does your State have this problem?

Governor CHAFEE. Yes, sir; we do. We have this serious problem. For instance, mental retardation has really come of age, if you would, and getting competent people in this field is extremely difficult. Everybody is looking for them. It is a seller's market.

Mr. NELSEN. In title III of that act there is a provision for stimulation of personnel training. Is there a great deal of activity in your State to train personnel in that area? Have you the facilities? What is being done?

Dr. CANNON. No, sir; there is not as yet.

Mr. NELSEN. This committee recognized at the time the bill was passed, that one of the important functions of the program was that of training adequate personnel and therefore we provided in title III provisions for stimulation of training of personnel so that the job may properly be done. We are trying to do the same thing in other areas because we do find that one of the great problems is the people to work in the various programs. Bricks and mortar do no good unless you have people there to make use of the facilities. I am hopeful that we may be able to stimulate the activities that need to be stimulated.

Thank you.

No more questions.

Mr. ROGERS of Florida. Although you commented some, I just wanted to get this clear in my own mind now. One of the significant features of the present HEW structure is the separation of mental health activities from those of general physical health. Do you see this as an advantage, or is it a disadvantage, and should this be changed? Just a general statement.

Dr. CANNON. Quite frankly, I feel that mental health is a part and parcel of total health and the psychiatrist is a physician, and that mental health has really been separated from the main stream of medicine too much already. I do believe that the community mental health program should be a part of the total health program. I can't conceive of a separate mental health clinic or building, which I have heard of, where there is also a public health building. I cannot conceive of a mental health nurse going into the family—we are going right back to the old categorical approach, when there were public health nurses there. As much as possible a community mental health

program, I would think, should be tied into the mainstream of public health service.

I do recognize in big States like California and New York that the magnitude of the institutional program for the mentally ill is so tremendous as to almost require a separate identity.

Mr. ROGERS of Florida. Let me ask you this, and if you don't have this figure available you can supply it for the record and it would be perfectly all right. What would you say is the percentage of your total health budget that is composed of Federal funds?

Dr. CANNON. Quite frankly, it has been in the past very high, almost 30 percent as I recall last year, not counting construction and special projects.

Mr. ROGERS of Florida. About 30 percent?

Dr. CANNON. Yes, sir.

Governor CHAFEE. That is operating, not counting construction. Those would be operating funds.

Dr. CANNON. This July, with two new programs added it will be about 22 percent because we are adding over a million dollars for local health services and some $300,000 for community mental retardation services.

Mr. ROGERS of Florida. From State funds?

Dr. CANNON. From State funds alone. I could get those figures for you.

Mr. ROGERS of Florida. If you could we would appreciate it.

Dr. CANNON. I will send those to the committee.

(The information follows:)

Federal grants (Rhode Island, 1963–67)

	Fiscal year 1963	Percent	Fiscal year 1964	Percent	Fiscal year 1965	Percent	Fiscal year 1966	Percent	Fiscal year 1967	Percent
Public Health Service:										
General health	$64,400		$55,300		$42,700		$43,300		$43,400	
Cancer	25,000		25,000		25,000		25,000		25,000	
Heart	67,700		67,500		67,600		93,900		93,900	
Chronically ill and aged	61,600		61,800		60,000		60,000		60,000	
Tuberculosis	17,300		15,600		16,900		16,200		16,200	
Radiological health	15,000		15,000		15,000		15,000		15,000	
Water pollution control	58,500		58,000		58,000		58,300		57,400	
Dental health					10,000		12,500		12,500	
Hospital and medical facilities program administration					13,070		21,788		21,788	
Home health service							75,000		75,000	
Children's Bureau:										
Maternal and child health A	107,600		106,839		129,330		151,706		163,062	
Maternal and child health B	35,000		35,000		45,000		55,000		60,000	
Crippled children A	108,430		107,745		129,388		150,739		161,391	
Crippled children B	35,000		35,000		45,000		55,000		60,000	
Total, Federal grants	595,500	28	582,800	27	657,000	27	833,400	30	865,600	22
State appropriations	1,494,400	72	1,563,500	73	1,759,900	73	1,922,000	70	3,155,300	78
Total, Federal and State	2,089,900		2,146,300		2,416,900		2,755,400		4,020,900	

Mr. ROGERS of Florida. Are there any other questions?

If not, we are very grateful to you, Governor and Doctor, for being here. It has been most helpful to the committee and if you have any further suggestions as our hearings proceed we will be delighted to have them at any time.

Dr. CANNON. May I just make one comment that relates to a comment from Congressman Nelsen. I think one of the concerns we have about personnel relates to the availability of present health personnel, and particularly administrative personnel in public health areas. They are scattered hither and yonder. We better pull them together so we can make the most effective use of those that we presently have.

Mr. ROGERS of Florida. Thank you very much.

Governor CHAFEE. Thank you very much, sir.

Mr. ROGERS of Florida. Thank you.

Our next witness is Dr. John H. Venable, who is director of the Georgia Department of Public Health. We are very pleased to have you with us, Doctor, and we are grateful to you for taking time to present your views to the committee.

STATEMENT OF DR. JOHN H. VENABLE, DIRECTOR, GEORGIA DEPARTMENT OF PUBLIC HEALTH

Dr. VENABLE. Thank you, Mr. Chairman and gentlemen of the committee.

Governor Chafee and Dr. Cannon have done such a good job, if I may save the committee's time I will make a few comments rather than read my statement.

Mr. ROGERS of Florida. Either way will be fine and your statement will be placed in the record at this point without objection.

(The statement follows:)

STATEMENT BY JOHN H. VENABLE, M.D., DIRECTOR, GEORGIA DEPARTMENT OF PUBLIC HEALTH

Mr. Chairman and gentlemen of the special subcommittee, the privilege of speaking to you today is deeply appreciated particularly because this hearing is only further evidence of the widespread concern of all who have responsibility for the health of the people of this nation, the President, the Congress, the Governors, and legislatures of our several states, and official, voluntary, and professional associations. All indicate by their actions, their studies, and their deliberations a search for more effective cooperative efforts, their concern for the shortening of time between the discovery of scientific health knowledge and its application to those in need, and a recognition of the part organizational patterns must play. I am especially appreciative of the efforts and attitudes of this Subcommittee seeking to provide the ultimate in federal, state, and local relationships for health.

Explosion of scientific knowledge in recent decades has been paralleled only by our industrial and economic advances. Earnest and continuous efforts have been made at all levels of government to translate this knowledge into immediate benefit for all our people but the large measure of success in individual efforts, no matter how heroic, cannot overcome inadequate funds or outmoded organization.

I represent, as director of the Georgia Department of Public Health, a state which has done much pioneer work in the organization and mobilization of state resources devoted to the goal of strong local health departments comprehensively serving the people within their jurisdictions. As one of the fifty states, we have almost exactly one-fiftieth of the national population but out of an average income substantially below the national average we have committed a high percentage to health affairs. Our organizational pattern has

been substantially changed four times in the last fourteen years and is on the verge of a fifth major revision, in order to better deliver the services for which we are responsible. Georgia, itself, has changed remarkably over the past few years. But need for organizational change has stemmed as much from the advances in health knowledge and the techniques for delivering the benefits thereof as from our industrial, social, and demographic change.

In Georgia, we have perhaps the greatest concentration of health responsibility in a single agency among the fifty states. We are the public health authority, the hospital and medical facilities planning and construction authority (Hill-Burton, now Hill-Harris), the mental health authority, and have been named by our Governor as the responsible agency for community mental health center construction, community mental retardation center construction, the air pollution control authority, and are the responsible state agency for Title 18 of Public Law 89-97. Moreover since 1959, our agency has had the responsibility for all state mental hospitals, schools for the mentally retarded, and for the alcoholic rehabilitation program. Only water pollution control responsibility is not wholly within this agency, having been placed two years ago under a separate Water Quality Control Board, one member of which must be from our Department and its executive functions housed and associated as a Division within the Department.

Within this wide range of responsibilities, including the crippled children's and maternal and child health programs in cooperation with the Children's Bureau, we deal with most of the federal grant programs for health including:

Formula Grants:
- Tuberculosis Control
- General Health
- Cancer
- Mental Health
- Heart Disease
- Chronic Illness
- Radiological Health
- Dental Health
- Home Health
- Water Pollution
- Maternal and Child Health A
- Maternal and Child Health B
- Crippled Children A
- Crippled Children B

Project Grants:
- Venereal Disease
- Tuberculosis
- Vaccine Assistance
- Office Economic Opportunity
- Mental Retardation
- Hospital Improvements
- Maternal and Infant Care
- School and Preschool
- Cancer Demonstration
- Training (various)
- Planning (mental retardation and mental health)

Contract Funds:
- Draft Rejectees
- Aedes Agypti
- Training (various)
- Medicare

Such fragmentation of grants naturally has led to fragmentation of both organization and service at the state level. Significant contributions to health services have undoubtedly resulted from the visibility and subsequent emphasis on program entities but at some significant cost in comprehensiveness and continuity of service.

Most scientific knowledge has resulted from the effective use of the fragmentation process. The anatomist has had to dissect, tear apart in order to learn. The bacteriologist requires a pure culture of bacteria for study. The physiologist must isolate cells or tissues to study their function. And the experimentalist must fragment his problem in order to reduce his study universe to as few variables as possible for true objectivity.

But there comes a time, both in research and in program administration, when the bits and pieces must be again brought together into a comprehensive whole if they are to be effectively applied to the universe of which they are a part.

Comprehensive health services require a comprehensive approach, a strong nucleus of coordinated services as the platform or base from which the newer and more experimental advances can be launched until our skill is such that they also can become a part of the vital, comprehensive whole.

It seems to me that we have reached the synthetic stage in many of our federal and state establishments for health, that we are at a point where we can view with pride the many individual accomplishments of the past but never-the-less lack the final synthesis into a comprehensive coordinated whole. We are still enamored with the brush strokes rather than the painting, the tiles rather than the mosaic.

The work of this Committee is absolutely essential to the continued improvement and vitality of organized health services.

The multiplicity of federal agencies involved in the administration and distribution of federal health funds is surpassed only by the categories of funds to be distributed. As I have tried to point out, this is no surprise but rather the way one would expect it to have evolved. A health problem becomes visible; people become concerned; and it appears that state or local agencies could, with financial support, reduce or solve the problem. That is when a categorical grant-in-aid program has come into being. Some two dozen of these are now in existence and have done much to improve our health services. But vith such proliferation of grant programs, each with its responsible and interested administrative agency, many problems are sure to develop, such as:

(1) The distribution of formula grant funds on a population basis falsely assumes that:

(a) There are only those needs for which a grant is available or that grant-aided programs have the highest priority.

(b) There is equal readiness in personnel, resources, and public acceptance from community to community or state to state.

(c) There is an adequate core of general and supportive services on which to base the categorical effort.

(d) State or regional differences in need or cost of correction of a problem do not require authority for discretion in application of resources.

(e) There is no need for some authorization to transfer from one category to another.

(2) Validation and accounting procedures, through their insistence on following the federal dollar, stimulate creation of:

(a) Organizational units for each grant-aided program.

(b) Reporting requirements with emphasis on activity rather than accomplishment.

(3) Health funds have been appropriated and administered under limited authorizations in contrast to welfare funds which in many cases are "open ended."

(4) Categorical formula grants, for various reasons, have developed many formula variations thus creating:

(a) Complex state budgetary procedures.

(b) Difficulties in passing federal funds on to counties and municipalities because of

(c) The complexities of the validating and accounting procedures.

It is no small wonder then that such diversity in grant-in-aid patterns has tended administratively to fragment the state health agency, the recipient, for what is more natural than to establish a new unit or organization to cope with the problems of a new grant program. Since the need is not equally distributed there have been instances where the allotment was larger than needed because of the method of appropriation and administration and funds not needed for this program could not be transfered to meet other serious problems or to "beef up" the general organization so necessary for operational support.

Some of these difficulties will be eliminated by the passage of H.R. 13197 now before the Congress but even this legislation will be less effective without either better coordination between federal agencies distributing grant funds or reduction in the number of agencies and grants with which the state must deal.

In Georgia where federal categorical formula grants are exceeded by state appropriation in a ratio of more than four to one, we have coined the phrase "planning by appropriation" to indicate the effect in program expansion of a small increase in a categorical grant. If this happens to us, where we are significantly overmatched in most categories, it is frightening to think of the serious effect such changes may have in a state which is barely able to meet its matching requirements.

One further point in relation to this problem is the difficulty in state health administration that arises when decisions of minute operational procedure are made by the granting agency. Rules and regulations or policy are made in large part by people who have had no state experience or have had state experience some time ago. No matter how fair and equitable such policy is, however, interpretations by people in the home office or in the field create frequent instances of interference with effective operation. The more agencies and staffs involved, the greater this problem becomes. To cite one instance, for example, our agency had a running argument over a period of almost three years with

three federal agencies at the regional level relative to the qualifications of social workers to be employed in a certain grant-aided program. The question hinged around the Georgia Merit System interpretation of the word "desirable" as opposed to the federal position that certain qualifications should be "required" of social work personnel. Now we support high qualifications, training and experience for all of our personnel in-so-far as they do not exclude us from the market. Social workers in Georgia, well-trained at the master's level and with experience are very few in number. The word "desirable" was an absolutely essential safety valve permitting us to employ highly qualified people if available but also permitting us, for the sake of the program, to accept somewhat lesser qualifications in case of necessity.

While I realize and support the reason for maintenance and support of standards, I think perhaps there is another factor involved and that is the apparent lack of federal agency confidence in the state's ability to do an adequate job. Admittedly the reverse may also be true. The reasons are not hard to understand. While the impression seems to be that each may feel the other not as devoted, as well trained, nor as interested in high standards as those who have no better training who work in the federal establishments, I am sure this is largely due to failure of communication and lack of understanding. You may recall some twenty years ago, with the initiation of the most important and effective Hill-Burton legislation, that there were those who argued that state health departments were not competent to do the amount and quality of planning necessary for this important program. Such responsibility was new to many state health departments but only a cursory look around the country today will prove to any objective observer that, by and large, states have done an outstanding job in this program and continue to do so. States need more assistance in planning; they need more personnel trained in many highly technical aspects of planning but it seems to be self-evident, supported by all the observations that can be made, that for their own jurisdictions state health departments and their staffs are highly competent planners if permitted to do so without undue influence of policy or funding; if permitted to be equal partners in the job.

The fewer the organizational units, the fewer and more effective are the lines of communication out of which grow greater respect, understanding, and effectiveness. We must work at this at both state and federal levels.

I would be delinquent, Mr. Chairman, if I did not say a word to you in relation to the problems created by the present form and administration of project grants. I would suspect that the project grant concept developed within federal agencies for two reasons primarily. First, the inflexibility of other grant programs made it desirable that funds with greater flexibility be made available for the investigation and demonstration of certain problem areas. Secondly, it has been my observation that in governmental activity one finds it easier to point with pride to activities rather than to actual accomplishments which are harder to measure. Activities resulting from project grants were more easily visible and could naturally be more completely reported in justification for additional funds. This is not a criticism of the concept of project grants but this, I think, is the mechanism that has led to their abuse. It is more and more necessary under present conditions to consider the project mechanism as an inescapable one if programs are to be adequately funded. This has led to the compounding of complexity of administration at the state level, to a number of abortive efforts to reach certain goals, and to the necessity of attempting to devise a means for financing a continuing program through dovetailing and careful timing of project grant applications. This has led to putting a premium on "grantmanship" with the state or local agency having the greatest ability in devising an application receiving the greater financial support regardless of the seriousness of the problems it has to solve.

Project grants have their role, an extremely important one, but not as a mechanism of supporting ongoing programs. We must sharpen and restrict the use of this tool to projects, demonstrations, etc. which are so necessary to the improvement of health services.

The project grant mechanism, perhaps partly for the reasons mentioned above but also because of certain other factors which I am not competent to discuss with this Committee, has been the mechanism by which state health agencies are being by-passed more and more frequently by federal agencies in a federal-local relationship. Let me say very quickly that competent local health agencies need funding just as seriously, if not more so, than state

health agencies. Here again fragmentation is a problem. The local agency can be concerned only with its own jurisdiction and not with those contiguous with it. The concern of the state health officer is total health planning and total health programs for his entire jurisdiction and when by-passed he is completely helpless in planning for total health services. This problem could be easily solved through the use of the state health agency as a link in both directions in federal-local relationships with improvement in both quality and distribution of services.

One other brief point before I summarize is that of the make-up of study sections and committees who act as advisers to federal health agencies and make decisions as to the validity and priority of research applications and particularly of project grant applications. I would be the first to admit that objective, scientific manpower is concentrated in our universities but I would also be the last to admit that this is the only sea of such expertise and submit further that the practical experience gained in service operations is equally as important in the consideration of such grant applications. I believe that this study section review would be far more effective if some way were found to diversify the make-up of the sections by the involvement of many more service agency viewpoints while maintaining a reasonable contingent of university personnel.

I have tried to present to you the view that the present federal-state-local relationships for total health service have been most effective in the past and are found in their present patterns as a normal stage in the evolution both of health knowledge and the problems of distribution thereof. I have further presented the viewpoint that what has been effective for the last decade or more is not likely to be nearly so effective in the next decade or two because of the explosion in health knowledge, the lag in time that has developed between its discovery and its application and the problems of administration and distribution within the state and local health jurisdictions. How effective action can be taken, I do not know in detail but would suggest that it must be the one or the other of two mechanisms or perhaps a combination of both. One of these mechanisms is through reorganization of health agencies. We have found that we must almost continuously be studying our organization to remain effective and, now perhaps, it may be time for changes in the organization of the federal health agencies. The other mechanism is the development of a better organizational or coordinative process for federal health units and agencies seeking a pattern that can be useful in state and local organizations. I have simply tried to state the problems and the goals with full confidence that you gentlemen, together with your colleagues, will be able to devise the means by which these problems will be solved and these goals attained.

I believe that, for many reasons, there is now a recognition at the national level of the need for continuing federal support both of basic ongoing health services and of developmental and research programs. If this is true it is essential that it be carried out in the framework of appropriate organizational and funding patterns and with an emphasis on the mechanisms of effective communication and understanding between agencies at the same level and at all levels of government.

Thank you very much!

BIOGRAPHICAL SKETCH OF JOHN H. VENABLE, M.D.

John H. Venable, M.D., Director of the Georgia Department of Public Health, has served both in public health and as a faculty member of the Emory University School of Medicine.

A native of Atlanta, Doctor Venable was graduated from the Emory University School of Medicine in 1933. He was a member of the Emory Medical School Faculty from 1934 until 1946.

In 1946, he accepted the position of commissioner of health for Whitfield and Murray Counties. He became commissioner of health for Spalding, Pike, and Lamar Counties in 1950.

He attended Tulane University and received a graduate degree in public health in 1951.

In 1952, Doctor Venable became director of the State Health Department's division of training. Later, he assumed responsibility for the health educa-

tion activities and became assistant to the Director of the Department in 1954. His term as state health director began on January 1, 1960.

Doctor Venable is a member of Phi Beta Kappa, national scholastic fraternity; Omicron Delta Kappa, leadership; Sigma Xi, scientific honorary; Alpha Kappa Kappa, medical; and Delta Omega, professional public health. He is a member of the American Medical Association, a Fellow of the American Public Health Association, and a Diplomate of the American Board of Preventive Medicine.

Doctor Venable is current President of the Conference of State And Provincial Health Authorities of North America, and Vice-President of The Association of State and Territorial Health Officers (1966).

Dr. VENABLE. I appreciate very much the opportunity of speaking to you this morning because I think this is just another evidence of the extreme national concern that is being exhibited in many ways about the need to bring the results of the laboratories and research to the services to people as quickly as possible. I speak from the standpoint of a State in which we have done a great deal of pioneer organization for health and would say to you gentlemen that we have found that we do need continuously to review our organizational patterns in order to do the job that has been given us to do in the most effective way.

As a matter of fact, we have changed our organizational pattern for health four times in the last 14 years and will change a fifth time July 1. These changes are needed not only because of the explosion of health knowledge of which we are all aware, but because of the change in our population and in our problem.

In Georgia we have perhaps the greatest concentration of health responsibility in a single agency within the 50 States. We are the public health authority, the hospital and medical facilities planning and construction authority, and the mental health authority.

We have been named by our Governor as the responsible agency for community mental health center construction, community mental retardation construction, the air pollution control authority, and are the responsible State agency for title XVIII of Public Law 89–97.

Since 1959 our agency has had the responsibility for all State mental hospitals, for schools for the mentally retarded, for alcoholic rehabilitation programs. Water pollution control is partly in and partly out of the Department, and we, of course, are the responsible agency for the crippled children's program and for the maternal and child health programs supported by the Children's Bureau at the Federal level.

I have listed on page 3 of my statement some 29 grants from the Federal Government with which we have to deal, and this is not an exhaustive list. I have categorized these into the formula grants, the project grants, and the contracts with which we work. And I would point out to you that while most of these grants are on a 1 to 1 matching basis, they run all the way from 20 percent State for the OEO program through 25 percent, 33⅓ percent, and the 50 percent of the 1 to 1 matching programs.

This, of course, is evidence of fragmentation, but I would say a word for fragmentation before I criticize it. Fragmentation is a very important process, gentlemen, in many areas of health. The anatomist has to dissect in order to learn the structure of the organism with which he is dealing. The bacteriologist needs a pure culture for his studies. There are many other illustrations of the need for fragmentation as we develop our scientific knowledge.

I would suggest that these grants programs develop in the same way as the need is recognized for people to become interested in that need and there is a program that develops a grant program, in most cases, for the solution of this problem.

On the other hand, if we do not put these things back together into a comprehensive whole fragmentation presents its most serious defects and I submit that we are probably at the stage now where we can look back with pride as to what has been accomplished through this fragmentation, but we look ahead to the absolute requirement for a resynthesis of these various programs into a comprehensive whole if we are to provide the services, both environmental and personal, that are needed by our people.

In such a fragmentation process and learning to deal with it there are many problems which have developed which I think would be largely solved if we do resynthesize both our activities and our organization. These I have listed for illustration beginning on page 4 in my statement. The distribution of formula grant funds on a population basis falsely assumes that—

(*a*) There are only those needs for which a grant is available or that grant-aided programs have the highest priority.

(*b*) There is equal readiness in personnel, resources, and public acceptance from community to community or from State to State.

(*c*) There is an adequate core of general and supportive services on which to base the categorical effort.

(*d*) State or regional differences in need or cost of correction of a problem do not require authority for discretion in application of resources.

(*e*) There is no need for some authorization to transfer from one category to another.

The second problem is that validation and accounting procedures, through their insistence on following the Federal dollar, stimulate creation of organizational units for each grant-aided program; reporting requirements with emphasis on activity rather than accomplishment; health funds appropriated and administered under limited authorizations in contrast to welfare funds which in many cases are "open ended"; and categorical formula grants, for various reasons, have developed many formula variations thus creating complex State budgetary procedures, difficulties in passing Federal funds on to counties and municipalities because of the complexities of the validating and accounting procedures.

In Georgia where our matching funds exceed by more than four times the funds coming in through Federal grants we have noticed that a variation in the level of the Federal support will create immediate and serious changes in the level of activity in the various programs, even though we are matched by more than four times the minimum amount.

It is frightening, therefore, to think of the effect that such changes in Federal funding may have in those States where the matching is only barely enough to meet the requirements of the the Federal grants. More important I think in this fragmentation process has appeared the trend toward fragmentation of organization, the multiplicity of agencies or units within agencies that are necessary to administer these programs.

I realize that the organizational pattern must, to some extent, follow this mechanism, but with additional communication, additional confidence between the Federal, regional, State, and local agencies in both directions, I think we are probably at the point where we will profit greatly from a serious attempt to resynthesize these many activities into a comprehensive whole.

May I say just a word also about the mechanism of the project grant, a group of which were listed on page 3. Project grants probably develop for two reasons:

One, the inflexibility of other grant programs and the need for some special type of grant to fill in the gaps created by such inflexibility. Secondly, the project grant has probably developed from the standpoint of the weight that we tend to give to activities rather than to accomplishments, and through the project grant it is easy to develop more home nursing visits, for example, more restaurant inspections if a project grant goes in this direction, than through a continuing comprehensive program that will continue as long as the need exists.

Project grants for the reasons that explain their development, it seems to me, have come to be abused. They have created a number of situations in which programs are aborted entirely too soon because of the termination of the project grants. There have been other types of abuses of this, although the appropriate use of the project mechanism demonstrations for learning, for research, is a very good one.

This whole business has led, I think, to the coinage of the term "grantsmanship," the ability to keep up with the availability of such mechanisms, the writing of applications, all of the procedures which go into a successful application for such grants. The concern of the State health agency regardless of the breadth of its responsibility, is for total health planning and when a grant, whether it be a project grant or another type of grant, bypasses the State planning agency, the one which is responsible, it destroys any mechanism for comprehensive statewide jurisdictional health plan.

May I say just a word also about the makeup of the study committees and sections which review project grant applications? These have been preponderantly made up of university or academic persons with, I think, entirely too little representation from the service agencies. Many decisions have been made that I think perhaps would have been modified had there been people from the firing line adequately represented in the advice that has lead to these decisions.

In summary, may I say, Mr. Chairman, that I believe for many reasons there is now a recognition at the national level of the need for continuing Federal support both of basic ongoing health services and of developmental and research programs. If this is true, it is essential that it be carried out in the framework of appropriate organizational and funding patterns and with an emphasis on the mechanisms of effective communication and understanding between agencies at the same level and at all levels of Government.

Thank you, sir.

Mr. ROGERS of Florida. Thank you very much, Doctor, for a very excellent statement and backed up by examples here which will be very helpful to the committee. We appreciate your letting us have the benefit of your experience.

Congressman Gilligan?

Mr. GILLIGAN. Thank you, Mr. Chairman.

Doctor, let me begin by commending you for a very excellent and judicious statement. I would agree with many of the points you made, both the favorable and the critical comments, in your paper about how some of these programs developed and of the necessity of their developing in the way that they did. But their need for some organizational changes at the Federal level may reflect themselves in a better administrative structure and operation at the State and local level.

Doctor, I would like to ask you if you are aware of a proposed reorganization of the Public Health Service and a restructuring of the existing four bureaus into a number of other bureaus, the Bureau of Disease Control, Bureau of Health Services, Bureau of Health Manpower, Bureau of Mental Health, Bureau of Child Health, and the National Institutes of Health?

Have you seen this program proposal?

Dr. VENABLE. In general. I have not seen it in detail, sir.

Mr. GILLIGAN. Would you have any comment at all? Have you seen enough of it or reflected enough about it or discussed it enough to have any comment for the committee about the advisability of such a restructuring and reorganization?

Dr. VENABLE. I am afraid the only comment I could make with my present knowledge of this is that I think this is in the right direction. Whether or not I would concur with its detail I do not know because of lack of familiarity.

Mr. GILLIGAN. One point that seems to bear on some of the comments you had to offer about the present methods of awarding project grants and so forth is that there in this proposal there is a recommendation that the Office of the Surgeon General would have within its structure a Division of Grants and Contracts Support by combining the present Division of Research Grants of the National Institutes of Health and the Office of Grants Management of the Bureau of State Services into one division. Presumably one of the intentions of this recommendation would be to simplify and coordinate the efforts of both research and applied use of the research.

Would you have any comment on such a recommendation as that?

Dr. VENABLE. Yes, sir. I think this would be a very excellent change that would not only make it easier for States to deal with the granting mechanism or granting office, but would make the results of its considerations and decisions much more effective in health services. As a matter of fact, I referred to a change we are making in our organization on July 1. It will be the same thing in my office for grants to counties. I would have to agree with it.

Mr. GILLIGAN. I noticed that point. That is why I asked the question. The last question I would ask, Doctor, is you refer to the concentration of health responsibility in your health agency in Georgia and the fact that you have changed it several times in the last 14 years and are about to change it again. You mention that "Only water pollution control is not wholely within this agency, having been placed 2 years ago under a separate water quality control board."

We have that sort of thing evidently happening at the Federal level. Do you have any comment to make about the advisability from the point of view of environmental health of combining the studies and

programs affecting water pollution, and air pollution, and waste disposal in one agency?

Dr. VENABLE. First, I would want to separate in my comments water pollution and air pollution. First, water pollution: I opposed very seriously the change that happened to us 2 years ago whereby water pollution was taken from a regular operating unit of the Department and put under a separate board, different from the State board of health which controls our Department.

As long as we are able, however, to retain within the Department of Public Health per se sufficient professional guidance to me, as chairman of this separate board, I do not think it is creating any serious hazard. We are moving faster in water pollution control in my State than we did prior to this time, but this is not necessarily cause and effect. I do not think without the change we would have moved any faster, but it is not creating problems as long as I can maintain within my own staff in public health sufficient professional competence in water supply and in water pollution to advise me, as chairman of this board, which directs the activities of the division of water pollution control. And I would not be too concerned, provided the Secretary, who I understand is a member of the Advisory Committee, even though water pollution is in the Department of the Interior, or will be moved there, can maintain sufficient staff to advise him.

Health is only one of the aspects, the important aspect, of water pollution control, and while I think it needs to be under a single administration, if it has the health aspects well enough represented it seems to me it may well work. Only experience can tell.

Air pollution, it seems to me, is not quite as amenable to this sort of separation from the rest of health as water pollution. It does have other than health aspects, but the health aspects of air pollution seem to me to be even larger in proportion than those of water pollution control.

Does this answer your question?

Mr. GILLIGAN. Yes, sir. Thank you. It does.

Thank you, Mr. Chairman.

Mr. ROGERS of Florida. Congressman Younger?

Mr. YOUNGER. No questions.

Mr. ROGERS of Florida. Congressman Nelsen?

Mr. NELSEN. No questions.

Mr. ROGERS of Florida. Doctor, I was interested in your statement that the accounting procedures and validations that the Federal Government insists on really emphasize activity rather than accomplishment Could you expand on that just a little?

Dr. VENABLE. To be slightly facetious, Mr. Chairman, I remember a situation in which I listened for 2 hours to an argument as to whether a public health nurse who drove 10 miles in the country to see a family and found them not at home could report this as a home visit. We have to report the number of home visits by category, but not whether we really did any good in seeing the child, or the pregnant mother, or the tuberculosis patient. We have to categorize them and these are difficulties of statistics as well as administration. These all too often are categorized into how much we did and not whether or not we accomplished anything for the people we visit.

Mr. ROGERS of Florida. What would you say is the shortage of nurses or doctors and dentists in your State? Would you have any late figures? If you don't have them available perhaps you could submit them for the record.

Dr. VENABLE. I do not have them available. We completed a study about 2 years ago in our State for all ancillary medical personnel. There were shortages in all of these categories. The greatest one numerical shortage which is, of course, nurses.

There were other shortages even greater than nursing on the basis of comparison with what was needed on a percentage basis. The Southeast in general—Georgia in no exception—does not have the number of physicians that other sections of the country have, but this shortage is relatively less than many of the others.

In certain specialists in medicine, however, we are quite short. Psychiatry, for example, with our mental health responsibilities is a very short area, one which we are trying to do something about through our own construction of a training institute.

I will be glad to furnish these figures.

Mr. ROGERS of Florida. That would be helpful if you could.

Dr. VENABLE. Yes, sir.

(The information follows:)

STATE HEALTH DEPARTMENT

Health department (local)

[Based on estimated civilian population of 4,245,900]

Public health nurse staff:		
Currently employed		578
Needed for ratio 1:5,000	849	(−271)
Needed for ratio 1:3,000	1,415	(−837)
Public health nurse supervisors:		
Currently employed		29
For ratio of 1 supervisor to 10 staff	85	(−56)
	140	(−111)

Health department (State)

Specialized nurse consultants:	
Currently employed	8
Additional needed	8

Alcoholic rehabilitation—Georgian Clinic

	Currently employed	Vacancies	Projected need
Licensed practical nurse	2		
Registered nurse	14	1	51

Georgia Mental Health Institute

	Currently employed	Vacancies
Registered nurse	22	18
Licensed practical nurse	8	0
Nursing assistants	23	9

Proposed paramedical staffing needs in mental health institutions based on American Psychiatric Association staffing standards

Position	Milledgeville, 12,000 beds		Gracewood, 1,800 beds		Proposed new regional hospitals, 6—300 beds	Proposed Thomasville, 800 beds	Proposed Bainbridge, 500 beds	Proposed Georgia Mental Retardation Center, 1,000 beds
	Currently employed	Needed	Currently employed	Needed				
Professional nurse	103	647	48	60	192	57	32	100
Licensed practical nurse	109	109	13	10	60	20	10	126
Nursing assistant	1,437	1,000	356	50	600	140	100	200
Social worker	42	54	2	16	30	8	5	10
Social worker aids	----------	50	----------	16	30	8	5	10
Pharmacist	2	10	1	1	6	2	1	3
Teacher	----------	18	----------	10	12	4	2	115
Music therapist	15	33	----------	1	6	2	1	2
Chaplain	8	16	1	4	18	5	3	6
X-ray technician	----------	4	----------	2	6	2	1	2
Laboratory technician	----------	2	----------	2	6	1	1	9
Physical therapist	----------	22	----------	6	6	2	1	5
Psychologist	41	36	1	18	30	8	5	13
EKG technician	----------	2	----------	2	12	2	2	2
Dietitian	----------	4	----------	2	12	2	2	2
Dentist	8	28	2	4	6	1	1	20
Occupational therapist	53	40	----------	6	12	2	2	3
EEG technician	----------	4	----------	2	12	2	2	4

Staff vacancies, community hospitals

[Survey representing approximately 80 percent of the beds in community hospitals as of December 1965]

General duty RN	625
Head nurse RN	48
Nursing supervisor RN	36
Director of nursing RN	17
Licensed practical nurse (LPN)	301
Nurses aid	263
Medical records librarian (registered)	20
Medical records librarian (nonregistered)	8
Dietitian (staff-ADA)	22
Chief dietitian (ADA)	8
Food service supervisor	25
Medical technologist (ASCP)	58
Medical technologist (AMT)	14
Laboratory assistant	7
X-ray technician	21½
Combination laboratory X-ray technician	13
Pharmacist (full time)	17
Nurse anesthetist (CRNA)	21
Physical therapist	14½
Licensed electrician	1
Upholsterer and carpenters helper	1
Mechanics helper	1
Orderlies	10
Operating room RN	3
Assistant director in-service education	1
Hospital librarian	1
Staff physician	3
Hospital social worker	2
Personnel officer	1
Accountant	1
Radiologist secretary	1
Medical secretary	3
Secretaries	5

Staff vacancies, community hospitals—Continued

[Survey representing approximately 80 percent of the beds in community hospitals as of December 1965]

House mothers (school of nursing)	4
Dietary aids	4
Credits and collections	1
Admitting officer	1
Typists	3
Nursing attendant	6
Ward clerk	2
Assistant directors of nurses	1

Source: Georgia Hospital Association.

Nursing homes

	Number facilities	Number beds
Medical care	80	5,490
Skilled nursing care	41	2,015
Nursing care	58	1,467
Personal care	14	514
Total	193	9,486

NOTE.—Total R.N.'s employed, 127.

Mr. ROGERS of Florida. One other statement I was particularly interested in because we are very much concerned with the research activities of the National Institutes of Health. I notice that you make a statement on page 8 that the makeup of study sections and committees, who act as advisers to Federal health agencies and make decisions as the validity and priority of research applications, and particularly of project grant applications, is too heavily weighted toward just the academic community without bringing in people who have the practical experience of how these programs must be carried out.

Dr. VENABLE. This is, of course, a judgmental statement that I have made but I continue to support it. We have had a number of experiences that have led us to believe this, not so much with research grants, because when you are supporting basic research the ability of the individual and the concept of his idea, I think, is important. You never know where it might lead. But when it comes to a project grant demonstration or for administrative research or program reasearch, the people in universities are not as familiar with the requirements of the service agency.

I certainly would not want anybody to think that I am proposing that one be replaced by the other, but that they be brought into balance so that both viewpoints are clearly available in such consideration.

Mr. ROGERS of Florida. And do I understand that it is your feeling, too, that the Federal Government is channelizing funds going into the States and requiring too much accounting and redtape, rather than giving more general authority to the States to meet the particular problems which exist in each individual State.

Dr. VENABLE. We believe not only this, but that there must be a strong platform of comprehensive general services on which to build the specialized programs that come out of the laboratories.

Mr. ROGERS of Florida. Are there any other questions?

Thank you very much, Dr. Venable. We appreciate very much your contribution to the committee's consideration of this problem.

Dr. VENABLE. Thank you, sir.

Mr. ROGERS of Florida. Our next witness was slated to be Dr. John H. Hanlon, who is commissioner of health, Detroit, Mich.

Dr. Hanlon was here this morning and has been taken ill, but he has submitted to us a statement which will now be made a part of the record, without objection.

(Statement referred to follows:)

STATEMENT BY DR. JOHN J. HANLON, HEALTH COMMISSIONER, CITY OF DETROIT AND PUBLIC HEALTH DIRECTOR, COUNTY OF WAYNE, MICHIGAN

The four general issues in which I am informed the members of this Special Subcommittee are interested at this time are as follows:

(1) The multiplicity of Federal agencies involved in the administration and distribution of Federal health funds, and its effect on the health programs of the various States;

(2) The alleged tendency of Federal authorities to bypass State and/or local health authorities when sponsoring health projects and activities within their States or communities;

(3) The desirability of allowing the States greater flexibility in spending Federal grant money;

(4) The desirability of fostering closer Federal-local relationships under appropriate circumstances.

Each of these issues has varying degrees of importance to different individuals depending upon their backgrounds and circumstances of professional and governmental activity. Necessarily, I too place greater emphasis upon some in contrast to others. In view of their over-all effects I would consider the first and fourth of greatest significance, and since they are somewhat interrelated I would like to spend most of the time available discussing certain aspects of them, leaving a few statements at the end for issues 2 and 3.

There is no question but that the most complex organizational picture in public health in the United States is to be found on the Federal level. In place of a Federal department of health there exists an illogical maze of miscellaneous departments, bureaus, offices, agencies, commissions, services and authorities, each with responsibility for one or several aspects of the Federal government concern with health. This situation has arise through a pyramiding over many generations of special legislation often originating from executive requests, bureaucratic expansion or the pressure of special interest groups. Typically, once an agency has been formed or designated to deal with a particular problem, group or interest, they and the independence of the agency involved are jealously guarded. If not, they may on the other hand get lost as a result of the ever fractionating system in some side eddy from the main stream. A somewhat extreme example is provided by the fact that the responsibility for the health of the admittedly few inhabitants of the Pribilof Islands was for many, many years vested in the Fish and Wildlife Service of the Department of the Interior. While historically there have been a number of attempts to consolidate and make some greater logic out of this perplexing and mushrooming group of Federal agencies dealing with public health it would appear that the centrifugal forces are somewhat greater than the centripetal forces. Meanwhile, the rapid acceleration of social and scientific progress have forced the development of numerous new programs, some of which have been appended to existing units of organization on the basis of primacy of discovery, chance and sometimes logic, while others depending upon sponsorship have set up shop on their own.

Presented as Appendix 1 is a table of Federal agencies engaged in health work, a table admittedly out of date. It does, however, provide illustration of the multiplicity of Federal agencies that are involved in the administration and distribution of Federal health funds. They may be separated perhaps into four primary categories. The first is more or less concerned with very broad, general interests. The United States Public Health Service, which is the closest we come to a Federal department of health, is perhaps the only true example. It is literally concerned with, and involved in all aspects of the public health; animate and inanimate, personal, group and environmental, the healthy as well as the ill, and all ages, sexes, races and other categories of the population. A second group of agencies is concerned with the welfare of special groups in the population. Most prominent here are components of the welfare administration, the Social Security Administration, the Children's Bureau, the Women's Bureau, the Farm

Security Administration, the Agricultural Extension Service, the Medical Divisions of the Department of Defense, the Veterans Administration and the Office of Indian Affairs. This is by no means an all inclusive list. A third category of agencies includes those concerned with special problems, such as the Office of Education, the Office of Vocational Rehabilitation, the Food and Drug Administration, the Federal Trade Commission, the Division of Labor Standards and the Bureau of Labor Statistics, various bureaus within the Department of Agriculture, the Bureau of Mines, the Maritime Commission and the Tennessee Valley Authority. Pieces of the Children's Bureau program such as those related to maternal health and crippled children might logically be placed in this group. In the sense that they provide medical care to special groups the Social Security Administration and the Bureau of Employees' Compensation might also be added to this third category. A fourth category that might be considered is made up of certain quasi-independent institutions, such as the St. Elizabeth's Hospital and the Freedmen's Hospital. To cap this off, the several components of the Federal government concerned with international health interests should be mentioned. As far as function is concerned, it varies from personal service to regulation, consultation, demonstration, research, training and education and grants-in-aid.

Over the years, the exercise of these functions has led to an ever increasing centralization of power and influence. For whatever interest it may have to this regard, there is presented as Appendix 2 a section from a book by the speaker which attempts to present the development of this trend toward centralization of power and its effects upon the health programs of the various States and local units of government. Briefly the local health agency increasingly has found itself on the horns of a dilemma: the need to analyze and meet local needs arising out of local problems as best they may be determined by those living and working in the local situation, while realistically recognizing the limitations of local resources, with a wistful if not envious eye toward the much more greater resources of the States and the Federal agencies. It is only natural to turn eventually to the latter. Admittedly the benefits over the years have been great, but the price has been a whittling away of local autonomy and determination. This seems to have been particularly true when categorical funds and assistance are available. More than one local health department has made the decision to "run with the fad" only to find itself being led by a succession of carrots on the end of sticks which in no sense add up to a well thought out and balanced public health program. The multiplicity of agencies involved in health have led to the local and state concept of going shopping in the Federal market for bits and pieces of the health program. By now it is even worse in that there exist competing cafeterias under the same management, where administrators of local health agencies may shop around to find where they can get the best deal for identical services from the different sources.

This leads, of course, to the subject of grantsmanship. As is well known, this is now a well established specialty and by no means a simple one. Not only must the local health officer be able to recognize a problem and know professionally how to meet it, but he must also know where to best seek funds and other resources. Beyond that he must develop expertise in the interpretation of the various laws, rules and regulations, and all of the guidelines that may be laid down in order to provide access to these resources. He must be astute with regard to which agency or subdivisions of a particular agency will give the best deal in terms of amounts of grants, matching requirements, length of grant, detail of accountability and required reports, phasing out requirements, and the like. Appendix 3 is presented to illustrate the variety of conditions that exist within one agency—the Public Health Service. In fairness, it should be emphasized that the complexity illustrated in this example is not the fault of the Public Health Service, which after all must administer public acts in accordance with the specified terms.

A few examples may illustrate the impact of the foregoing on the local scene. For the past several months we in Detroit and Wayne County have devoted a great deal of staff time and effort to the development of an extensive project proposal in order to bring to the children of the area benefits

intended by the Congress in section 532. As we understood the spirit and intent of the federal legislation we were to think of comprehensive total health services for low income families who otherwise would not receive it. Consultation with professional conferees appeared to substantiate this view. After a great deal of time and effort had been expended and a number of extensive drafts of the project developed we have just recently been presented with a new administrative interpretation of the law, which from our viewpoint tends to fragment the entire program and indeed fragment the individual. The result seems to us to be the antithesis of the entire spirit of the law. Nevertheless, we proceeded to try to redefine the program for a small number of children with no local option as to how we are to provide the basic screening services or upon what logical basis to choose a target population. New interpretations as to what constitutes local matching funds have appeared. This would necessitate the establishment of a whole new system of administrative personnel in the program in order to process the pieces of the local matching and the administration of the program as a whole. Because of what appears to us to be confusion at the federal level and because on the State level the matching basis is for the time being at least somewhat better if title 19 is administered by Welfare, an organizational shift has taken place on the state level and the state agency has now preempted our local matching resources that were needed in order to get the program going on the local basis, where the people and their problems reside. To us, this experience seems to have made a mockery out of the concept of local matching.

Measles vaccination provides another good example. At long last the vaccine is available from two Federal sources. The direct Public Health Service source involves considerable paper work and will not in itself provide sufficient vaccine to meet our entire problem. Meanwhile, the State has available other Federal money which was allocated for more general purposes, and some of which is now available for measles vaccine. Suddenly we have to develop two separate programs more or less on a crash basis, each with its separate aspects of distribution and requirements for accounting purposes. The State has practically no requirements other than children, while the Public Health Service vaccination funds are just for preschool children. By putting the two pieces together we end up with a program. However, this requires endless conferences with school administration, nursing associations, community leaders, medical societies, while we tried to make sense out of the dilemma of having to satisfy the technicalities of one unit of government which are quite different from those of another, but both of which, along with us, are aimed at the same goal—the protection of children against measles.

Speaking of children I would like to describe the situation in which we find ourselves in Detroit. For a great many years the child health program has been one of the most important if not the most important component of the Detroit Department of Health. I has provided a variety of services for both well and sick children. About a year and a half ago some state funds became available for a new National and Infant Care Project with the meritorious goal of decreasing prematurity. This necessitated setting up a somewhat separate Infant Care Project in conjunction with a few selected hospitals. About a year ago the antipoverty program got under way and I am happy to report that health and medical activities, especially as they relate to children, constitute one of its most important components. However, the funds come from still a different source and must be administered separately. Fortunately, our local Office of Economic Opportunity has turned to the Department of Health for guidance and over-all professional development and administration. Nonetheless, we have still another set of clinics and similar resources. Actually, we in Detroit are very fortunate in this regard since all of my fellow health officers elsewhere have complained quite bitterly of the development in their jurisdictions of quite separate and competing public health programs through this aegis. If we succeed in the development of a project under section 532 we will of course be faced with the necessity of establishing still another parallel or competing child health program. Add to this the separate programs under the Vaccination Act, separate provisions elsewhere for tuberculin testing, hearing testing, vision testing,

crippled childrens services and the like, not to mention the rapidly multiplying state and federal activities in mental health and mental retardation as they affect children and the result is a finely chopped up child and child health program. These are only a few examples from the world of reality as seen by those of us who operate the ultimate delivery routes. Numerous similar examples could be presented in relation to dental health, many aspects of environmental health and the like. Allow me to present just one more brief example of confusion originating from a non-health federal agency, in this case education. Public Law 10 empowers local school systems to purchase nursing services and medical services or any type of health care they might wish irrespective of any participation by a health department. As a result, in the County we now have a number of school systems with educational funds hiring scarce public health nurses away for a 10 month year, where they are not even doing public health work but rather day to day first aid in the schools, an activity that could very well be performed by a much lesser trained individual.

Finally a few general comments. It would seem to me that there is a great need for fewer categorical grants and more general or block grants provided on the basis of certain basic factors such as population, gross state product, per capita income, special problems and needs and the like. Certainly the number of different matching requirements could be reduced. If nothing else the matching requirements in two or more agencies dealing with the same problem should be uniform and not competitive. A tremendous amount of scarce and very expensive professional time could be saved by simplifying and standardizing the format of grant requests and progress reports. I would suggest that consideration might be given to the assignment of one or more very competent representatives of the Department of Health, Education and Welfare in each of the major metropolitan areas, not to police and not to review, but as a ready resident source of advice and consultation with regard to program assistance, grants, the meaning of rules and regulations and the like. This would be far more useful to us on the local level than the two screening and sometimes blocking levels of the state agency and the regional office. Certainly the more urbanized and metropolitan areas which contain such large proportions of the population should be allowed to develop ever closer relationships directly with federal agencies. Finally it is my strong belief that one of the most effective means of achieving greater understanding, cooperation and lack of confusion would be to provide a means of obtaining experience on different levels of government. While my conferees on the state and federal level are due a great measure of credit and often personal liking it is unfortunately true that far too many have had limited if any experience on the local level where in the final analysis the work must be done. This is the ultimate delivery point. The rest exists for it. In this regard it was with pleasure and satisfaction that the Section on Interchange of Personnel in House Bill 13197 introduced by Congressman Harley O. Staggers, Chairman of this Committee, was read. This alone could be one of the most significant turning points in greater intergovernmental understanding and efficiency.

APPENDIX 1

TABLE 27.—*Federal agencies engaged in health work* [1]

Participating agency	Health activities	Method of administration [2]
Department of Health, Education, and Welfare: Public Health Service	Maintenance of research laboratories for study of cause, prevention, and treatment of disease.	Direct service; research.
	Assistance to States in establishing and maintaining proper sanitation facilities, general public health services—including dental health, occupational health, training of personnel, and extension and strengthening of full-time local health organizations—and special programs for the control of the venereal diseases, tuberculosis, mental health disorders, cancer, heart disease, water pollution, and for development of hospitalization plans and construction of hospital facilities.	Grants-in-aid; studies and demonstrations; advisory service; loan of personnel; regulation.
	Provision of hospitalization, general medical and dental care, and preventive health service for American merchant seamen, members of the U.S. Coast Guard, Coast and Geodetic Survey, and other legal beneficiaries of the Service.	Direct service.
	Operation of special hospitals (leprosarium and narcotic hospitals)	Do.
	Provision of treatment for general and allied special illnesses of Negroes in the District of Columbia and surrounding areas.	Do.
	Establishment and operation of Federal employee health service programs to promote and maintain the physical and mental fitness of Government employees.	Direct service; advisory service; loan of personnel.
	Conduct of studies of mental diseases and drug addiction, and investigation of needs for narcotic drugs for medical and scientific purposes.	Studies and demonstrations.
	Assistance to institutions and to competent research workers for research in medical and related sciences.	Research grants.
	Assistance to medical institutions for treatment of cancer.	Loan of radium.
	Cooperation with official and nonofficial national organizations and institutions on health matters.	Advisory service.
	Estimation of requirements of controlled materials for civilian health, and arrangement for allocation of materials for this purpose during the emergency.	Direct service; advisory service.
	Collection and publication of vital and public health statistics, including epidemiological data.	Do.
	Control of the spread of communicable diseases in interstate traffic.	Direct service; regulation.
	Assistance to States, municipalities, or interstate agencies for defraying expenses in connection with plans for construction of waste treatment works.	Grants-in-aid; advisory service.
	Assistance to States, municipalities, or interstate agencies for construction of necessary waste treatment works.[3]	Advisory service; loans.
	Supervision of milk, food, and water used on interstate carriers.	Direct service; regulation.
	Training of public health workers	Grants-in-aid; direct service.
	Production and dissemination of health information and education materials.	Direct service.
	Protection of this country from the importation of communicable diseases from abroad.	Direct service; regulation.
	Supervisory control and licensure of biological products used in the prevention and treatment of diseases.	Do.
	Control of diseases in the event of epidemics and disasters.	Direct service; regulation; advisory service.
	Administration of medical care and public health among Indian wards of the Government and Alaskan Eskimos.	Direct service.
	Assistance to other Federal agencies in the discharge of their health functions.	Advisory service; loan of personnel.
	Collaboration with foreign governments and with international organizations on world health matters.	Advisory service; loan of personnel; studies; information.

See footnote at end of table.

TABLE 27.—*Federal agencies engaged in health work* [1]—Continued

Participating agency	Health activities	Method of administration [2]
Department of Health, Education, and Welfare—Con.		
Welfare Administration:		
Children's Bureau [4]	Assistance to States in extending and improving maternal and child health and crippled children's services.	Grants-in-aid; studies; advisory service.
	Cooperation with official and nonofficial national organizations and institutions on maternal and child health and crippled children's matters.	Advisory service.
	Collaboration with foreign governments and with international organizations on maternal and child health and crippled children's programs.	Studies; advisory service; information; loan of personnel.
	Collection and dissemination of information in the field of child life and maternal health, and results of research studies under way in universities, schools, child welfare institutes, and other public and private agencies.	Studies; information and education.
Bureau of Family Services.[4]	Assistance to States for public assistance payments (which may include provision for medical care) to the aged, to dependent children, to the blind, and to the permanently and totally disabled.	Grants-in-aid; studies; advisory service.
Office of Vocational Rehabilitation.[4]	Assistance to States in rehabilitating persons who are vocationally handicapped because of a mental or physical disability.	Grants-in-aid; advisory service.
	Rehabilitation of disabled residents of the District of Columbia.	Direct service.
Food and Drug Administration.	Stabilization of the quality of foods and drugs through inspection, analysis, and control of labeling.	Direct service; regulation research; advisory service.
St. Elizabeths Hospital	Provision of care and treatment for certain civilian beneficiaries of the Federal Government and for residents of the District of Columbia suffering from mental disorders.	Direct service; research.
Office of Education [4]	Stimulation of education in the fields of public health, school health, and physical education.	Studies and demonstrations advisory service; information.
	Assistance to States for vocational education which includes training in health fields.	Grants-in-aid; advisory service.
	Collaboration with national and international groups in fields of school health and physical education.	Advisory service; information.
Department of Agriculture:		
Agricultural Research Service.	Direction and coordination of physical and biological research activities, many of which have a direct bearing on health.	Direct service; advisory service.
Bureau of Animal Industry.[4]	Investigation of the cause, prevention, treatment, and control of diseases affecting both man and animals.	Direct service; payment of indemnities; studies; regulation; research; advisory service; information.
Bureau of Human Nutrition and Home Economics.	Control of sanitation and wholesomeness of meat or meat-food products sold in interstate and foreign commerce.	Regulation; direct service.
	Conduct of research on food and other goods essential to healthful everyday living; studies of housing and equipment; and dissemination of information obtained.	Studies; research; information.
Bureau of Agricultural and Industrial Chemistry.	Investigation of the properties and industrial utilization of farm products for foods, feeds, drugs, and other products of health significance.	Research.
Office of Experiment Stations.	Assistance to States in cooperative research in agriculture, rural health, nutrition, and diseases affecting man and animals.	Grants-in-aid; advisory service.
Bureau of Dairy Industry.	Promotion of dairy industry and development of sanitary methods of handling milk and the processing of milk products.	Direct service; studies and demonstrations.
Bureau of Entolology and Plant Quarantine.	Control of the manufacturing or processing of renovated butter.	Regulation.
	Investigation and control of insects affecting the health and well-being of man, and collaboration with State, foreign, and other organizations on control of such injurious pests.	Direct service; regulation research; advisory service.
Bureau of Plant Industry, Soils, and Agricultural Engineering.	Promotion of improvement of design and sanitary aspects of farm homes, buildings, and storage facilities.	Research.

See footnote at end of table.

TABLE 27.—*Federal agencies engaged in health work* [1]—Continued

Participating agency	Health activities	Method of administration [2]
Farmers Home Administing Administration.	Provision of supervised credit and loans to farmers for construction or repair of houses and farm buildings, and for meeting the needs for family living, including health services, sanitary facilities, and insect pest control.	Direct service; credit and loans.
Extension Service	Promotion of rural health and better farm living, environmental sanitation, and improved farm housing.	Grants-in-aid; advisory service; information.
Forest Service	Provision of sanitary facilities in the national forests and supervision of general sanitation of forest areas.	Direct service.
Rural Electrification Administration.	Improvement of rural sanitation facilities and water supplies.	Direct service; advisory service.
Production and Marketing Administration.	Assistance, through State agencies, to schools having nonprofit school lunch programs in the interest of better nutrition and health of children.	Direct service; grants-in-aid.
	Establishment and enforcement of standards of purity and wholesomeness of various food products and control of the manufacture and sale of insecticides, fungicides, rodenticides, and disinfectants to prevent injury to man and other animals.	Direct service; regulation advisory service.
	Administration of defense functions with respect to availability of farm equipment, fertilizer, and the supply and allocation of foods for proper nutrition.	Direct service; advisory service.
Bureau of Agricultural Economics.	Collection, analysis, and distribution of statistics of health significance such as farm accidents, incidence of disease, and patterns of health care.	Direct service; surveys and studies; advisory service information.
Office of Foreign Agricultural Relations.	Cooperation with Food and Agriculture Organization of the United Nations and with Federal agencies on international programs to raise the level of nutrition and standards of living, and to improve conditions of rural populations.	Advisory service; information.
Department of Commerce: Bureau of the Census	Collection and publication of basic statistics of population, housing, agriculture, industry, and other data for use by other agencies in planning health programs and services.	Direct service; advisory service.
Maritime Administration [4]	Provision of medical and dental care for enrollees of the U.S. maritime service and for cadet-midshipmen of the U.S. merchant marine cadet corps; operation of health and sanitation program at merchant marine training stations.	Direct service.
Business and Defense Services Administration.	Distribution of controlled materials needed to meet the needs for civilian health requirements and coordination of other Federal, State, and local agencies in obtaining such materials.	Direct service; advisory service.
Coast and Geodetic Survey [4]	Insurance of safe navigation of coastal and intracoastal waters by means of surveys and charts of coastal areas; provision of emergency health and medical services to shipwrecked and destitute persons in Alaska and other remote localities.	Direct service.
Department of Defense	Provision of basic policies, plans, and programs in the medical and health fields as will provide guidance for the several military services in safeguarding the health of military personnel and their dependents.	Do.
	Operation of health and medical care programs for military personnel and their dependents.	Do.
	Provision of pure water for military posts and the District of Columbia, and improvement of navigable rivers, harbors, and waterways in the interest of flood control, maintenance of water supply, abatement of water pollution, and other use of water.	
	Training of personnel for health work	
	Cooperation with other Federal agencies on health and medical problems.	Direct service; advisory service.
	Direction of research, in and out of the Department, toward solving health problems arising out of military operations.	Research.

See footnote at end of table.

TABLE 27.—*Federal agencies engaged in health work* [1]—Continued

Participating agency	Health activities	Method of administration [2]
Department of the Interior:		
Bureau of Mines	Investigation of causes of mine accidents; inspection of mines; training in mine rescue and recovery work.	Direct service; studies and demonstrations; information.
	Production of lightweight, noninflammable gas helium used in nonexplosive anesthetics and in the treatment of some respiratory diseases.	Direct service.
Fish and Wildlife Service [4]	Promotion of programs for control or destruction of wild animals that endanger men or domestic animals through the transmission of diseases.	Do.
	Detection and elimination of stream pollution hazards.	Do.
	Conduct of research on methods of canning or processing of fishery products to insure a sanitary and wholesome food.	Research.
	Provision of medical and health services for the inhabitants of the Pribilof Islands and destitute natives.	Direct service.
National Park Service	Provision of safe water and sanitary camp facilities in national parks.	Do.
Department of Justice:		
Immigration and Naturalization service. [4]	Provision of physical and mental examinations of immigrants, and medical care of quarantined aliens.	Direct service; regulation.
Bureau of Prisons [4]	Provision of medical, psychiatric, dental and nursing services to inmates in Federal prisons and correctional institutions.	Direct service.
Department of Labor:		
Bureau of Labor Standards	Promotion of industrial health and safety	Direct service; studies and demonstrations.
	Coordination of enforcement of wage, hour, industrial home work, child labor, and safety and health laws.	Direct service; advisory service.
	Training of state and foreign personnel in health and safety.	Direct service.
Women's Bureau	Promotion of the welfare of wage earning women and conduct of studies on health and working conditions of women in industry.	Studies; advisory service.
Bureau of Labor Statistics	Collection and analyses of data on environmental conditions in industry significant to health and publication of reports.	Direct service; investigations and studies; information.
Wage and Hour and Public Contracts Divisions.	Administration of Fair Labor Standards Act to insure minimum wage rates and the proper use of child labor in the production of goods for interstate commerce.	Regulation.
Bureau of Employees Compensation. [4]	Administration of health and safety standards in industries under government supply contracts in excess of $10,000.	Direct service.
	Administration of benefit payments to injured workers for necessary medical and hospital services and compensation for disability and death.	Direct payment of benefits.
Bureau of Employment Security. [4]	Provision of medical and health services for migratory farm laborers at reception centers and while enroute to and from work contractor and reception centers.	Direct service.
Department of the Treasury:		
U.S. Coast Guard [4]	Enforcement of regulations to insure the safety of life and property on high seas and navigable waters under jurisdiction of the United States.	Direct service; regulation.
	Provision of medical and surgical aid to crews of United States vessels, and to shipwrecked and destitute persons in Alaska and other remote localities.	Direct service.
Bureau of Narcotics	Enforcement of Federal narcotic laws and regulation of quantities of narcotic drugs to be imported, manufactured, or exported for medical purposes.	Direct service; regulation.
Atomic Energy Commission	Production and distribution of radioactive materials used in medical research.	Direct service; advisory service.
	Conduct of medical and clinical research at field installations and hospitals, and provision of research guidance in the physical and biological sciences.	Direct service; grants-in-aid; research; advisory service; information.
	Training in radiological safety in the interest of civil defense.	Direct service; research grants.
	Control of distribution of information regarding the use and safety of radioactive materials.	Direct service; advisory service; information.

See footnote at end of table.

TABLE 27.—*Federal agencies engaged in health work* [1]—Continued

Participating agency	Health activities	Method of administration [2]
Defense Production Administration.[4]	Establishment of policies regarding health manpower needs and the expansion of production and general allotment of strategic materials used in meeting civilian and military health needs.	Direct service, advisory service; loans.
Federal Civil Defense Administration.[4]	Assistance to States for protective equipment and facilities.	Grants-in-aid.
	Provision of a coordinated plan for the protection of civilian life and property from enemy attack.	Direct service; advisory service; public education.
Federal Trade Commission..	Control of unfair or deceptive advertisements of food, drugs, devices, or cosmetics in interstate commerce.	Regulation.
Agency for International Development.[4]	Assistance to foreign countries to promote health and economic development.	Direct service; grants-in-aid; studies and demonstrations; advisory service; information.
	Training of foreign students in public health and other fields through educational exchange programs.	
Housing and Home Finance Agency.	Assistance to local public housing authorities for planning, financing and construction of safe, sanitary, and adequate dwellings for low-income families.	Grants-in-aid; advisory service; loans; studies.
	Assistance to State and local governments for repair of damages and rehabilitation of disaster-stricken areas.	Grants-in-aid; advisory service.
Interstate Commerce Commission.	Promotion and enforcement of health and safety standards in the railroad industries and in the operation of railroads and motor carriers in interstate traffic.	Investigations; regulations advisory service.
National Science Foundation.	Development and strengthening of a national policy of basic research in the medical, biological, physical, and other health sciences, awarding of scholarships and graduate fellowships in these fields.	Direct service; advisory service.
National Security Resources Board.	Coordination of activities of Federal agencies with respect to manpower and natural resources as they affect national health and security; provision of advice to the President on the coordination of these resources.	Do.
Selective Service System....	Provision of health data of draftees examined for military service.	Direct service.
Tennessee Valley Authority.	Maintenance of medical and public health service for employees.	Do.
	Cooperation with State and local health authorities in the control of insects, water pollution, general sanitation, and other public health services for the area.	Direct service; advisory service.
Veterans' Administration...	Provision of authorized health and medical services, including hospitalization and rehabilitation to former members of the Armed Forces.	Direct service; research.
	Administration of training benefits for veterans of the armed services; through this program more trained personnel will be made available for health work.	Training grants.
	Training of personnel in health work.....	Direct service.

[1] Adapted from Mountin, J. W., and Flook, Evelyn: Guide to Health Organization in the United States, Washington, 1953, U.S. Government Printing Office, Public Health Service Publication No. 196, pp. 6–13.
[2] As used here, "direct service" refers to services actually performed or directly purchased by the designated Federal agency; "grants-in-aid" are funds allotted by the Federal agency to State or local agencies for performance of service; advisory service is limited to the giving of advice and setting of standards.
[3] Funds have been authorized but not appropriated for this purpose.
[4] Agencies to which Public Health Service officers are detailed for assistance in administration of the functions described.

Source: Principles of Public Health Administration, Hanlon, John J., C. V. Mosby Co., St. Louis, 1964.

APPENDIX 2

EXCERPT FROM "PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION" (HANLON, JOHN J., C. V. MOSBY CO., ST. LOUIS, 1964

Centralization. Originally the powers of the Federal government were limited quite strictly to affairs of interstate and international concern. So intense was the desire to restrict the scope of these powers that they were re-

ferred to explicitly in the Constitution and its subsequent Amendments. Innumerable aspects of our social, scientific, industrial, and political development have led in a direction that makes an increasing degree of centralization necessary, if not also desirable, for survival. To allow this change and still maintain the basic principles of our form of government presents a difficult problem indeed.

In order to accomplish both purposes, Federal agencies in recent years, with the tacit assent of the states, have increasingly resorted to indirect but constitutionally permissible techniques resulting in increased centralization of power in state governments themselves and more significantly in Federal agencies. This movement received greater acceleration during the 1930's when the widespread economic depression dealt a devastating blow to local and, to a great extent, to state finances, rendering them incapable of meeting the demands placed upon them. A procession of local governments, having fruitlessly appealed to their state capitals for assistance, turned to Washington as the only source of relief. In the light of the underlying social and economic causes, these trends toward centralization are certain to continue and increase.

There are many methods short of total assumption of power and function that may be resorted to in order to achieve a practical measure of centralization. Perhaps the simplest is the offering of advice and information by a Federal agency to the states or by the states to the local governments. This is so common in the field of public health as to have become one of the prime activities of state and Federal health agencies. It takes but a short step to move from the transmission of printed advice and information to occasional visits of state and Federal consultants followed by the loaning of personnel to serve as resident consultants, especially in the face of local shortages in personnel. Increasingly, officers of Federal agenices, originally intended as consultants, are found assigned on a semipermanent basis to serve as directors of divisions of a state health department. Field technical units, developed by state health departments for the purpose of assisting the local units, in many instances assume the position of supervising and even determining the programs of local health departments. Thus we see activities designed for the purpose of rendering advice and information develop into programs of cooperative or outright centralized administration. A variation is a program of inspection and advice, often without authority, to bring about compliance with recommendations made. The inspecting and advising officials, for example, may merely report their findings to the central authorities who may then promote additional legislation, often giving them increased supervisory powers. This has occurred, for example, in the matters of hospital construction and inspection of sanitary installations.

The requirement of periodic fiscal and service reports may appear innocuous on the surface and is certainly justifiable in order to obtain and share information concerning the general welfare. However, even this may have an indirect centralizing influence of considerable impact. Theoretically a state or local health department has the right to organize its records and reports any way it sees fit to serve its purposes. However, on obtaining the right to require certain reports, the next step is to standardize them. Beyond this, in more than one instance, the requiring of a certain type of report has resulted in an actual change in the local program itself, the local personnel following the path of least resistance. This has occurred in varying degrees as a result of requirements for birth and death records, reports of communicable disease, and the standardized fiscal reports of health departments to Federal health agencies. An accelerating technique that may be employed is to give the local official a nominal appointment as the local representative of state or Federal agency. Thus, we find most local health officers with appointments as collaborating epidemiologists of the United States Public Health Service.

In some areas local activities are subject to direct supervision and review by the higher government. For example, local assessments often must be reviewed and approved by a state board of equalization or by state tax commissioners. Prior permission may be required and is especially effective when the higher level of government participates in financing. It is rapidly becoming accepted practice to require that plans for city, county, and state hospitals be approved by state boards of health and national health agencies before the letting of contracts is allowed.

Of a similar nature are approval requirements for the appointment and removal of local officers. While in most states it is theoretically the prerogative of local governments to select their own health officer, in practice this is often not followed for various reasons discussed elsewhere. Not only is approval by the state health officer usually required, but often selection is limited to lists prepared by the state health department. In some states local health officers are appointed and removed directly by the state board of health. In Ohio, employees of health districts are appointed from state civil service lists and, if no eligible individuals are available, from the register of local commissions. The requirement of prior permission is sometimes rendered unnecessary by the determination of standards by a state or Federal agency.

The extent to which the average county health officer is affected by these influences may be pictured somewhat as follows: In the first instance, he may be recruited by and trained under the auspices of the state health department, using Federal funds. His appointment, if not made directly by the state health officer, will probably require his approval. Monthly reports of his activities and those of his staff will have to be made to the state health department on standard forms and a record of all work kept in a form book prescribed by the latter agency. By virtue of his frequent designation as registrar he will have to report births and deaths to the state health department on forms, this time prescribed by the National Office of Vital Statistics. Since in most instances he is appointed a collaborating epidemiologist, it becomes necessary to send weekly reports of communicable diseases to the United States Public Health Service as well as to the state health department. His maternal and child health program may necessitate operation, inspection, and approval of clinics and hospitalization facilities, using standards developed and required by the Children's Bureau which will also ask for reports on standard forms. Arrangement for the use of x-ray equipment and for hospitalization of persons with tuberculosis will in most instances be made by him with the state agency. Finally, he will probably find it convenient if not necessary to obtain education materials, biologics, and even office forms and supplies through the state health department.

While all this may appear on the surface to result in an effective emasculation of the position of the local health officer, to be fair and practical it should be pointed out that all of these various relationships actually represent effective resources to which he may turn for assistance in order to carry out a much more effective and satisfying program than he otherwise could. Considering the limited resources on a local level, one might with justification answer those who disclaim any concurrent limitation of local autonomy with the saw, "You can't have your cake and eat it too."

Details of contracts and design of hospitals and health centers have been specified as conditions for approval of plans by state and Federal agencies in order to obtain Federal funds. More and more types of licenses are being placed within the jurisdiction of state health departments and through them the United States Public Health Service and the Children's Bureau. The wartime program for the provision of Emergency Maternity and Infant Care administered by the Children's Bureau through the state health departments presented many examples of the centralizing influence of the right to determine standards. The central agency may be vested with the right to issue general regulations that are binding on the locality or orders that result in a single centralized authority. Both measures are widely resorted to in public health work. Here the initiative passes from the local to the central agency. While common within states, this type of control is rare in the Federal-state relationship.

A more complete method of centralization is the partial or total assumption of function. In some states the state health department has direct control of local water and sewage facilities. In some the department of agriculture has complete responsibility for food inspection. In one state the department of conservation has authority over hotels, resort areas, taverns, and other similar places including their sanitation. Not infrequently clinics and even complete programs dealing with tuberculosis, venereal and other diseases are maintained and operated directly by the state health department.

Grants-in-Aid. What many consider to be the most potent factor tending toward centralization is found in use of the fiscal technique of grants-in-aid, subventions, or subsidies. These have been defined as "sums of money as-

signed by a superior to an inferior governmental authority." Grants-in-aid represent one form of transfer of public funds for the purpose of equalizing revenue among the several levels of government and among the states and their contained local areas. They are intended to improve the quality and expand the quantity of governmental programs in less affluent areas by augmenting their revenue with legal transfers of funds from more wealthy regions. No reasonable person would sanction the continuance, for want of adequate funds, of insanitary conditions and inadequate public health programs in some areas that might adversely affect others. This being the case it becomes necessary to provide some method for assisting the smaller or less favored units of government to meet their obligations. Another justification of the increasing use of grants-in-aid may be found in the situation previously discussed, i.e., the local government units are more restricted as to types of revenue and are administratively in a disadvantageous position for levying and collecting some of the more lucrative sources of funds. Few would deny the right of local governments to share in the fiscal benefits of automobile excise taxes since the local areas must share in the building and maintenance of the roads over which vehicles travel. It would be confusing, however, to say the least, should each locality attempt to apply and collect its own automobile excise tax. A revenue such as this is obviously applied most efficiently by a higher level of government.

Another purpose of grants-in-aid is to provide some measure of supervision or control over the activities of the lower units of government. Snavely comments that on an intrastate basis. "state authorities, more frequently specialized in their fields and free from local prejudices, can offer valuable suggestions and advice to the communities. Advice, however, even of an official character, is often unwelcome unless an immediate gain can be realized by its acceptance or a loss sustained from its refusal. A double-barrelled gun of this nature, loaded with a reward for compliant counties and with a penalty for recalcitrant districts is available for the central governments in the form of State subventions."[1] What is said here with regard to state-local relationships applies perhaps even more in the Federal-state relationship.

Related to this, and arising as a result of it is a fourth purpose of grants-in-aid: the enforcement of minimum standards upon the recipient of the grant. Undoubtedly few things have been as influential in promoting the employment of qualified local public health personnel, for example, as have been the conditions attached to grants by both the state and Federal health agencies.

The idea of grants-in-aid is by no means new, having been first applied in this country in New York State in 1795 for the improvement of schools in the poorer, particularly in the rural areas of that state. Federal grants to states began as early as 1808 when Congress instituted an annual appropriation to assist the states in the development of their respective militia. No conditions were attached to these grants and no Federal supervision was exercised. Perhaps the next development of significance was the passage in 1862 of the Morrill Act which entitled each state to a grant of public lands based upon its total area. States not containing public land were given script. The only condition was that not less than 90 percent of the gross proceeds was to be used for the establishment, endowment, and maintenance of agricultural and mechanical colleges. Subsequent acts added to the original provisions an annual grant of cash to each state. In 1887 the Hatch Act was passed, providing $15,000 a year to each state for the establishment of agricultural experiment stations. With this act there was instituted the condition of submission of an annual financial report, followed eight years later by provision for a Federal audit. This established a pattern which has never since been altered.

Federal grants-in-aid for public health work began with the passage of the Chamberlain-Kahn Act of 1918. Stimulated by the increased threat of venereal diseases resulting from World War I, Congress provided an appropriation of one million dollars for each of two years to be distributed to the states on the basis of population. The program was administered, not by the Public Health Service but by an interdepartmental social hygiene board. After the second year, the appropriation was cut and then finally eliminated. As a result little of a lasting nature continued in any but the wealthier states.

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[1] Snavely, T. R., Hyde, D. C., and Biscoe, A. B.: State Grants-in-Aid in Virginia, New York, 1933, The Century Co., p. 14.

The next use of Federal grants for public health purposes was in the field of maternal and child health. Again as a result of increased interest during the war, the Sheppard-Towner Act of 1921 was passed, providing grants of $1,240,000 a year to the states for five years "for the promotion of the welfare and hygiene of infancy." Contingent upon certain conditions, chiefly the existence of a bureau of maternal and child health, each state was eligible for a flat sum of $10,000 and a share of the remainder on the basis of its proportionate population. The share of the remainder and one half of the flat grant had to be matched by the state. This act was the subject of strenuous opposition, not only on the part of states-rightists, but also of many members of the medical profession who, as they did a quarter of a century later in relation to the Emergency Maternity and Infant Care Program, viewed it as an entering wedge toward state medicine. Since some professional jealousy existed between the administering Children's Bureau and the Public Health Service, some criticism of the act was also forthcoming from the latter. After extending the provisions of the act for two years, Congress terminated the grants in 1929.

Thus the second venture in Federal grants for public health programs was short-lived and relatively unsuccessful. Despite this, many authorities consider the need for Federal and state initiative and aid to be greater in public health than in any other governmental function.

"Experience has shown that local governments of rural communities in general will not appropriate sufficient funds for the support of full time health units unless some assistance is forthcoming from outside agencies. Since it is in the rural sections that unsafe water supplies, unsanitary sewage disposal, inadequate medical attention and malnutrition combine to spread disease, it is in these communities that the greatest expenditures should be made. Despite the existing needs, the rural districts, even when aid is offered them, frequently hesitate or refuse to expand their revenue for the protection of health." [2]

The Federal government cannot dictate to the states the manner in which they should organize their governmental structures, establish their policies, or conduct their programs. However, actual dictation of these matters is not necessary in order for Federal agencies to play a part in the improvement and expansion of public health and other services throughout the nation. The significance of holding the purse strings is well understood by all. As stated in an old saw, "He who pays the piper calls the tune."

Sums of money transferred may be granted either conditionally or unconditionally; Federal grants are usually of the former type, state grants more often of the latter. Because of this, Federal grants are more apt to act as catalyzers than are state grants. In the ideal situation the local taxpayers would constantly exert whatever control might be necessary for the insurance of the proper use of the funds and it would be unnecessary to attach conditions to grants. When revenue is raised locally, this is more apt to occur than when funds come unfettered from without. By tying strings in the form of conditions to grants, therefore, the higher unit of government is in effect substituting for the controls that should ordinarily be exercised by the citizens themselves. There is danger, however, that conditions and standards may become too detailed or rigid to suit the diverse situations existing in a complex nation such as this. As Maxwell points out:

"Regional heterogeneity is of the essence of federalism, and . . . would seem to indicate that federal grants should be conditioned and closely policed. In practical fact, however, this would be an impairment of state sovereignty. Moreover, any detailed and uniform set of conditions would be unsuited to the diversity of regional and state needs. In a federalism, variations in standards of many governmental functions is common, and therefore the federal government is likely to get into difficulties if it attempts to prescribe common standards in grant programs . . . to surround federal grants with numerous conditions is to assume a homogeneity in state governmental needs which does not exist; to prescribe uniformity where there are deepseated reasons for diversity is an error. Here, then, is a dilemma of federalism." [3]

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[2] Snavely, T. R., Hyde, D. C., and Biscoe, A. B.: State Grants-in-Aid in Virginia, New York, 1933, The Century Co., p. 186.

[3] Reprinted by permission of the publisher from Maxwell, James A.: The Fiscal Impact of Federalism in the United States, Cambridge, 1946, Harvard University Press, pp. 38–39.

Usually, conditional Federal grants-in-aid require adherence to certain steps. First, the state must formally accept the terms of the grant, sometimes by means of legislation. Preparation for use of the grant must next be made by preparing and submitting specific plans and by establishing whatever organizations or agencies are indicated for their fulfillment. Plans are approved centrally by a national administrative agency. Usually, but not always, Federal grants must be matched by the state or local government. The program or project itself is carried out by state or local agencies, but subject to central as well as local inspection and audit. On satisfactory completion of the project or an agreed-upon part of it, payment is made to the state. Often, partial payment is made in advance.

A number of means of central influence and control are evident from the steps outlined above. The Federal agency may refuse to approve plans or to cooperate financially in a state program because of unsatisfactory state organization or procedure. Payments may be withheld if conditions of agreement are not observed. Furthermore, the state has little or no recourse beyond the Federal agency administering the grant. The application of central influences such as these has occurred frequently in the field of public health. In order to benefit from grants-in-aid administered by both the Children's Bureau and the United States Public Health Service, the states have found it necessary to establish or to remodel their personnel standards and merit systems to the satisfaction of these Federal agencies. Record systems, auditing procedures, clinic and hospital construction and maintenance standards, and many other factors have been similarly affected.

The tendency toward centralization has been most evident in the three fields of highway construction, education, and social security. It is interesting to study the similarities in the patterns followed in these three areas of public administration. Of particular interest to those engaged in public health work may be a comparison of the history of federal interest in public roads and in maternal and child welfare. The national government first became concerned with highways in 1893 when it established the Office of Road Inquiry, later the Office of Public Roads The original bill establishing this agency included the following statement: ". . . it is not the province of this department to seek to control or influence said action (in building highways) except in so far as advice and wise suggestions shall contribute toward it. . . . The department is to furnish information, not to direct and formulate any system of organization, however efficient or desirable it may be." From the date of its establishment until 1912 the Office of Public Roads restricted itself to experimentation, advice to state and local highway officials, the dissemination of information, and the construction of demonstration roads.

In 1912 an act was passed authorizing construction of post roads, followed in 1916 by a more potent Federal Highway Act which set up a system of grants to the states to assist them in meeting the increased demand for good roads and the increased cost of building better types of roads. Where originally the local county governments had the chief responsibility for the construction and maintenance of highways, this major responsibility and its accompanying authority passed first to the state and then to the Federal government. States now receive a large proportion of their highway funds through Federal grants-in-aid, and the Bureau of Public Roads as the Federal administering agent establishes the standards, approves plans, audits the accounts, and inspects the completed work. The effectiveness of these indirect forms of control is indicated by the fact that in 1916 when the Federal Highway Act was passed, fifteen states had no highway departments. By the following year every state had a recognized highway department acceptable to the Federal Bureau of Roads.

Compare with this the act of 1912 which established the Children's Bureau directing it "to investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people." It was designated as a clearing house for information on child health and was authorized to carry on research and also field studies. During the first seven years of its existence, the Children's Bureau adhered strictly to these specified functions. In 1921 with the passage of the Sheppard-Towner Act, the Bureau was authorized to participate in the promotion of maternity and infancy programs throughout the nation by means of Federal grants to the states. Here the Bureau received its first major administrative responsibilities. As in the case of highways some states anticipated the passage of the Maternity and Infancy Bill and created maternal and child health bureaus or divisions to administer the funds they

would obtain if and when the bill became law. Accordingly by the beginning of 1921 thirty-three such state agencies had been established and during the following two years fourteen more were created. By 1929 maternal and child hygiene bureaus or divisions had been formed and were functioning in the territory of Hawaii and in all the states except Vermont where the work was carried on under the immediate supervision of the state health officer. In administering the act, the Children's Bureau, as had the Bureau of Public Roads, set standards, approved projects, inspected work within states, and audited accounts. Although the functions involved in the Sheppard-Towner Act came to a halt in 1929, they were essentially reestablished in an expanded degree by the provision of Title V of the Social Security Act of 1935.

Further comparison is possible by considering the passage in 1942 of a bill (although temporary) to provide Emergency Maternity and Infant Care for wives and children of men in the Armed Forces. This program, administered by the Children's Bureau through the state health agencies, made possible and paid for personal medical care of patients.

Concerning roads one recognized authority has said:

"Related expenditures on highways were thrown out of balance in 1933 and the latter years of the depression as a result of the huge emergency expenditures for public works and the resulting grants and loans to the states. From the fiscal point of view the national government has emerged in the crisis as the senior partner in the firm." [4]

One might have cause to wonder if this is an indication of the ultimate effect of the Emergency Maternity and Infant Care program and other war emergency programs on the functional relationship between the local, state, and Federal governments. A large part of the considerable opposition to the Maternity and Infancy program was on this basis.

The above may make the grant-in-aid appear as a power-thirsty annelid increasingly draining off the life blood of local self-initiative and independence. Somewhat this viewpoint is expressed by Mustard, who said:

"Directly, through the broad interpretations of the Federal Constitution, and by new laws, or indirectly through grants-in-aid, parity payments, benefits, and rewards, the Federal Government is assuming prerogatives and accepting obligations, particularly in the field of social security, that a quarter-century ago were regarded as lying exclusively within the jurisdiction of the states. Pertinent in this connection is the fact that public health activities are more and more being considered as an integral part of the developing social security program and are receiving increasing federal attention. Thus the Federal Government is at present a potent influence in public health. Perhaps it is more virile than any other area of governments for . . . many state governments are static in this field, and leadership has focused in the United States Public Health Service. The policy of federal grants-in-aid for state and local health work is becoming increasingly popular, and apparently will continued in spite of what the opponents of this principle believe it implies sociologically and in terms of state and local autonomy." [5]

However, in fairness to the administering agencies several considerations should be pointed out. First, it is doubtful that the promotion of bills to provide subsidies for highways, education, and public health programs represented at any stage determined premeditated attempts to transfer power to a central agency. When all aspects of the questions involved are reviewed, it would appear that the acts were passed and the programs developed to meet public demands and needs which could not possibly be fulfilled by the state or much less by the local governments.

"Local governments have an administrative ability for performance of functions which is greatly in excess of their administrative ability for the collection of revenues. The case of the national government is the other way around: it has an ability to make efficient collection of taxes which is greater than its ability to handle expenditure . . . It will not be necessary to suppose that all governmental functions are handled by the national government. Local government will have tasks to perform, not because of any defect in the national power, but for the sake of administrative efficiency." [6]

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[4] White, L. D.: Introduction to the Study of Public Administration, New York, 1939, The Macmillan Co., p. 149.

[5] Mustard, Harry S.: Government in Public Health, New York, 1945, The Commonwealth Fund, pp. 185–186.

[6] Reprinted by permission of the publisher from Maxwell, James A.: The Fiscal Impact of Federalism in the United States, Cambridge, 1946, Harvard University Press, pp. 38–39.

The second consideration that must be conceded by all is that these programs have resulted in a considerable improvement of service and facilities for all the people. Speaking of highways, White comments:

"It is no exaggeration to state that in the . . . years since the first federal highway act a national highway system has been established at the direction of Congress by the Bureau of Public Roads, and that the standards of construction and maintenance by the states, and their subdivisions have been greatly improved as a direct result of national intervention through the grants-in-aid device. It is impossible to conceive that the transportation needs of the present could be met without coordination, guidance and supervision furnished by the national administration and the support of national funds." [7]

These conclusions could be applied with equal justification to the improvements which have occurred in the field of maternal and child health as a result of the activities engaged in by the Children's Bureau. In fact, the first recognized medical specialty as represented by the American Board of Pediatrics owes its existence to considerable degree to the persistent efforts of the Children's Bureau.

An interpretation of grants-in-aid quite different from that ordinarily made was presented in a study of state aid in New York by Pond, who stated:

"American government involves a system of checks and balances unique among the societies of the world. A persistent effort to retain the maximum independence to the individual and preserve to him the minimum of interference on the part of government is clearly discernible. Every state has two opposite evils to avoid, on the one hand over-centralization and on the other, local autonomy run riot. It is often taken for granted that efficiency can be secured by excessive control over localities which largely eliminates the citizen's participation in local affairs. On the other hand, it is quite as frequently believed that local autonomy is something sacrosanct, even when it results in much greater evils than those arising from centralization. Many competent observers believe that England stands alone in achieving both efficiency and a large measure of local self-government. This has undoubtedly been the result of grants-in-aid. And this is a political mechanism which may fit in perfectly with our own system of checks and balances." [8]

Grants-in-aid are intended to promote progress and improvement in lower governmental units by making it possible for them to provide better services and facilities than they can from their own unaided resources. Sometimes, however, this purpose is defeated by the system of distribution. Injudicious methods of subsidization may demoralize a community by fostering overreliance on the higher unit of government with loss of local initiative and sense of responsibility, by causing them to indulge in lavish expenditures or by allowing them to use the grants as an excuse for unwarranted reductions in local tax rates. Similarly there is a risk of pauperizing communities which happen to be poor in the first instance by enticing them into increasing local taxation and even indebtedness in order to raise funds for matching purposes.

The sound, effective, and equitable distribution of subventions, therefore, presents a difficult problem indeed. Most plans result in proportionately and absolutely more aid being allotted to wealthier communities than to those most in need. By distributing grants on the basis of taxable capacity, either directly or indirectly through complete matching requirements, by granting equal amounts to all communities or even by granting on the basis of population alone, there is a tendency, if anything, to increase the inequalities rather than to solve the problem.

The circumstances causing increased needs and high governmental costs are the same as those which result in insufficient resources for meeting the needs and costs. States and communities with proportionately many children, inadequate sanitary facilities, high disease and death rates, and slum conditions have need for more extensive and costly public services than the more salubrious states and communities but find it less possible to provide them. In order to accomplish their fundamental purpose, grants-in-aid therefore must be allotted, at least in part, in inverse ratio to the wealth of the various recipient areas. In this way the proportionate amounts received by communities tend to be in accordance with their relative needs.

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[7] White, L. D.: Introduction to the Study of Public Administration, New York, 1939, The Macmillan Co., p. 149.

[8] Pond, Chester B.: Special Report of the New York State Tax Commission, No. 3, 1931, Foreword, Albany, N.Y., New York State Tax Commission.

In distributing grants-in-aid there exists the possibility of taking funds from some areas and giving them to others which may be just as able to finance themselves as those providing the funds. One method of avoiding this involves correcting the apparent taxable capacity of communities to a true common denominator by determination of equalized assessments, which is difficult to do, or by the use of assessment ratios to provide estimated true valuations.

A plan of distribution based on actual financial needs, supplemented by additional grants to encourage compliance with minimum standards, will provide some assistance to all communities and in addition will give consideration to those unable to raise funds enough of their own to supply the necessary services. If the superior governmental unit allots only a partial share of the maximum possible subsidy to those areas failing to raise the estimated amount of revenue as determined by the use of assessment ratios, this will act as a powerful incentive to provide local funds more in keeping with local financial ability. A plan like this is admittedly more difficult and costly to administer but in the long run will justify itself in terms of greater general improvements and satisfaction.

The Social Security Act of 1935 provided for federal-state cooperation in public health matters on an increased and more or less permanent basis. It provided for annual grants "to assist states, counties, health districts and other political subdivisions of States in establishing and maintaining adequate public health services." The annual sum of 8 million dollars which was subsequently increased ($38,879,300 for the year 1952) was to be distributed among the states by the Surgeon General of the United States Public Health Service on the basis of three factors: population, special health problems, and financial need. The relative weight given to these factors was left to the discretion of the Surgeon General after "consultation with a conference of the State and Territorial health authorities."

Grants-in-aid by the Public Health Service for fiscal year 1959 were as shown in Table 23.

TABLE 23.—*Grants-in-aid, Public Health Service (fiscal year 1959)*

Purpose	Type of grant	Amount
	Venereal disease special projects	$2,400,000
	Tuberculosis control	4,000,000
	General health	15,000,000
	Mental health	4,000,000
	Heart disease control	2,125,000
	Cancer control	2,250,000
	Water pollution control	2,700,000
	Alaska—Disease and sanitation investigation and control.	[1] 638,000
Subtotal		33,113,000
Grants to States	Construction:	
	Hospitals	150,000,000
	Medical facilities:	
	Diagnostic or treatment centers	7,500,000
	Chronic disease hospitals	7,500,000
	Rehabilitation facilities	10,000,000
	Nursing homes	10,000,000
Subtotal		185,000,000
	Waste treatment works	[2] 50,000,000
Total grants to all States		268,113,000
Grants to interstate agencies	Water pollution control	300,000
Grants available to public agencies only	Air pollution demonstration projects	40,500
Grants available to individuals directly or through institutions.	Training: Public health personnel under title I, Public Law 911, 84th Cong.	2,000,000
Grants available to individuals, public agencies, and training institutions.	Training: Air pollution	100,000

[1] In addition, $1,000,000 is available in fiscal year 1959 for a mental health program, and $6,500,000 for the construction of mental health facilities is available until June 30, 1960.

[2] Appropriation is for $45,000,000 but appropriation act provides that allocations to States be based on $50,000,000.

The failure to specify more exactly the method of distribution of funds appropriated by legislatures has given cause for objection from many quarters. Thus, a report of the Municipal Finance Officers Association states:

"The federal government has never had a continuing relief policy. The total amount of grants available has hinged primarily upon vacillating concepts of necessity. In addition, allocation of individual grants has been based upon wide administrative discretion. Such a procedure has hardly contributed to predictable municipal budgets. . . . The financial aid of the upper levels of government has undoubtedly saved many localities from complete disaster. Yet the unstable aid policies which have accompanied the greater reliance upon state-collected, locally shared taxes and grants-in-aid have served to accentuate revenue fluctuations for many local governments."[9]

In like manner, many health officers have complained of the difficulty involved in attempting long-range programs due to the uncertainty surrounding the amount of both Federal and state funds that might be counted on for budget planning.

An attempt has been made by the Public Health Service to determine indices of financial need and of special health problems, but the results have not been completely satisfactory and the relative bases of distribution have been somewhat variable. Thus, in the first year, 1936, 57.5 per cent was distributed on the basis of population, 22.5 per cent on the basis of special health problems (judged by the number of deaths from all infectious and parastic diseases and from pneumonia but not including venereal disease for which a separate grant is made), and 20 per cent on the basis of financial need. But, for the year 1941, funds were distributed on the basis of 29.4 per cent for population, 41.2 per cent for special health problems, and 29.4 per cent for financial need.

The Public Health Service has tried to consider other factors such as the relative cost of rendering health services in each state and the existence of special programs in particular states. Of the amount distributed on the basis of special health problems, one half has been based on mortality, one fourth according to relative costs of services, and one fourth as a remainder. Financial need has been based essentially on per capita income as computed by the United States Department of Commerce.

Matching requirements have been a result of administrative decision rather than of legal specification. In general, at the present time, the States must provide one dollar for each two dollars of Federal funds. This is true in the programs for general health, mental health, heart disease, and cancer. Tuberculosis funds must be matched dollar for dollar. The requirements for hospital construction funds are variable. In any case, the Federal share must be not more than two thirds or less than one third.

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[9] The Support of Local Government, Municipal Finance Officers Assn., Chicago, 1939, pp. 18–19.

The conditions under which states make grants-in-aid to localities vary in the extreme. This was brought out by several papers and discussions at the National Conference on Local Health Units held in Ann Arbor, Michigan, in September, 1946. The policies of state health departments in this matter varied from no specific predictable basis of distribution to the use of complex mathematical formulas which, incidentally, were admittedly sidestepped more often than not. One conclusion was that no standard formula could be applicable to all of the states and that each would have to work out its own solution to its own satisfaction. A summary of a number of current state plans may be of illustrative interest.

Florida

Per capital grant varied by population size, with required per capital local contribution (50¢ considered basic) and system of bonus for excess local contribution and penalties for deficiencies in local contributions. One percent is added to or deducted from basic State contribution for each cent above or below 50¢ per capita from the county—not to exceed more than 50 percent of original basic state contribution. The State retains the right to add or subtract 5 percent or less of this.

Allocations may be made for special needs not subject to formula.

Georgia

Percentage of State participation varies with population with most populous areas receiving 30 percent and least populous receiving 75 percent.

Illinois

One dollar subsidy for three dollars local money or 30¢ per capita, whichever is the lesser. Special need subsidy added in poorer counties to equalize available resources to approximate $1.20 per capital state-wide.

Louisiana

Total amount available for allocation to local departments is divided by population—this per capita amount is used as general basis and then modified by past progress, health and financial need of area.

New York

In counties and cities over 50,000 population on basis of 50 percent of cost of public health services, except where a county health department is established in which event State aid is given in amount of 75 per cent on first $100,000 expended and 50 percent on balance of expenditure.

North Carolina

Based on population, financial needs, and specific program needs.

The most progressive state action in this regard is the Public Health Assistance Law passed by California. This law became effective September 19, 1947 and provides an annual sum for local health services which is allocated according to a formula written into the law. Each county receives either a basic allotment or a capitation, whichever is less. The remainder, after substraction of 7.5 percent of the total for administrative and consultative services and training, is allocated to health departments meeting standards on a straight per capita basis.

It is of further interest to note that this act officially provides for a California conference of Local Health Officers which, among other things, must approve standards relating to local health service before they can be established by the State Department of Public Health. This plan warrants close study by the Federal agencies responsible for the distribution of grants to state and local governments, since it appears to go far in eliminating many causes for dissatisfaction.

The rising tide of Federal influence in state and local affairs is well illustrated by another phase of social security, the relief of dependents. Traditionally the care of such individuals in America has been a local and often a private affair. The economic depression of the 1930's changed all this, when, because of lack of funds, first private charity then local governments and in turn state governments found themselves quite incapable of meeting the tremendously increased demands. Only one other source of assistance remained—the national government. As a result, numerous alphabetically designated Federal agencies were established, forming for the first time a basis of a broad system of Federal social security, concerned with the unemployed, the handicapped, dependent children, and the aged. This soon crystallized to a permanent legally established program. Again it should be pointed out that this represented not a premeditated design or plan of Federal officials but merely evidence of the increasing incapabilities of governmental units of lower levels to meet problems which essentially were those of the nation as a whole. Some writers have pointed out that even if the Federal government were to withdraw from this field of activity a definite change in attitude on the part of the public has occurred and the psychological loss of prestige by the states is practically irreparable.

The changes that have occurred in the relationship between the Federal and the state governments have also resulted in some change in the relationship between state and local governments and local and Federal governments. Theoretically, the national government has no relationship with cities. However, even antedating the depression there had appeared signs to indicate closer contacts between national and municipal authorities. In 1925 Anderson pointed out numerous instances in which national agencies played a significant role in the determination and management of municipal affairs. A more detailed study of Federal service to cities was made in 1931 by Betters who commented: "The wide range of activities of the national government which touch intimately on current problems of municipal administration may surprise many." He pointed out that Federal agencies already developed standards in weights and measures, traffic and safety, zoning and building, highway construction and milk sanitation, and carried out studies and surveys on local education, finances, crime, vital statistics, and public health. In addition, Federal agencies were actively engaged in a cooperative sense in food and drug administration, municipal water supplies, sewage disposal, and in other fields. Again the depression and the subsequent Second World War accelerated the intimacies of these relationships

Although the Federal agencies operated for the most part through the state governments as an intermediary, they did in some instances deal directly with cities. The possible revolutionary consequences of this caused White to comment:

"The extent to which actual control of municipal affairs was lodged in Washington as a result of these emergency measures is not easy to define. The federal government did not attempt to weaken the control of the state over its political subdivision, and no change in the legal status of the city was imposed . . . contacts between cities and the national government were broad and in their extent spectacular; but the states were not dispossessed of their traditional constitutional position as guardians of municipal government. The change has been a change in climate rather than a change in topography. Future lines of development are not clear, but it seems likely that the research and advisory services of the national government to cities are destined to increase in importance. So far as the cities enter into debtor-creditor relations with Washington, an element of fiscal supervision may appear. . . . Movement has been rapid since 1933, and a federal bureau of municipal relations is much more within the realm of the practical than it was before the events of the depression. Here is an aspect of central tendencies which in the case of the great urban centers may be of special significance, for they have little to derive from the state capitols as they have much to gain from in Washington." [10]

The rural areas of America were not absent from this scene of changing governmental relations. Except for the financing of the county agent program and aid to rural education and agricultural research, contact between the Federal government and the rural areas was lacking until the establishment of the Agricultural Adjustment Administration. With its establishment in 1933 the Federal government entered into cooperative programs with the farm population, involving the adjustment of farm production to nationally established quotas and the direct payment to individual farmers for compliance with contracts with regard to certain crops. County production control associations were established, covering practically all parts of the rural area of America and including several million cooperating farmers. In the process the state governments were largely ignored. Associated with this program were activities such as the national nutrition program which had a direct bearing on the health not only of the farm families but of the nation's population as a whole.

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APPENDIX 3

Summary data covering the allocation of Public Health Service grants, fiscal year 1962

Grant	Amount allocated	Statutory authorization	Matching requirements	Allotment formula	
				Population and financial need	Extent of specific problem
General health	$15,000,000	Sec. 314(c) Public Health Service Act.	$1 State, $1 Federal	95 percent, population weighted by index of financial need.[1]	5 percent, reciprocal of population density.
Chronically ill and aged:					
Formula grant	6,000,000	do	do	40 percent, population weighted by index of financial need.[1] 60 percent, population 65 and over weighted by index of financial needed; [1] minimum allotment $40,000.	
Project grant	[2] 2,319,000	Sec. 316(a) Public Health Service Act.	None	None	None.
Tuberculosis:					
Formula grant	3,500,000	Sec. 314(b) Public Health Service Act.[3]	$1 State, $1 Federal	20 percent, population weighted by index of financial need.[1]	26 percent, tuberculosis mortality for 1956–58; [1] 43 percent, tuberculosis morbidity for 1956–58; [1] 11 percent, basic grant.
Project grant	500,000	Public Law 87–290	None	None	None.
Cancer:					
Formula grant	3,500,000	do	$1 State, $1 Federal	60 percent, population weighted by index of financial need.[1]	35 percent, cancer mortality for 1956–58; [1] 5 percent, reciprocal of population density; minimum allotment $25,000 or 25 cents per capita, whichever is less.
Project grant	1,500,000	do	None	None	None.
Mental health	6,750,000	Sec. 314(c) Public Health Service Act.	$1 State, $1 Federal	30 percent, population weighted by index of financial need.[1]	70 percent, extent of emotional and psychiatric disorders considered directly proportional to population; [1] minimum allotment $65,000.
Heart disease	5,000,000	do	do	37 percent, population 35 cents per capita for 1st 100,000 population or fraction thereof; 63 percent, population weighted by index of financial need.[1]	
Venereal disease, special projects	2,585,000	Sec. 314(a) Public Health Service Act and Public Law 87–290.	None	None	None.

Construction of hospitals	150,000,000	Sec. 621, Public Health Service Act.	Variable, based on State standards, Federal share not more than 66⅔ percent or not less than 33⅓ percent. (See sec. 631(k), pt. 11-3).	100 percent (fixed by law), variable allotment based on population weighted by the square of the allotment percentage.[1] Allotment percentage may not exceed 75 percent or be less than 33⅓ percent. Minimum allotment, $200,000 (except Virgin Islands and Guam). To compute weighted population: (1) Assign 50 as index for U.S. per capita income (3-year average 1957–59); (2) Determine index for each State income in relation to U.S. income; (3) From 100, subtract the State income index; (4) Square the remainder (the "allotment percentage"); (5) Multiply State's population by allotment percentage squared.	
Construction of medical facilities:					
Diagnostic or treatment centers.	14,228,000	Sec. 651, Public Health Service Act.	do	100 percent (fixed by law), variable allotment based on population weighted by the square of the allotment percentage.[1] Allotment percentage may not exceed 75 percent or be less than 33⅓ percent. Minimum allotments $100,000 for diagnostic or treatment centers, chronic disease hospitals, and nursing homes; and $50,000 for rehabilitation facilities (except Virgin Islands and Guam). To compute weighted population: (1) Assign 50 as index for U.S. per capita income (3-year average 1957–59); (2) Determine index for each State income in relation to U.S. income; (3) From 100, subtract the State income index; (4) Square the remainder (the "allotment percentage"); (5) Multiply State's population by allotment percentage squared.	
Chronic disease hospitals	20,000,000				
Rehabilitation facilities	7,000,000				
Nursing homes	18,500,000				
Hospital and medical facilities research and demonstration gram.	[2] 8,117,000	Sec. 636, Public Health Service Act.	None for research grants; not more than 66⅔ percent for remaining program.	None	None.
Air pollution:					
Research grant	[3] 1,855,000	Public Law 159, 84th Cong., sec. 301, Public Health Service Act.	None	do	Do.
Training grant	113,000	do	do	do	Do.
Radiological health:					
Research grant	1,198,000	Sec. 301, Public Health Service Act, sec. 314, Public Health Service Act, Public Law 87-290.	do	do	Do.
Training grant	1,000,000	do	do	do	Do.
Public health traineeships	2,000,000	Sec. 306, Public Health Service Act.	do	do	Do.
Professional nurse traineeships	[2] 6,604,000	Sec. 307, Public Health Service Act.	do	do	Do.
Grants to schools for public health training.	[2] 1,173,000	Sec. 314, Public Health Service Act.	do	do	Do.
Project grants for graduate training.	2,000,000	Sec. 309, Public Health Service Act.	do	do	⅔ allocated on basis of the number federally sponsored students in each school; ⅓ divided equally between each school.

See footnotes at end of table, p. 54.

Summary data covering the allocation of Public Health Service grants, fiscal year 1962—Continued

Grant	Amount allocated	Statutory authorization	Matching requirements	Allotment formula	
				Population and financial need	Extent of specific problem
Water pollution:					
Program grant to States	$4,500,000	Federal Water Pollution Control Act, as amended.	Federal share is variable; based on per capita income—nor more than 66⅔ percent nor less than 33⅓ percent. Percentage for each State is shown in exhibit 1. (See sec. 55.5 of the regulations governing grants for water pollution control programs.)	66⅔ percent, population weighted by index of financial need.[1] (Percentages applied to total amount allocated less total basic grant.)	Basic grant ($12,000 to each State); 16⅔ percent, density of population; 16⅔ percent, number of industrial establishments discharging industrial wastes. (Percentages applied to total amount allocated less total basic grant.)
Program grant to interstate agencies	300,000	do	do	66⅔ percent, population of area served by interstate agency weighted by index of financial need.[1]	16⅔ percent, density of population; 16⅔ percent, number of industrial establishments discharging industrial wastes.
Research grant	[2] 2,462,000	do	None	None	None.
Training grant	700,000	do	do	do	Do.
Demonstration grant	300,000	do	do	do	Do.
Fellowships	100,000	do	do	do	Do.
Grant for construction of sewage and waste treatment works	80,000,000	do	Not more than 30 percent of the estimated reasonable cost of a project or $600,000, whichever is smaller. (See sec. 6(b) of the Federal Water Pollution Control Act, as amended.)	50 percent, population; [1] 50 percent, financial need.[1]	Do.
Hawaii leprosy grant program	1,200,000	Public Law 411, 82d Cong.	None		Do.

[1] Source of data: Population, 1960 Decennial Census for construction of hospitals and medical facilities only—P-25, No. 230, for States, and 1960 census as certified by the Bureau of the Census for Guam, Puerto Rico, and Virgin Islands; financial need, per capita income estimates, Department of Commerce 1955-59—5-year average. (3-year average 1957-59 for water pollution control and construction of hospital and medical facilities); cancer and tuberculosis mortality, vital statistics 1956-58; tuberculosis morbidity, annual tuberculosis report, form PHS-1293.

[2] Amount available.

[3] Modified by appropriation act, Public Law 87-290.

NOTE.—This table does not include NIH grants.

Source: "The Public Health Service: Background Material Concerning the Mission and Organization of the Public Health Service," prepared for the Interstate and Foreign Commerce Committee, U.S. House of Representatives, April 1963.

BIOGRAPHICAL SKETCH OF JOHN JOSEPH HANLON, M.D.

Massachusetts Institute of Technology, B.S. 1933, M.S. 1934; special student, Harvard School of Public Health, 1934; Wayne University, M.B., 1940, M.D. 1941; Johns Hopkins University, M.P.H., 1942.

Assistant Sanitary Engineer, Eaton County, Michigan, 1934; Assistant Epidemiologist and Statist., Detroit Department of Health, 1935–40; Intern, Harper Hospital, Detroit, 1940–41; Health Officer, Bradley County, Tenn., 1941; Director of Nutrition, Tenn. State Department of Health, 1941–43; Chief of Health Mission, Institute of Inter-American Affairs, Bolivia, 1949–51; Special Assistant to Commissioner of Health, City of Detroit, 1951–52; Medical Director, U.S. Public Health Service, 1952–57; Chief, Public Health Division, U.S. Foreign Aid Program, Dept. of State, 1952–57; Director, Community Health Services, City of Philadelphia, April 1, 1957 to Sept. 11, 1964; Public Health Director, Detroit and Wayne County, since Sept. 14, 1964.

SUMMARY

Rural: Eaton County Health Department, Michigan; Bradley County Health Department, Tennessee.

Urban: Department of Public Health, Detroit and Wayne County, Michigan; Department of Public Health, Philadelphia, Pennsylvania.

State: Department of Public Health, Tennessee.

National: U.S. Public Health Service; U.S. Department of State.

International: International Cooperation Administration.

Foreign: Servicio Cooperative Inter Americano de Salud Publica, Republic of Bolivia.

TEACHING EXPERIENCE

Associate Professor of Public Health Admin. Univ. of N.C. Sch. of P.H. 1943–44.

Instructor in Preventive Medicine, Univ. of N.C. Sch. of Medicine 1943–44.

Resident Lecturer, Associate, Prof., Pub. Health Practice, Univ. of Mich., Sch. of P.H., 1944–52.

Lecturer at various times:

School of Public Health: California, Columbia, Harvard, Johns Hopkins, Minnesota, Pittsburg, Puerto Rico.

Medical Schools: Duke, Hahnemann, Howard, Pennsylvania, Wayne, Woman's.

Other: Tuskegee Institute; Johns Hopkins University School of Advanced International Studies; London School of Hygiene and Tropical Medicine; American University at Beirut; University of the Philippines; All-India Institute of Hygiene; High Institute of Public Health, Alexandria, Egypt; Universidad de Buenos Aires; Universidad de San Marcos, Lima, Peru; Universidad de LaPaz, Bolivia; Universidad de Cochabamba, Bolivia.

Professor and Chairman, Dept. of Preventive Medicine and Public Health, Temple University School of Medicine 1957–64.

Professor and Chairman, Dept. of Community Medicine, Wayne State Univ. College of Med. 1965.

Adjunct Prof. of Public Health Administration, School of Public Health, Univ. of Michigan 1965.

SPECIALTY CERTIFICATION

Diplomate, American Board of Preventive Medicine and Public Health.

MEMBERSHIPS AND ORGANIZATIONAL ACTIVITIES

International: Expert Panel on Public Health Administration, World Health Organization (Geneva) 1952 to present; Exec. Comm. and Counsellor, International Union for Hlth. Educ. (Geneva); Consultant, International Cooperation Administration (Washington) 1957–61; Consultant, Pan American Health Organization, 1962 to present.

National: American Public Health Association—Fellow, Governing Council, 1958–64; Program Committee, 1955–60; Health Officer's Section, Vice Chairman, 1958–59; Chairman, 1959–60; Section Council, 1961–64.

man, 1958–59; Chairman, 1959–60; Section Council, 1961–64. American College of Preventive Med. and Pub. Health, Fellow. American Academy of Political and Social Science, Fellow, Rep. from APHA. Association of Professors of Preventive Medicine, Member.

Member of numerous state and local professional and community organizations, societies, committees, commission and councils.

DELEGATIONS

Regional World Health Conference, Bandung, Java, U.S. Rep., 1952; World Health Assembly, Geneva, Member U.S. Delegation, 1953, 1955, 1956; International Union for Health Education of Public-Rome, Member U.S. Deleg., 1956.

HONORS

Recipient, Order of the Condor, Republic of Bolivia, 1951; Delta Omega (National Honorary Public Health Society); Sigma Xi (National Honorary Scientific Society); Sociedad Boliviana de Salud Publica (Honorary Member); Hellenic Public Health Society (Honorary Member).

PUBLICATIONS AND EDITORSHIPS

Design for Health (with McHose) (Lea and Febiger) 1963; Principles of Public Health Administration (C. V. Mosby Co.) 1950, 1955, 1960, 1964; Principios de Salud Publica (Pan American Sanitary Organization) 1951, 1963; Nutrition and the Public Health (with Beeuwkes) (Overbeck) 1945, 1947; Numerous articles on public health, preventive medicine, social science, archeology, and philately; Editorial Board, American Journal of Public Health, 1956–62; Editorial Board, Public Health Reports, 1966.

Listed in World Biography, Directory of Medical Specialists, Who's Who, Who's Who in the South and South West, Who's Important in Medicine, American Men of Science, Who's Who in Education, International Directory of Anthropologists, Who's Who in the Mid-West.

Mr. ROGERS of Florida. Now we will move to the next witness, Dr. David J. Vail, the director of medical services, Minnesota Department of Public Welfare.

Dr. Vail, it is a pleasure to welcome you to the committee this morning, and we appreciate your being prepared to give us your statement.

And, as a matter of fact, I think, since we have a distinguished Member from your State here who makes a great contribution to the consideration of this committee, as he has over the years, I would like to defer to him.

Mr. NELSEN. Thank you very much. You are very, very generous in your comments.

I would only say that I am happy to introduce our fellow Minnesotan, and also pleased to note that in our State I think we lead in many respects relative to the mental health program going back a number of years.

We pioneered in that field, and I think our Minnesota program has been a very effective one.

I have no further comments to make except to welcome you, Dr. Vail.

STATEMENT OF DAVID J. VAIL, M.D., DIRECTOR OF MEDICAL SERVICES, MINNESOTA DEPARTMENT OF PUBLIC WELFARE

Dr. VAIL. Thank you, Congressman Nelsen.

Mr. Chairman, members of the committee, first I would like to express my appreciation for this opportunity, and to bring you the greetings from the great State of Minnesota.

I will read my statement, which is general. I can give examples, as I am sure will come out in questioning.

I feel not reluctant, but a little one down in the sense that a great deal of what I have to say has already been said, and I would underline and emphasize all the points that have been made. I think I would agree with almost all of the testimony of the other witnesses.

Mr. ROGERS of Florida. Do you prefer to read your statement, or would you like to just comment?

Dr. VAIL. Yes, sir; I would like to read it.

Mr. ROGERS of Florida. All right. That will be fine. Thank you.

Dr. VAIL. I am Dr. David J. Vail, medical director of the Department of Public Welfare of the State of Minnesota. I represent the commissioner of public welfare, who is the State mental health authority of Minnesota. The commissioner of public welfare is also designated as authority for both mental health and mental retardation facilities construction under Public Law 88–164, and under State law is charged with the administration of institutions for the mentally ill and mentally retarded, and the development of community mental health programs.

First, I express my appreciation to you, Mr. Chairman, and to this committee, for this opportunity to bring you my observations on the administration of public service programs.

Next, I must identify myself not only by name and title, but along certain other dimensions. My reason for this is that views expressed on health, mental health, and related matters will vary, among other things, in relation to the profession of the witness, his bureaucratic status, his personal political philosophy, and other commitments. Therefore, so that you will understand my position, I should make these points very clear:

1. I am a public administrator.
2. I am a psychiatrist.
3. I work for the State of Minnesota.

That is important in two respects. One is that I work for the State. The other, of course, is Minnesota.

4. I work comfortably in a setting in which the field of public mental health is, so to speak, subsidiary to the more general order of public welfare.

This means that my view of the public service world will differ, for example, from that of one who views mental health as subsidiary to public health, or, in contrast, an entity unto itself.

5. My orientation about the field of public "mental health" is inclusive rather than categorical. That is, I regard the problems of mental illness, mental retardation, alcoholism, forensic psychiatry, child guidance, et cetera, as part of the same general order, rather than separate issues.

Here again you will encounter different points of view, depending on who appears before you.

6. In political terms, I would be viewed as somewhat in the center, which still puts me to the left of the great majority of my brethern in the medical profession.

Despite the above qualifications, I have reason to believe that, generally speaking, my sentiments are not far removed from those of other State—and I underline that—administrators in the human services field.

One reason I am glad to have this opportunity is that I am worried not only about the particular programs in which I directly participate, but also about the implications of current trends in the public services field for the future of this country.

I quote from the final section of my editorial which will appear in the April 1966, issue of the Minnesota Mental Health Newsletter:

> We have been warned about the dangers of a technocracy surrounding the military-industrial elite. Are we seeing the start of a new elite, a new technocracy in the human services field? If this were coupled with management practices that pit the Federal and State governments against each other, the consequences to constitutional government in the United States could be very grave indeed.

Rather than demean these proceedings by simply airing gripes, I have organized my presentation into three main parts, which greatly interlock: (1) Problems specific for the field of public mental health, (2) problems general for the humanitarian field, and (3) recommendations.

With regard to the problems relating to the public mental health field, my effort here generally has been to make my comments as general as possible, and therefore I have omitted considerable detail, but some of the specific items are spelled out in the newsletters of the last three issues, which have been submitted and are submitted for the record, so I touch on just these three major points, and I can elaborate on any of them.

1. Excessive paperwork. The Minnesota plan for comprehensive community mental health centers construction—the first one submitted from my State, by the way—written according to the official instructions, was clocked out when we submitted it in December 1964, at over 600 pages and a total weight of 5 pounds 10 ounces per copy—and it was judged to be incomplete at that.

This production job would have been less frustrating if we could have seen its intrinsic connection to other public mental health, or, for that matter, public human services efforts, or even to the other State plans submitted by our own division, by the department of public welfare, or by other State departments.

2. Bureaucratic manipulation. This is covered in the newsletter editorials, especially that of March 1966, entitled "Government Games."

3. Problems of logic and ideas. This is the most serious level, actually. This is covered, though incompletely, in the newsletter editorials.

My second major category or area of discussion is problems that are general for the humanitarian fields.

1. Goals. Goals are now being defined not in output terms of reduction of public problems, but primarily in input terms of services to be provided. This puts a premium on activity rather than accomplishment.

I was rather startled to hear Dr. Venable use that same phrase, and we did not get together beforehand.

2. Categories. In my view, there is an overabundance of categories of Federal programs, each of which, in varying measure, entails special offices at both Federal and State levels, advisory committees, written plans, budgets, et cetera.

For example, the medical services division of the Minnesota Department of Public Welfare, which is my own domain, now has to contend with all this machinery in regard to general community mental health, comprehensive community mental health centers construction, which is a separate category and requires a separate plan, community mental health centers staffing, another separate category and slightly variant, mental retardation facilities construction.

The Minnesota Department of Public Welfare as a whole is charged with the following additional categories of Federal grant programs: public assistance—as you know, this breaks down further into categories—crippled children, tuberculosis, blind services, child welfare, and most recently, title XIX of the Medicare Act.

The Minnesota Health Department has hospital construction, maternal, and child health. And so it goes.

On the positive side, it should be said that certain Federal programs force interdependence among the State agencies, which is all to the good. Examples are mental retardation facilities planning and MDTA.

3. Multiple convergence. This is related to the problem of categories. The Federal agencies are in a position to establish staff positions as soon as a Federal agency or subagency is created. The States move more slowly. The result is that a single State agency may be the target for not a single counterpart Federal agency, but rather for a group of Federal agencies or teams which may sometimes appear to be in competition with one another.

This is burdensome and perplexing to the States.

4. Squeeze. This is a complex phenomenon which stems from too rapid proliferation of programs at the Federal level, inadequate administrative machinery at the State level, and stimulation of pressure locally—from below, so to speak—through publicity and other forces generated from Washington.

Typical examples are the November 10, 1965, missive from the National Institute of Mental Health—this is a letter that went out to medical societies, mental health associations, various psychiatric clinics, and so forth, urging them to take advantage of Federal funds—and the Public Law 89–10 fiasco.

I must qualify that. This is the title I of the education bill which has been a fiasco in Minnesota, maybe not in other States.

The story of the resignation of Dr. Fred P. Roessel from the Minnesota Department of Education is a perfect case in point. I won't have time to look at it now, but it is submitted for the record.

I deliberately chose this from another field—namely, education—because I think it does illustrate some of the problems that one finds in a variety of fields at the State level these days.

5. Absence of dialog; confusing messages. The State agencies are ultimately called upon to implement programs. Discussion between State and Federal counterpart agencies has been inadequate. Related to this and to other factors is a serious problem of confusing messages.

6. Downgrading the States' efforts. Federal programs may be formulated, justified, and brought forth with heavy emphasis on States' failure to solve the problems. While this position may be accurate in some respects, it is not pleasing to the State agencies, and not calculated to win their cooperation, especially when the State agencies may

be bypassed in new efforts or required to perform under conditions of degradation and/or beyond their capabilities.

7. Cross-referencing. Sometimes, either in law or regulations, it is made clear that category A funds will be withheld unless standards in category B are upheld. One wonders whether such practice is always appropriate, wise in the long run, or, for that matter, fair.

I would comment here sometimes that it may be appropriate, in order to bring about coordination of programs, but if this is the case, then the cross-referencing should be done on a program basis, and not, as it sometimes appears, simply to push a project that the Federal agency desires.

8. Manpower. This, of course, as you have heard, is a critical problem.

New programs will not only drain available manpower sources for direct services—for example, social workers, nurses, et cetera—but also competent administrators.

You have heard already about the really frightful administrative overhead in these programs, and my belief is that simply better administrative methods and better administrative rules would relieve a great deal of the drain.

What is happening now is that our program people, our nurses, and our social workers, and we have therapists who should be concentrating on the programs, are giving up enormous amounts of time simply on the administration, and the State machinery is not able to keep pace with the administrative demand related to this, which is another point later on, and I notice some inconsistency about the Federal programs providing for administrative costs.

9. Emotional strain. Let us not overlook the human element. The work of setting up and administering the programs is done by human beings. The resulting strains may be overwhelming. Show me a State man who has worked up a new program by Federal standards, and I will show you a case of traumatic neurosis, or combat fatigue.

The third major point, recommendations: I divide these comments into two groups: (A) those consonant with current Federal practice, and (B) those that would depart from current Federal practice.

A. Consonant with current Federal practice:

1. Accountability. We uphold the principle that the States should be accountable for program performance in qualifying for moneys received. In fact, we believe that accountability for results—by that I mean program results—should be strengthened and improved.

This is a very basic point.

I have been misunderstood by people working at the Federal level. I think there is a general idea that what the States want is, "Simply give us the money and go away and don't ask any questions," but this is not what I am saying.

I am saying that we welcome the accountability, but in the appropriate area where it belongs.

Below I make more concrete suggestions about new ways in which accountability systems might be organized.

2. Nonsubstitution. We uphold the principle that Federal grants of whatever kind should not be used to substitute for State effort, but to supplement it, to help advance capability.

B. Departing from current Federal practice:

1. Planning should be based on the reduction of public problems, again, based on accomplishment, and not solely activity.

2. Categories for grants should be trimmed back as much as possible. I personally favor the idea of lump-sum grants. I think you will also find the so-called Heller plan quite attractive to State-level workers.

Again, I would like to repeat that I think maybe the phrase "lump-sum grant" is unfortunate, because it does connote the idea of, "Give us the money and go away." This should not be construed as a suggestion that there should be then no accountability. There must be accountability, but accountability in its appropriate use.

3. Whatever else is done, paperwork must be reduced. The present situation is simply ridiculous, and I wonder, frankly, who reads all this stuff that we send in.

4. There should be clear and uniform policies allowing for support of costs of administering Federal grant programs. Current practice appears to be inconsistent.

5. Dialog between the Federal and State agencies should be enhanced. Stated in another way, those who are entrusted with the implementation of programs should be included in the discussion of the programs before their enactment, and as programs get underway, better feedback channels should be provided than now exist.

6. Programs must start where they are. An old rule in chess is, do not try to get a piece out of trouble by getting another piece in trouble. Do not try to solve problems by creating new problems.

This statement as written here is a little open ended. The best example that I can think of, but there must be many others, is what is going on in the mental health field now, and that is the premise State hospitals have done a poor job, which nobody argues with, State agencies are weak, therefore, the answer to this is to produce a complex new program.

This is not, I submit, an appropriate way of solving the problem.

7. Work in the humanitarian fields should be decentralized. Can we hark back to the wisdom of the Constitution? Extramural functions of the Nation, such as defense and foreign relations, are quite properly in the jurisdiction of the Federal Government. But the evidence seems to be accumulating that the intramural functions of regular stewardship—protection of the public health, safety, and morals, for example—must be reserved to the States. Otherwise, considerations of political philosophy aside, it just won't work.

This I would repeat again. It won't work.

8. We should try to remodel existing administrative systems connecting the Federal and State Governments along imaginative and if necessary novel lines.

For example, why not require only one State plan per agency, not according to preconceptions about program jurisdictions within agencies, but simply taking the State agencies as they exist? A controllable number of plans could then be put together into a total plan for the State by a State planning authority in the Governor's office.

Minnesota, I am glad to say, does have such a State planning authority, and this looks like a very exciting prospect.

Patterns of program consultation might be greatly modified. At the present time, Federal regional offices are the headquarters of consulting staff teams organized by program categories.

Might it be more feasible to station Federal consultants directly in the States themselves on a full-time basis, to function as generalists in relation to the State agencies as they exist? The personnel for such a system could come from thinning out and not adding to existing Federal agency staff.

Incidentally, and curiously, there is a precedent for this approach in one area—fiscal—in the person of auditors employed by the Federal Government and stationed permanently at the State offices to go over all the Federal accounts in a given State agency.

It would be interesting to see if through setting up similar mechanisms in program areas the superior quality of fiscal control could somehow be transmitted to program control.

The above is offered as one of many possible ideas that should be looked at and discussed.

Finally, I would offer as examples of moves in the right direction title XIX of the medicare bill, which I think is generally very good—I refer to the portion that deals with providing moneys for support of services for patients over 65 in mental hospitals—and the recently introduced S. 3008 and its companion bill, H.R. 13197, which was introduced by your own chairman, Representative Staggers.

As to the Department of Health, Education, and Welfare, I would pursue the above lines of approach in favor of an integrationist philosophy. That is, I think that the Department should be forged in a department, and not allowed to bumble along as a special professional interests arcade, as it is at present.

Civilian rule should be maintained at HEW just as at the Pentagon.

Education, health, mental health, public welfare, and related fields are now a multi-billion-dollar industry. We should, as an enterprising people, apply to this industry the same management talent and techniques—that is to say, the best available—that we would apply to any other industry.

Thank you very much.

CURRICULUM VITAE

DAVID J. VAIL, M.D., MEDICAL DIRECTOR, DEPARTMENT OF PUBLIC WELFARE, STATE OF MINNESOTA

M.D. Degree—Harvard Medical School, 1948.

Internship—St. Lukes Hospital, Chicago, Illinois, 1948–1949.

Residency Training in Psychiatry—Johns Hopkins Hospital, Baltimore, Md., 1949–1952.

Psychoanalytic Training—Baltimore Psychoanalytic Institute, 1950–1955. Status on Termnation: Advanced Student.

Rosewood Training School, Owings Mills, Md., 1952–1956. Staff Psychiatrist, 1952. Director of Psychiatric Education, 1952–1955. Clinical Director, 1955–1956.

New Hampshire State Hospital, 1956–1959. Director of Outpatient Services, then Assistant Superintendent.

Minnesota Department of Public Welfare, 1959 to present. Assistant Medical Director, 1959–1960. Medical Director, 1960 to present.

Teaching Appointments in the Johns Hopkins University and the University of Minnesota. Present Academic Grade: Clinical Associate, Professor of Psychiatry.

Publications on Group Therapy, Mental Retardation, Geriatrics, Suicide. Administrator, Others.
Past member, Board of Directors, National Association of State Mental Health Program Directors.

Mr. ROGERS of Florida. Thank you very much, Dr. Vail. I think you made some very telling points there that I know the committee will be interested in pursuing.

Congressman Gilligan?

Mr. GILLIGAN. Thank you, Mr. Chairman.

I enjoyed your comments, Dr. Vail, quite practical and quite pointed, and refreshing in the phraseology you chose in some instances.

I am interested, Doctor, in your comments as a psychiatrist about attempting to solve one problem by creating another. You used as an example the recent approaches in the field of mental health.

Do I understand you to suggest that you consider the attempt to foster and sponsor the development of community mental health centers to be an unwise program?

Dr. VAIL. Phrased in that way, I would have to answer "Yes," because I think you used the key phrase when you spoke of community mental health centers.

Our view in Minnesota is that there has been entirely too much emphasis on centers, as, if you like, an institution existing in time and space that has to be set under according to certain preconceived regulations about which, by the way, the States have little consultation.

Our view in Minnesota is that we should aim at the concept of community mental health programs, not just centers, but programs based on the community level.

We are trying to do this in our State, and it has been tough going, because the pressure and the eligibility, if you like, for funds is all based on the center concept.

To give an example, in our State—now, this would not be the case, maybe, in Georgia or other places—the county welfare departments have really the core responsibility for carrying out public mental health functions at the community level, but by the existing regulations, unless they are changed or widely interpreted, we would not be able in any way that I can see to really beef up the county welfare department work as we would like to do to implement a community mental health program.

Mr. GILLIGAN. I think the point is well taken that conditions that apply in Minnesota don't necessarily apply in other States.

For instance, in my own State of Ohio, that is not true, that the mental health programs are under the county welfare department. It is a State centralized agency of all things providing mental health, and prisons, and there is more poetry than truth in that comparison, because our mental health institutions in the State of Ohio have been human warehouses for a great many years, with virtually no phychiatric care for these people.

They have just been stored away as though in prison, and in Ohio there was a good deal of jubilation among not the State people, the State officials, necessarily, but among the various citizen groups that have been attempting to sponsor and promote a more humane, and a more intelligent, and a more progressive approach to the problems of

mental health in these Federal programs, because they saw them as the only way they were going to break out of that old stretchout act.

Dr. VAIL. That is a very serious problem, Congressman, and of course, although I came from Ohio originally, in fact from your own district there in Cincinnati, originally, I really could not extend my comments about Minnesota to the State of Ohio.

I do believe that the emphasis on the community centers may not only not do away with the old warehousing system, but may actually make it worse. This is a possibility, if it is not programed properly.

Mr. GILLIGAN. It could very well be, and I think, again just speaking from a practical point of view, the Federal funds were made available for the centers first because making funds availaible for brick and mortar is always more popular politically than making available for staffing or for programs that can't be nailed down, and only last year did they finally provide additional funds for aid to the States in attempting to staff these centers.

I would offer one further practical point, since you have been so eminently practical in some of your comments about the problems raised in this field of Federal-State relationships.

I speak from my vast experience of 15 months in this body, but it seems to me that one of the things that calls for excessive paperwork, and regulation, and detailed accounting, and I believe this, and thought this before I came to Washington, after spending more than 10 years in a city council where we were dealing largely with Federal programs in the field of urban renewal and so forth, is the great and consuming fear of the people at the Federal level that somebody is going to steal something somewhere down the line, or do something foolish and stupid, and every Member of Congress who votes for one of these programs knows perfectly well that the press of this country and some of the Members of Congress are waiting to find any tiny example of the misappropriation of funds, or foolish expenditure of funds, or somebody hiring his brother-in-law as a postal clerk, to discredit the entire program.

When we vote for these vast, nationwide programs, one talks very much about what good they are doing, but let one guy go wrong in Walla Walla, Wash., and every one of us is held accountable in our own districts for what somebody did somewhere off across the frozen plains.

So it is almost in the nature of the beast that the Members of Congress who vote for these programs, and the executive department people who are charged with the responsibility of administering them, tend to safeguard themseves by layer upon layer of paperwork armor, and so if something does go wrong, they can say, "Well, this man in his 10½ pound document that he filed with us simply lied. We are in the clear."

And I am not exactly sure how we can cure that situation so long as we have the kind of press we have in this country.

Thank you, Mr. Chairman.

Mr. ROGERS of Florida. Thank you.

Congressman Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

I have no questions. I think the doctor, as a psychiatrist, has put this problem on the couch and given some real good answers.

Thank you very much.

Dr. VAIL. As a psychiatrist, I should ask you what do you mean by that comment.

Mr. ROGERS of Florida. Congressman Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

I noted your reference to your Minnesota Mental Health Newsletter in which you quote a paragraph.

I would be interested, Mr. Chairman, in seeing some of the excerpts from these newsletters which deal with this problem, if they are not too voluminous, for the record.

Mr. ROGERS of Florida. Yes; I think you submitted them for the record.

Dr. VAIL. Yes; they have been submitted.

Mr. ROGERS of Florida. This material will be made a part of the record and will be furnished to you by the staff.

(The materials furnished follow:)

[From the Mental Health Newsletter, vol. 6, No. 2, Department of Public Welfare, St. Paul, Minn., February 1966]

EDITORIALLY SPEAKING: PROMOTING MENTAL HEALTH

It is a pity that complaining about the federal bureaucracy is getting to be one of the favorite indoor sports of workers in state government. But things are becoming very difficult.

The present situation in mental health probably reflects recent trends in many other national programs, especially those in the humanitarian fields, which seem to be difficult to control. Here are some recent developments.

1. It is now an open secret that the National Institute of Mental Health is on the spot because the comprehensive community mental health centers program is not moving fast as they would like: the states and localities "aren't buying." This means that the NIMH will have to face the Congress with a report that large sums of money are still unencumbered. This then imperils the program, and as everyone knows, the first goal of any program is to keep going. It must have been anxiety about the future of the comprehensive centers program that promoted NIMH Director Stanley F. Yolles to write, on November 10, 1965, to professional agencies and organizations all across the nation to remind them that federal construction and staffing funds are available and for further information to contact—guess who?—the state agency. Leaving aside the ethical question whether a government agency should be promoting itself in this manner, the simple fact is that these letters have produced enormous confusion wherever they have landed, and a multiple convergence on the state agency by aspiring grantees who are inevitably disappointed.

2. In December the NIMH and Council of State Governments co-sponsored the National Conference on Community Mental Health Programs. The purpose of the meeting was never clear, except seemingly to stimulate interest in comprehensive community mental health programs. The passage of a "spontaneous" resolution in favor of implementing the programs was a classic performance. In addition to this the participants were treated to an impassioned tongue-lashing by Congressman Billie S. Farnum of Michigan, who admonished them to hurry up and take advantage of these funds or else they would lapse, which Heaven forfend.

Possibly it is time for the NIMH and the Congress to inquire into why the comprehensive centers program is moving slowly. To date, for example, only 16 of the states have their centers plan approved. Are the other 34 full of incompetent, faint-hearted sluggards? Or could it be that there is something wrong in the plan-writing procedure, that the requirements are unrealistically cumbersome, tedious, and busy-work? Pushing through the individual project applications is an obstacle course, like the children's games "Go back three spaces," "lose two turns," etc. The overhead in consultation time and frustration is enormous.

Now come the regulations for the administration of staffing funds. Reading them, and the associated 19-page application form, one doesn't know whether to laugh or cry. It is like seeing a bad movie through for the second time.

We have urged for months to simplify the application procedures, but things will get worse, not better. We interpret the complexity as insurance for the NIMH that they will never be accused of giving money away too easily. Otherwise there can be no valid explanation for stimulating the appetite and discouraging the effort at the same time. There appears to be essential confusion over the concept of control: the steering apparatus is being judged not by how well it works, but by its weight.

There are deeper, intrinsic reasons why the comprehensive centers program has not moved. The premises are wrong. It is not the "bold, new approach" that President Kennedy called for. It is becoming institutionalized. We will explore these matters further next time.

DAVID J. VAIL, M.D.,
Director, Medical Services.

[From the Mental Health Newsletter, vol. 6, No. 3, Department of Public Welfare, St. Paul, Minn., March 1966]

EDITORIALLY SPEAKING: GOVERNMENT GAINS

In last month's issue we discussed difficulties in the administration of the new comprehensive community mental health centers program. This time we explore deeper problems of institutional zeal.

The comprehensive center, as promulgated by the National Institute of Mental Health, is useful as one of the strategies for overcoming psychosocial disorders. Placed in proper perspective and put to work as a unit in the line, it has much to offer. Strong points, for example, are the emergency services requirement and, at another level, the collaborations which can be brought about among social agencies and among different professional individuals and groups in the public and non-public sectors of the humanitarian field.

What is wrong is the doctrinaire push for the comprehensive center as the mental health strategy for the future. In this sense the comprehensive center is rapidly becoming institutionalized. "Institutionalized" in this sense follows the usage of Mulford Q. Sibley: ". . . all organizations are suspicious of change, become self-satisfied and forget their own purposes . . ." The amazing part is how quickly—within a few short years—this process could have overtaken the National Institute of Mental Health, which now appears to have "pushing comprehensive centers" if not as its raison d'etre, at least as item number one on the agenda.

The evidence:

1. Through the non-duplication clause under federal hospital construction fund administration, general hospitals desiring a psychiatric unit must partake of the comprehensive center mode, ready or not.

2. Through a particularly adroit play, the NIMH has rigged it so that state mental hospital facilities are in effect ineligible for the regular federal construction funds, but must apply for comprehensive center funds once the state plan is approved. This forced one state to the unusual move of withdrawing its comprehensive centers plan.

3. In another bureaucratic maneuver, Title XIX of the Medicare law, which makes millions of dollars available for care of aged patients in mental hospitals, is neatly cross-referenced to require a comprehensive community mental health services plan as one of the points of state eligibility.

4. Federal standards for mental hospitals, as spelled out in the hospital construction regulations, are at least 15 years out of date; we construe this at best as ignorance about modern mental hospital programming, at worst a cynical effort to reduce the mental hospital to second-class status while meanwhile ignoring its necessity.

The effect of all this is the degrading experience for state administrators (in NIMH-ese: "the state hospital crowd") of being herded into a chute. One must raise serious questions generally about present grant-in-aid practices. Furthermore, the states have not been adequately consulted and still are not being consulted about those programs which it will be their responsibility to implement.

There is no quarrel about the need for standards. But standards have different values, and different ranges of flexibility. Is the comprehensive centers program being standardized into still birth?

A basic problem is that the comprehensive centers drive develops out of the admitted failure of state mental hospitals and state mental health programs generally to solve the problems before them. But can one best bring about change in an institution by setting up another institutional system? Minnesota has shown how the best way to improve institutions is by direct action.

Here is one suggested remedy: put the money in a lump-sum grant and let the states build their own programs.

Next time we will complete this series by discussing the definition of need, the services shibboleth, and the mental health ideology.

[Minnesota Mental Health Newsletter Editorial, April 1966]

IDEAS GONE WRONG

In the last two issues we discussed administrative problems arising from the post-1963 federal comprehensive community mental health centers program and the way it is being managed by the National Institute of Mental Health. We now complete this series by taking up basic issues of logic and ideas.

The comprehensive centers concept as presented, is shot through with *non sequiturs*, half-thinking and false premises. The most serious of these are:

1. *The services shibboleth.*—The NIMH, along with the humanitarian field generally, suffers from the delusion that "providing services," in the sense that professional services are made available and attractive to voluntary consumers, will be sufficient and appropriate toward the solution of public problems provided that the services are manned and sophisticated to a certain level and are made "continuous." This is about like hoping that mass illiteracy can be reduced by building libraries; if a small library doesn't work, then a bigger, better staffed, more "comprehensive" library should do. The Services banner may wave proudly, but unless it is made quite explicit who is being served and for what purposes, it does so in vain.

2. *The definition of need.*—Here there are three problems. One is the view that need is self-evident and either requires no definition or at best definition only in professional and not public terms. Another is a sloppy non-differentiation of needs whereby crime, marital disharmony, ordinary neuroses, etc., are dumped into the same mental health stew in which major mental disorder is lost sight of. Most important, there is often no logical connection between the "need" and the "service" that is supposed to do something about it. Examples: (1) Federal reports stress the "need" arising from the increasing incidence of problems among children and adolescents; in fact, the kind of youngsters coming into mental hospitals nowadays could dismantle a community mental health center in 23 minutes flat, so it is dishonest to pretend that the new centers could do anything really significant that could not be done better in other ways. (2) In the regulations, "need" for a comprehensive center in an area is tied to economic distress. Other than the obvious fact that poverty begets despair, is there a connection between poverty and mental health? If so, maybe we should ship psychiatrists to India along with the wheat.

3. *The mental health ideology.*—Robert Reiff and his co-workers have written convincingly about the core problem. That is that the philosophical base of the mental health idea, which is a Rennaissance concept of self-fulfillment, has no meaning to the millions of dispossessed Americans who do not essentially see themselves as masters of their own destiny. Reiff has stated flatly that unless the ideology is changed, the comprehensive center model is "old wine in new bottles." Ironically, the stunning contributions of the Reiff group in using "indigenous non-professionals" in the line operation are neatly acted out by comprehensive centers staffing regulation number 54.303, which calls for rigid professional standards.

We have been warned about the dangers of a technocracy surrounding the military-industrial elite. Are we seeing the start of a new elite, a new technocracy in the human services field? If this were coupled with management practices that pit the federal and state governments against each other, the consequences to constitutional government in the United States could be very grave indeed.

The American people traditionally look to the Congress as a balance against runaway trends in the executive agencies. It now appears that the Congress will study organizational and administrative aspects of the Department of Health, Education, and Welfare. In our opinion, the time is right for such an inquiry.

[From the Minneapolis Tribune, Apr. 7, 1966]

SPECULATION OPEN: STATE'S U.S. SCHOOL AID CHIEF RESIGNS

(By Richard P. Kleeman, Minneapolis Tribune staff writer)

The administrator of Minnesota's troubled $24.5 million federal aid program for schooling of deprived children resigned Wednesday.

Dr. Fred P. Roessel, who has held the post of Title I administrator under the 1965 Elementary and Secondary Education Act in the Minnesota Education Department since Nov. 17, turned in his resignation, effective April 22, to Education Commissioner Duane J. Mattheis.

Mattheis and Asst. Commissioner Farley Bright attributed the surprise resignation to "personal" reasons and Roessel's dislike of administrative paperwork.

Roessel, declining to explain his resignation while still on the job, left room for speculation, current in school circles yesterday, that he did not have as much freedom and responsibility as he had expected when he resigned last fall as principal of Lincoln Junior High School on Minneapolis' North Side to accept the new state post.

Roessel, 54, who once said his special interest was "helping the youngster who doesn't get along well in school," had put in the last 10 of his 30 years in the Minneapolis school system doing just that at Lincoln, located in the area of great racial, economic and social mixtures.

Under Bright and Mattheis he was charged, in his state job, with administering a federal program aimed at improving the educational lot of children from low-income families.

The program became the focus of controversy, and some politics, in February when an advisory committee told the State Board of Education of a tremendous backlog of unprocessed project applications for the federal funds.

With prodding from Gov. Karl Rolvaag, the State Board and its advisory committee, the small staff rapidly was increased and processing of applications speeded.

Last Friday, according to figures issued yesterday, 530 applications for $10.3 million had been approved, leaving another 402 requests for $6.2 million pending—and more coming in daily.

Then over the weekend the program was dealt another blow with a surprise Washington announcement that the deadline for approving programs under this year's federal allocation would be May 2 instead of June 30, as originally announced.

Dr. C. F. McGuiggan, Marshall, State Board of Education president, had not heard officially of Roessel's resignation yesterday but said "it is unfortunate to lose a man of this caliber.

"We should be hiring more of this kind, instead of having them leave us."

Mattheis said Roessel, while never intending to remain permanently, apparently "found the job was not quite what he thought it to be."

"His leaving makes it a little more difficult now and compounds our problem."

Because of the new federal deadline, Mattheis explained. "I can see applications flooding in the next couple of weeks—applications we had hoped to process in 60 days we are going to have to process in 20 or 30."

Bright said "the pressures in this job have been tremendous for (Roessel).

"It's a lot different from being a principal in a Minneapolis junior high school."

He said the State Board of Education will be asked Monday to approve a promotional examination to elevate Jack W. Hanson, 35, Roessel's assistant since Jan. 3, as his successor.

Roessel, who called his last few weeks "worse than murder" and "like sitting in a straitjacket," declared:

"I am so deeply committed to Title I and its importance to American education that anyone who knows me knows I couldn't resign without some terribly important emotional reasons.

"I came over here with more enthusiasm than anybody could imagine: This is exactly what I devoted my whole career to in education."

He said it was not, the heavy work load that led to his resignation: "I like to work."

The new May 2 deadline, he added, will result in "a lot of hastily thrown-together projects." It also will make it more difficult to determine how much unspent money from projects already approved could be "shaken out" and reallocated.

Over 100 Minnesota school districts, he noted, have not yet applied for any Title I funds.

There were reports that some professional staff members hired under short-term contracts to help process Title I applications were paid more than Roessel's salary of $13,344 under state Civil Service. Bright said this was true of only one man.

Roessel, who reportedly has sold his home at 8135 Knoll St., Golden Valley, said he plans to spend the next three months at his cabin near Pillager, Minn., then go to California "to get involved in the Watts situation."

He referred to the predominantly Negro Los Angeles suburb which was the scene of bloody rioting last year and again last month. Said Roessel of his possible role in Watts:

"I'll substitute—teach in those high schools if nothing else."

Mr. NELSEN. I would like to have you go into the reference that you made in point 4 relative to 89–10. I am not sure that I get the point, whether you found there was a conflict there, or a squeeze play, or whatever it was you termed it. I would like to have you elaborate on that.

Dr. VAIL. Yes, sir; I would be glad to.

This is not my field, but this was one reason I chose it, to illustrate that these problems are general, I think, in States now.

I would like to read from this article in the Minneapolis Tribune of April 7, 1966, where it deals with the resignation of Dr. Fred Roessel. It says:

"The program"—this is Public Law 89–10—to implement programs of education for underprivileged children—

I might say we know a little something about this, because we are eligible, that is, some of our children in the institutions. Some close to 2,000 in various institutions are eligible, so we have been working on Public Law 89–10, and it has taken two men almost full time for the last month or month and a half to get this worked up, not counting what the institution people had to submit.

The article says:

The program became the focus of controversy and some politics in February when an advisory committee told the State Board of Education of the tremendous backlog of unprocessed project applications for the Federal funds.

It speaks about 530 applications had been approved, leaving another 402 requests pending, and more coming in daily.

Then over the weekend the program was dealt another blow with a surprise Washington announcement that the deadline for approving programs under this year's Federal allocation would be May 2 instead of June 30.

This created enormous problems.

Mr. NELSEN. Mr. Chairman, I think I get the point.

I thought that you had in mind there is an interference with your activities in this 89–10.

Dr. VAIL. No.

Mr. NELSEN. I think I am familiar with the conflict between the State and Federal agencies, where a State might approve, Federal disapprove, and vice versa.

Dr. VAIL. And in this case the State agency was caught right smack in the middle, and I think the result here is certainly tragic for Minnesota. Dr. Roessel has left, and I don't know what they are doing about it now.

Mr. NELSEN. I have no further questions, Mr. Chairman, except to add to the comment that has been made by the other members of the committee, that I have appreciated your very direct, understandable, and forthright statement. It has been very helpful.

Thank you very much.

Mr. ROGERS of Florida. Doctor, just a question or two.

You state that we might redefine or restate the goals in the health area so as to emphasize accomplishment rather than activity.

Dr. VAIL. Yes, sir.

Mr. ROGERS of Florida. Would you amplify that for us?

Dr. VAIL. I think that this can be done. I think the field of public health has shown this in a spectacular fashion in the work that they have done over the last decades in the field of communicable disease, where the problem of typhoid fever, for example, has been virtually wiped out.

I think we are not anything like close to this type of approach in the mental health field, because we are not approaching the problem as a problem, as a public problem, aiming at ways of reducing the problem.

I think we are aiming more in the area that we call input, that is, the way to deal with this is to obtain certain professional staff, establish a mental health center, et cetera, et cetera, so that this becomes, then, really the end of the whole operation, that if you have your mental health center, you have done what you were supposed to do.

But this is not true. The truth is that you cannot get to where you are going until you have defined the goal, and have charted some course of getting there.

I think, as I say, the current emphasis tends to be much more on activity, rather than accomplishment.

Mr. ROGERS of Florida. Are there any other questions?

Your testimony has been most helpful, and we are grateful to you, Dr. Vail, for being here.

Dr. VAIL. Thank you, Mr. Chairman.

Mr. ROGERS of Florida. It is my understanding that Dr. John H. Hanlon, the commissioner of health of Detroit, Mich., who had an attack this morning, is feeling a little better now, and would be willing to summarize a point or two of his statement for us.

We have made your statement a part of the record, Dr. Hanlon, and if you would care to come forward, if you feel well enough, to just briefly give us the main points that you feel the committee should have, we would be very grateful.

STATEMENT OF JOHN H. HANLON, M.D., COMMISSIONER OF HEALTH, DETROIT, MICH.

Dr. HANLON. Thank you.

Chairman Rogers and members of the subcommittee, this morning I personally experienced an excellent example of intergovernmental relationships. Having become ill, I was very well taken care of here in the Capitol.

Mr. ROGERS of Florida. We are glad you are better.

Dr. HANLON. Thank you.

Of the four general issues that I was informed this subcommittee was concerned with in particular, two I can dispense with quickly, from my own point of view.

On the question of the alleged tendency of Federal authorities to bypass State or local authorities when sponsoring health projects and activities, it has been my experience that there is little cause for complaint.

I have found that both State and Federal agency representatives have tended to be quite meticulous in informing local health agencies where there was any pertinence in doing so.

With reference to the desirability of allowing the States greater flexibility in spending Federal grant money, I would state unequivocally that there is a great need for more flexibility than exists at the present time.

Many of us in the field of public health are pleased to observe the trend in thinking toward block grants, general grants, as against the categorical grant approach.

On the other two questions, the multiplicity of Federal agencies involved in health, and the desirability of fostering closer Federal-local relationships, I would like to make a few comments.

Mr. ROGERS of Florida. Fine.

Dr. HANLON. There isn't any question that in our Nation the health structure is far more complex on the Federal level than anywhere else.

As I have stated in my written presentation, in place of a Federal department of health, we are confronted in this country with an illogical maze of miscellaneous departments, bureaus, offices, agencies, commissions, services, authorities, each with pieces of the overall responsibility.

The closest we come to a department of health or some unified approach is what we find in the Public Health Service.

This situation I think we all recognize has come about by evolution, as a result of pyramiding over generations of special legislation originating from Executive requests, bureaucratic expansion, and the pressures of special interest groups.

Very often these pieces of programs that have been developed tend even to get lost in the overall structure. An extreme and somewhat humorous example which I believe is still true is that the responsibility for the health and welfare of the inhabitants of the Pribiloff Islands off the coast of Alaska throughout our history has been vested in the Fish and Wildlife Service of the Department of the Interior. Some day we will join them organizationally to the rest of the human race.

I have appended to my written statement a table of Federal agencies engaged in health work. It is admittedly out of date and I am sure the staff of the subcommittee has much more up-to-date information. However, it does present, I think, a picture of the plethora of agencies involved.

One is tempted to say that there is hardly any part of the Federal Government that in some way or another does not have a piece of the health picture, and many of these are overlapping, competing, and, perhaps even worse, there are gaps that nobody takes care of.

These agencies do tend to break down into four groups. First, those with broad general interest, and as I stated, the Public Health Service is the closest, if not the only example of this, being concerned with all

aspects of public health, animate and inanimate, human and animal, group and environmental, the healthy as well as the ill, and all ages, sexes, races, and other categories of people.

A second group is concerned with the welfare of special groups, such as children, women, farmers, members of the Armed Forces, to mention just a few.

Then there is a third group of agencies that have their respective pieces of the health programs on a substantive basis. They are concerned with special problems, such as the Office of Education, Office of Vocational Rehabilitation, Food and Drug, the Federal Trade Commission, the Bureau of Mines, TVA, Agriculture, Maritime, and so on.

A fourth category is made up of certain quasi-independent institutions, such as St. Elizabeths Hospital and Freedmen's Hospital. For good measure I have thrown in the numerous, and increasing number of agencies involved in international health, predominantly the Agency for International Development and the Peace Corps.

What effect does all this confusion and complexity have upon the local health agency? I would like to feel that we in the field of health are selling a product in the same way that a commodity such as automobiles are sold.

The manufacturer in the building of a production plant accomplishes nothing. The actual building of the automobiles accomplishes nothing. The only thing that counts in the final analysis is the actual sale and use of an automobile by the consumer.

We are selling a product—health—and everything that is done on every level of government, be it in the National Capital, the State capital, a city hall, or a county building, is worthless except to the extent that a worthwhile product is delivered to the person who needs the help.

And those of us, especially, I think, who work on the local level feel very strongly that we are the ones who are the local sales and delivery men, if you will, who must bring that product to the public. In this role we find ourselves increasingly on the horns of a dilemma: the need to analyze and meet local needs that arise out of local problems as best they may be determined by those of us who live and work with them, while at the same time realistically recognizing the limitations of local resources, with an admittedly wistful and envious eye toward the much greater resources of the State and Federal agencies.

It is only natural for us eventually to turn to them. What other practical alternative is there?

Admittedly, the benefits over the years have been extremely great, but the price we have paid, and the price I think our Nation has paid, has been a whittling away, almost unconsciously, of local autonomy here of local determination, and therefore inevitably of a sense of local responsibility.

This is especially true when categorical funds and assistance are available. More than one local health department has made the decision to "run with the fad," only to find it leads by a succession of carrots on sticks, to a cafeteria list of activities which is a poor substitute for a well-thought-out and balanced local public health program. You take what you can get while you can get it. Furthermore, the very multiplicity of agencies involved in health has led to the local and

State concept of going shopping in the Federal market for bits and pieces of the health program.

By now it is even worse, in that there exist competing cafeterias, sometimes even under the same management, where administrators of local health agencies may shop around to find where they can get the best deal for identical services.

This leads to the subject of grantsmanship. This by now is a well-established specialty, and a rather complex one. Not only must a local health officer be able to recognize a problem, and to know professionally how to meet it, but he must also know where and how best to seek funds, and how to write up grant requests and program proposals that will appeal to various prospective granting agencies.

Beyond that, he must develop expertise in the interpretation of laws, rules, and regulations, and all of the many, many guidelines that may be laid down in order to provide access to these resources. He has to be astute with regard to which agency or subdivisions of a particular agency will give the best deal in terms of amounts of grants, matching requirements, length of grant, detail of accountability, required reports, phasing out requirements, and the like.

Appended to my written statement is a rundown of the grant requirements and conditions in just one of the Federal agencies, the Public Health Service, and the variety there I think speaks for itself.

However, in fairness, it should be emphasized that the complexity illustrated in that example is not the fault of the Public Health Service. After all, it has to administer the public acts in accordance with the specified terms, and they all seem somewhat different.

May I present a few examples of what this does to us on the local scene? For the past several months we in the Detroit and Wayne County area have devoted a very significant amount of time and effort to the development of an extensive project proposal in order to bring to the children of the area the benefits that were intended by the Congress in section 532—I am sorry, there is an error in that in the written presentation—in section 532, title V, of Public Law 89-97, the so-called kiddie-care part of the Medicare Act.

As we understood the spirit and intent of the Federal legislation, and as it was first explained to us by State and Federal representatives, we were to think of comprehensive, total health services for low-income families who otherwise could not get it. Consultation with professional conferees substantiated this. After a great deal of time and effort, and the development of a number of drafts of a proposal literally I would say about 3 inches thick, just before we were to submit our final draft to Washington recently, we were presented with some new administrative interpretations and rules which, if they are correct, from our viewpoint tends to fragment the entire program, and indeed fragment the individual.

The result seems to us to be the antithesis of the entire spirit of the law. Nevertheless, we have proceeded to try to redefine the program for a smaller number of children with no local option as to how we are to provide the basic screening services or in what logical basis to choose target populations, or target areas which we are now told we must do.

New interpretations as to what constitutes local matching funds have appeared. This will necessitate the establishment of a whole

new system of administrative personnel in the program in order to process the many pieces of the local matching and the administration of the program as a whole.

Because of what appears to us to be influences at the Federal level and because on the State level the matching basis is for the time being at least somewhat better if title XIX is administered by the department of welfare, an organizational shift is in process in the State legislature to move, for example, the crippled children's services out of the State health department into the State department of social services. As a result, that agency will be able to preempt about a quarter of a million dollars of funds for medicare that we were planning to use for matching purposes for the kiddie-care part of the same act.

Measles vaccination provides another example. We are delighted that at long last measles vaccine is available. We can now obtain and have applied for some measles vaccine directly from the Public Health Service through the Vaccination Assistance Act. At the same time we find that with other Federal funds the State can provide some additional measles vaccine. The former can be used only for preschool children. The latter can be used for all children. And yet, the money all comes from the same place, and is intended for the same outlet, for the same purpose. Furthermore one agency has arranged for a type of vaccine which requires also an injection of gamma globulin while the other source provides a vaccine which does not. And in order to obtain sufficient vaccine, two different projects and proposals must be developed and a great deal of needless administrative work has to be done.

Speaking of children, I would like to mention another interesting situation in which we find ourselves. Child health has traditionally been one of the mainstays of public health work. Certainly in our situation it has. However, our child health program now consists, in effect, of four different programs instead of the original and logical one.

For generations we have conducted child health programs in the department of health. Along came the antipoverty program. That established in effect duplicate services, very largely for the same people, under a different administrative organization.

Then along came some maternal and infant care funds that were aimed specifically at decreasing prematurity. We wrote up a project to get some of that, and we administer that program, but there is another separate program. Now, under Public Law 89-97, as I have described, we are in the process of developing a fourth child health program.

The only fortunate thing in our particular situation is that we have been successful in capturing all of these pieces. This includes the health and medical part of the poverty program which while set up under a different agency under the Office of Economic Opportunity, has been delegated to the department of health.

We have convinced them our local Office of Economic Opportunity, as I believe no place else in the country has, that this is a specialized field, and the planning and administration and evaluation should be left to the health department. The same is true of the other programs.

I was delighted to hear the comment of Representative Gilligan a few minutes back, because it fits in very much with one of the last comments I would like to make.

It would seem to me that there is a great need for more general or block grants provided on the basis of certain basic factors, such as population, gross State and local product, per capita income, special problems and needs, and the like, and certainly the number of different projects and the number of different matching requirements could be reduced.

If nothing else, the matching requirements in two or more agencies dealing with the same problem should be made uniform, and not competitive.

A tremendous amount of increasingly very scarce and very expensive professional time could be saved by simplifying and standardizing the format of these grant requests and progress reports and, as Representative Gilligan has said, by a greater trust in the responsibility of State and local health officials which are watched assiduously by the public, community groups, and others.

Certainly I can attest to the fact that locally we live and work in a glass case. As Congressman Gilligan said, I don't think we could get away with very much.

I would also like to suggest that consideration might be given to the assignment of one or more very competent representatives of the Department of Health, Education, and Welfare in each of the major metropolitan areas; not to police, and not to review, but as a ready resident source of advice and consultation with regard to program assistance, grants, the meaning of rules and regulations, and the like.

It is well and good to say such help is available from regional offices of HEW, but this is one or two steps removed. Certainly the great urbanized and metropolitan areas of the country which contain most of the population and of the problems merit some closer relationship with the Federal agencies.

In this same regard, traditionally, the Surgeon General of the Publice Health Service, and the Chief of the Children's Bureau must have an annual conference with State and territorial health officers. This has, until 2 years ago, been very much a closed-door affair.

An organization of local health officers was formed several years ago somewhat in self-defense, and beginning about 2 years ago our officers began to be invited, if the States wished it, to sit in and listen at these conferences. However, we could not speak voluntarily, much less vote.

To use myself as an example, this is an ironic situation where I, as a local health officer, am responsible for more people than well over half of the States contain; yet, I cannot be considered a member of this inner circle to get the latest, up-to-date information and guidelines.

Finally, it is my strong belief that one of the most effective means of achieving greater cooperation, understanding, and lack of confusion, would be to provide a means for obtaining experience on different levels of government.

While my conferees on the State and Federal level are obviously due a great measure of credit, it is unfortunately true that far too many of them have been limited with regard to experience on the

delivery end, the local level, where in the final analysis the work must be done.

In this regard, it was with great pleasure and satisfaction that the section on interchange of personnel, in House bill 13197, introduced by Congressman Staggers, chairman of this committee, was read. This alone could be one of the most significant turning points, I believe, in greater intergovernmental understanding and efficiency.

Thank you very much.

Mr. ROGERS of Florida. Thank you very much, Dr. Hanlon.

We appreciate your being here and being willing to give us the benefit of your experience in spite of your condition this morning.

Congressman Gilligan?

Mr. GILLIGAN. Thank you, Mr. Chairman.

Doctor, I, too, appreciated your very thoughtful comments on this problem, and again maybe it is because of 11 years' experience in a city council that I share some of your viewpoints about wrestling with the Federal octopus in an effort to get a job done at the local level.

I was interested in your suggestion, which seems to me to be quite a worthwhile suggestion, of having a Federal man at the local level who would be able to assist the local agencies to coordinate their programs, and to develop their grant applications, and so forth.

You may be aware that under the proposed Demonstration Cities Act under the Department of Housing and Urban Development, one of the sections of that act proposes the position of Federal liaison officer be assigned to the city getting one of these grants for this purpose, and I might tell you that in the subcommittee hearings, some of which I attended, before the Banking and Currency Committee, this was one of the most savagely attacked features of the act, on the ground that this was the "Gestapo" man who was going to be sent into the area, that we were going to have an agent looking over every local official's shoulder.

I think, as probably you do, that it would depend on how he acted, and what the scope of his responsibility and authority would be, but I for one believe that such an official could be of great help in the field of urban affairs and health matters.

I note further, Doctor, that you dismissed in your earlier comments the fear about the bypassing of State authorities, and the direct relationship between Federal and city people, or local people, and you make a somewhat stronger statement on the same point, on page 9:

> Certainly the more urbanized and metropolitan areas which contain such large proportions of the population should be allowed to develop ever closer relationships directly with Federal agencies.

In your experience representing the great city of Detroit have you found it difficult to work through your State agencies, or are there other reasons for your desire to see a closer direct relationship between the city and the Federal Government?

Dr. HANLON. The pattern in my experience has varied a good deal, depending on what part of the Nation you are in. I say that, having worked in a number of different parts of the country.

It depends on the attitude of the particular regional office of HEW, and regional offices of PHS, the attitudes of respective State health departments, and State health offices.

Again, I think that what variation exists is dependent pretty largely on the degree of knowing each other, and trusting each other.

In one area of the country where I worked, we would get things done locally quite expeditiously by, despite the rules, picking up the phone or coming down to Washington and getting off in a corner with the particular staff and professional people of the particular agency that was involved, talking the thing out and getting their help in developing something up to the point of final submission, and then shoot it on through the State, practically a fait accompli.

In some other areas of the country the State and the regional offices are meticulous in their insistence on being involved every step of the way.

I do not in any sense deny the importance and necessity of their knowing what is going on. On the other hand, this procedure often causes delays that can be quite considerable and sometimes even to the point of missing a grant application date.

Mr. GILLIGAN. Doctor, I might say to you that I have discovered with some dismay that Congressmen are expected to be the Federal liaison officer in many cases between local agencies and executive departments, and it demands an expertise on the part of Congressmen with the Federal bureaucracy, which I am afraid that at least freshmen don't often have. But that may be helpful, too, because it helps us to understand perhaps a little better and a little more deeply some of the problems confronting the local officials when they attempt to deal with the bureaucracy.

One final question, Doctor. I assume that in the city of Detroit there is a Community Chest, or a United Appeal. How many agencies do you have under that umbrella at the present time? Do you have any idea?

Dr. HANLON. The United Foundation of Metropolitan Detroit was the parent United Fund of the Nation.

I should remember the figure you ask but I don't. However, it is a very substantial number, somewhere in the neighborhood, I believe, of around 50 or 60, at least.

Mr. GILLIGAN. Fifty or sixty. Well, the city of Cincinnati which is a city of a half million, now has a 5-county Metropolitan United Appeal program, with 126 agencies at latest count, participating in it, all of them in one way or another dealing in the general field of human health and welfare.

I would simply suggest that this is a symptom on the private side of the picture of the categorical approach, if you will, to the problem of human health and welfare.

I know and have served on the boards of such local agencies as the Babies Milk Fund, which was founded 60 or 70 years ago, with the idea of providing a cup of milk to children who otherwise would not see it. Today the original purposes of the organization have long since gone, and they are sponsoring research programs into vitamin deficiencies in children's diets, and what happens to children when they chew the paint off their cribs, and so forth.

But try and get them to go out of existence. They still fight for their share of that Community Chest fund every year, and heaven help the man who proposes that maybe their day is done and they

should retire to the sidelines and let a more comprehensive program take over.

And I think there is a little of that built, in terms of human nature, into the Federal, and State, and some of the local problems as well.

Dr. HANLON. If I might make a comment, our local United Foundation during the past decade has been quite successful in getting many of these agencies either to merge or to go out of existence.

Rehabilitation, the various agencies involved in vision, and the like, have been all compressed into one rehabilitation institute, and into one vision group. That automatically must have done away with around 20 agencies, altogether.

Mr. GILLIGAN. I take that as a sign of hope. Maybe we can accomplish the same at the Federal level.

Thank you, Doctor.

Mr. ROGERS of Florida. Congressman Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

I have just one comment, and I think if a local facility were faced with a representative from the Federal Government practically all you would be doing would be putting a layer on the cake, and my experience is that whenever you appoint anybody on the Federal Government they cloak themselves immediately with all the powers of Uncle Sam and you just have one more contention to pass by, you don't get where you want to go.

I don't think it would work too well.

Dr. HANLON. If I may make a comment on that, in making the suggestion I specified that the individual should not be there to police, and so on.

We in the field of public health have had a great deal of experience, and I think very good experience, especially with the Public Health Service, over the years detailing an individual or individuals to State or local agencies and when an individual is detailed he is told that, although he is still a Federal employee, he is being detailed to be of assistance to the State or local agency, and to be a part of it.

As long as he is there, he is a part of that agency, in the same way that a Public Health Service officer is detailed to the Coast Guard. While he works in the Coast Guard, he is of the Coast Guard, and it usually works out all right.

Mr. ROGERS of Florida. If I may just ask you a couple of quick questions, now, and just give me your general feeling. Do you think it would be practical to combine the health activities of the Federal Government in a separate Department of Health? What would be your reaction? Favorable, or unfavorable?

Dr. HANLON. My general reaction to this, Congressman Rogers, would be favorable.

It is true, as witnessed by the current complexity, and as I stated, that there is hardly any part of the Federal Government that isn't interested in and concerned about some aspect of health. However, the same is true of defense, or roads, or anything else.

Someone once said that there should be only two departments of government, a "department of things," and a "department of people," but that would carry logic a bit too far.

I think that the concern that led to the establishment of this subcommittee and its hearings is evidence of the fact that the creature

has gotten so big and complex, the total HEW picture, that is, that it has gone beyond the bounds of administrativability, if I may use that term. Health activities are relatively well definable, and the kinds of people who work in health are a particular breed that are bred in particular kinds of professional schools, namely, schools of public health and affiliated profession schools, so that I think there is a great deal that could be said in favor of consolidating these all into a single Federal Department of Health.

Incidentally, I think we are about the only nation in the world that does not have one.

Mr. ROGERS of Florida. We might be in touch with you, if it would be agreeable with you, to get your suggestions as to what actual activities could best be combined to set up a Department of Health, if that would be agreeable with you.

Also, if you could find time to let us have your experience as to those Federal agencies and programs which give you the best deals, financially, in comparison to others—for the same health problem—if you could let us have that for the record, it would be helpful.

Then, finally, what percentage would you say of your total health budget is composed of Federal funds?

Dr. HANLON. Sir, fortunately at this particular time our local economy is very good, so that it is a minor percentage of the budget.

Mr. ROGERS of Florida. Thank you very much, Dr. Hanlon. It has been most helpful, and we appreciate your consideration in being present to allow the committee the benefit of your extensive experience in this field.

Thank you very much.

Dr. HANLON. Thank you, sir.

Mr. ROGERS of Florida. This will conclude the hearing for today, and we will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 12:42 p.m., the special subcommittee adjourned, to reconvene at 10 a.m., Tuesday, April 19, 1966.)

INVESTIGATION OF HEW

TUESDAY, APRIL 19, 1966

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON HEW INVESTIGATION
OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. ROGERS of Florida. The committee will please come to order.

We start our second day of hearings in the investigation of the Department of Health, Education, and Welfare, with regard to health functions, and we are pleased to have as our first witness today Dr. George James, who is dean of the Mount Sinai Medical School, and chairman of the Task Force on Community Assessment for Planning and Action of the National Commission on Community Health Services.

Dr. James, we are particularly pleased to have you, with your extensive background, and we will be delighted to have you proceed with your statement.

STATEMENT OF GEORGE JAMES, M.D., DEAN, MOUNT SINAI MEDICAL SCHOOL, AND CHAIRMAN OF THE TASK FORCE ON COMMUNITY ASSESSMENT, PLANNING, AND ACTION (NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES)

Dr. JAMES. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I trust we can all begin by agreeing that one of the essential goals for this Nation is the attainment of universal access to high quality, comprehensive, health and medical care.

While programs such as medicare move toward the goal of universal access to care, they do not attain it. The Nation is also sadly deficient in its ability to deliver high-quality comprehensive care. Partly this is due to a lack of the scientific knowledge required for the control of the major killers of our day, but it is also caused by our inability to translate the fruits of our scientific knowledge into widespread practical programs for our population.

The three ways in which the Federal Government has sought to meet these problems has been through research, demonstration, and service. Each of these approaches makes separate demands upon our organizational framework. It is important to emphasize one major overriding principle: the pace of scientific and social change in this era is so

rapid that every health program must be considered as experimental and tentative in both its scientific and organizational components. This suggests strongly that legislation must permit a maximum of flexibility consistent with its overall purpose. It implies that rather than insisting upon uniformity of approach, legislation and Federal organization should emphasize experimentation and innovation.

It further mandates that Federal personnel supervising these programs be of the highest caliber, highly trained in local health problems and versed in both medical and social skills. These skilled personnel must have both the responsibility and authority to make decisions which can and should sacrifice uniformity of operation in the quest for higher quality of result.

The simplest starting point is research. Here there has already been essentially complete agreement on the need for lack of uniformity and for the greatest freedom, innovation, and experimentation.

The research program of the National Institutes of Health is superb. Its reliance upon peer judgment for the process of decisionmaking has never yet been surpassed. There are areas for improvement, which I have already helped to record as a member of the Wooldridge Commission. However, the detachment of its processes from the usual Federal-State-local framework is decidedly not one of them. The NIH program works well and serves research needs admirably.

The demonstration, however, long a stepchild of the Federal health agencies, is facing far greater problems.

1. The skilled manpower for the performance of scientific demonstration is in short supply at all levels of government.

2. When the Public Health Service has used the National Institutes of Health research support mechanism for the demonstration, it has led to difficulty. For example, National Institute of Mental Health which has supported many demonstrations, has on occasion supported an isolated group whose program has been planned without reference to other related community endeavors. One such program in New York City led to much confusion and less progress—to the best of my knowledge still unresolved—because the granting agency did not insure that the proper community background had been laid before the project was funded.

I might add parenthically that I am happy to say that the heart, stroke, and cancer programs appear to ge giving very careful consideration to this principle.

3. Different demonstrations in the same general fields are supported by several separate Federal agencies and even different branches of the same Federal agency. This practice leads to federally sponsored competition for the same personnel, with the project offering the higher salaries for the longer duration winning out in the competition instead of the preference going to the most significant project. While this may be justified for discrete research projects, it is destructive of community planning and operations when applied to demonstrations, whose greatest value lies in their ability to establish future patterns of community service.

The corrective measures which should be applied relate specifically to—

(*a*) Greater coordination of all demonstration granting activities by the Federal agencies.

(*b*) Greater leadership in the support of demonstrations by Federal agencies. These agencies should plan demonstrations cooperatively with selected local groups and not operate as they usually do now by acting only after applications are received. It also mandates the Federal recruitment of a large number of skilled health workers who can operate in these demonstrations.

(*c*) Continual evaluation by Federal personnel of all existing demonstrations to see whether they are worthy of continuance, what is their impact on other community services and to find those instances where additional coordination or new activity would be productive.

The problem with service programs in this era of rapid change revolves around the need for great flexibility. I am heartily in favor of the present plan of the Public Health Service to provide less categorical and more comprehensive support for State and local health services.

I would emphasize, however, that here, too, we require more leadership from the Federal agency than has occurred in the past. The funds should not merely be allocated by fiscal formulas.

The Public Health Service must do more than require a careful plan from each State which provides for the proper allocation of these funds. It should perform routine evaluations of all results, and be prepared to increase or decrease allocations when special needs arise, even within a given fiscal year.

A particular problem is the fact that large cities have unusual health problems which differ from those in the rest of the State. In 1963, New York City experienced a 10.6-percent increase in tuberculosis cases during a year when the State health department was reducing local support for tuberculosis control.

It was necessary for me at that time as commissioner of health of New York City to appear before the proper committees of the House of Representatives and the Senate in order to support a sizable increase in the national appropriations for tuberculosis control in order for New York City to obtain a small portion of this sum in support of its local program. The rise of tuberculosis in New York City was also experienced by more than a dozen other large cities in this Nation.

I need hardly point out that an increase in tuberculosis in large cities poses a threat to the entire Nation. As Federal program grants become more comprehensive, the large cities must receive assurance that their special needs, often of crisis proportions, will be met by selective attention through a flexible Federal program which need not operate through a State health agency which has different priorities. Remember that New York City had more tuberculosis even in 1960 than any other State in the Union other than California. In 1962 it had four times its share of veneral disease, about half the narcotic addicts in the Nation and great problems in tropical diseases, to mention just a few.

During the recent increase in tuberculosis in New York City, upstate New York experienced its usual decline. The increasing proportion of indigent persons in the city also leads to special health problems of great importance along with a lowered ability to raise the funds required to meet their needs.

For example, between 1950 and 1962 the proportion of babies born as ward deliveries in Manhattan rose from 45 to 54 percent of all deliveries, and this indication of medical indigency is still increasing.

SUMMARY

1. Research is well handled by the Federal agencies.

2. Demonstration activities require far more attention. There is a need for greater coordination at the Federal level and between the Federal and local levels. There is also great need for more continuing leadership by Federal agencies which, in turn, requires more skilled personnel who will be used to initiate, participate, evaluate, and modify local demonstration activities.

3. Service programs should be supported by comprehensive grants allocated and administered with great flexibility by Federal officials who should accept more responsibility for the way in which these funds are used. Former patterns which emphasize that grants be made largely to States must be modified to permit flexibile Federal support of health problems where and when they exist when State support is inadequate.

Thank you.

CURRICULUM VITAE—GEORGE JAMES, M.D.

Born: November 15, 1915, New York, N.Y.

Business Address: Mount Sinai School of Medicine, Fifth Avenue and 100th Street, New York, N.Y., 10029. *Telephone:* TR 6-1000, Ext. 8654.

Home Address: 52 First Street, Garden City, New York.

Education and training:

New Rochell High School, Diploma 1933.

Columbia University, A.B. 1937.

Yale University School of Medicine, cum laude, M.D. 1941.

Intern in Pediatrics, New Haven Hospital, Yale University School of Medicine, 1941–1942.

Health Officer-in-Training, N.Y.S. Department of Health, 1944–1945.

Johns Hopkins School of Hygiene and Public Health, M.P.H. 1945.

Licensure: Licensed to practice medicine in States of New York, Ohio, Tennessee. Diplomate National Board of Medical Examiners, 1942. Diplomate American Board of Preventive Medicine and Public Health, 1949.

Public Health Administrative Positions:

1942: Assistant Health Officer, Williamson County (Tenn.) Department of Health.

1942–44: Director, Obion-Lake (Tenn.) Health District.

1945–55: New York State Department of Health:

1945–46: Assistant District Health Officer.

1946: District Health Officer.

1947–49: Commissioner of Health, Ulster County (New York).

1949–50: Assistant Director, Bureau of Epidemiology and Communicable Disease Control, Division of Medical Services.

1950–51: Assistant Director, Division of Medical Services.

1951–52: Regional Health Director for Liaison with N.Y.C.

1952–55: Assistant Commissioner for Program Development and Evaluation, and for Liaison with N.Y.C.

1955–56: Director of Health, Akron City Department of Health.

1956–65: New York City Department of Health:

1956–59: Deputy Commissioner.

1959–62: First Deputy Commissioner.

1962–65: Commissioner of Health and Chairman of Board of Health.

1965–; Mount Sinai, Executive Vice President, Medical Center. Dean, School of Medicine. Chairman, Department of Community Medicine, Hospital and School of Medicine. Professor of Community Medicine, School of Medicine.

Academic Medical and Public Health Positions:

1941–42: Yale University School of Medicine, Assistant in Pediatrics.

1946: Johns Hopkins School of Hygiene and Public Health, Laboratory Assistant in Biostatistics.

1947–52: Yale University School of Medicine, Assistant Clinical Professor of Public Health Practice.

1949–55: Albany Medical College of Union University:

1949–52: Instructor of Preventive Medicine and Public Health.

1952–54: Assistant Professor.

1954–55: Associate Professor.

1956–; Columbia University School of Administrative Medicine and Public Health:

1956–63: Adjunct Associate Professor of Public Health Practice.

1963–66: Adjunct Professor.

1957–63: St. John's School of Education, Professorial Lecturer in Preventive Medicine.

1962–63: Harvard School of Public Health, Visiting Lecturer on Public Health Practice.

Professional Organizations:

American Association for the Advancement of Science 1950–.

American Association of Public Health Physicians 1948–.

American College of Preventive Medicine 1955–, Vice President for Public Health 1964.

American Geriatric Society, Fellow 1964–.

American Heart Association, Fellow of Council on Epidemiology 1964–.

American Hospital Association, 1966–.

American Medical Association, Fellow 1946–.

American Public Health Association, Member 1943–45, Fellow 1946–.

Governing Council 1955–58, 1962–68; Technical Development Board 1964–67.

Health Officers Section 1954–; Counsellor 1955–58.

Committee on Administrative Practice, Subcommittee on State and Local Health Administration 1954–57.

Program Committee 1955.

Committee on Professional Education 1955–61; Chairman, Subcommittee on Professional Examination Service 1960–.

Committee on Public Health Administration 1957–58; Subcommittee on Local Health Services 1957–58.

Mental Health Committee, Subcommittee on Primary Prevention, Chairman 1958–62.

American Society for Public Administration 1954–.

American Thoracic Society 1963–.

Association of Teachers of Preventive Medicine 1957–.

Conference of County, City and District Health Officers, New York State 1949–65; President 1961–62.

Harvey Society 1959–.

Medical Administrators Conference 1965–.

National Advisory Committee on Local Health Departments (National Health Council): Executive Board 1956–63; Vice President 1960–61; President 1961–63.

National Committee for Day Care of Children 1963.

National Health Council: President 1965; Executive Board 1964–67; Program Committee 1957, 1961, 1963.

National League for Nursing 1959–: Committee on Records, Statistical Reporting and Cost Analysis 1959; Committee on Community Participation 1961–63.

National Publicity Council, Vice President 1954–55; Executive Board 1954–58.

New York Academy of Medicine 1957–: Committee on Social Policy for Health Care 1963–; Committee on Medical Education 1965–.

New York Academy of Sciences 1957–.

New York City Public Health Association 1956–; President 1961–62.

New York Diabetes Association 1963–; Board of Directors 1964–66.

New York State Academy of Preventive Medicine 1955–; President 1960–61; Executive Board 1957–62; Chairman, Committee on Tobacco and Lung Cancer 1958–60.

New York State and County Medical Societies 1956–; Advisor to Council Committee on Public Health and Education (State) 1963–65.

New York State Epidemiology Society, President 1948–49.

Royal Society of Health, member 1956–64, Fellow 1964–.

World Federation for Mental Health, U.S. Committee, member 1963–.

Special Activities:

American National Council for Health Education of the Public (ANCHEP), Board of Directors and Executive Committee 1964–.

American Nurses' Foundation, Inc., Technical Committee 1963–65.

Associated Hospital Service of New York, 1964–: Board of Directors, member Medical Advisory Committee.

Columbia University School of Public Health, Cardiovascular Disease Epidemiology Committee, Chairman 1956–58; Co-Chairman 1958–61.

Community Council of Greater New York, Board Member 1962–65.

Community Service Society, Board of Trustees 1962–65.

Greater New York Safety Council, member 1966–69.

Health Insurance Plan of Greater New York, Board of Directors 1965.

Health Research Council of N.Y.C., Executive Committee 1962–66, member 1962–.

Hospital Review and Planning Council, Southern New York 1962–65; New York State 1963–65; Health Facilities Committee 1965–.

Hospital Society of New York 1964–.

Interdepartmental Health Council 1962–65; Vice Chairman 1965.

Institute of Public Administration, Consultant 1956–58.

Jewish Guild for Blind, Advisory Committee 1965.

Mayor's Commission and Council on Physical Fitness, Vice Chairman 1965–.

Mayor's Commission on Narcotics Addiction 1965; Executive Task Force 1965.

Medical and Health Research Association, Inc., President 1957–64, Executive Committee 1957–1966.

Medical Library Center of New York Academy of Medicine, Board of Directors 1963–.

Morningside House, Advisory Medical Board 1962–.

National Commission on Community Health Services, Committee on Community Action Studies Project and Task Force on Community Assessments, Planning and Action, member 1962, Chairman 1963–66.

National Conference on Public Health Training, U.S. Public Health Service, Consultant 1963.

National Conference on Teaching of Mental Health in Schools of Public Health, Committee on Curriculum Content 1958–60–.

National Institutes of Health, Health Services Research Study Section, 1963–64, 1965–.

National Planning Committee for Postgraduate Education of Health Officers, 1958–61.

New York Blood Center, Community Blood Council member; member of Board of Directors 1965–.

New York City Advisory Committee to Selective Service 1965.

New York City Community Mental Health Board 1962–65.

New York City Council Against Poverty 1965.

N.Y.C. Welfare Department, Acting Administrator of Medical Welfare Programs 1958–60.

New York Heart Association, Advisory Council on Research 1964–.

New York State Atomic Energy Coordinating Council, 1964–65.

New York State Senate Committee on Public Health, Technical Advisory Panel 1965–.

New York Tuberculosis and Health Association, Board of Directors 1965–68.

President's Office of Science and Technology, Ad Hoc Committee on Narcotic Addiction, 1962–63; White House Conference on Narcotic Addiction 1963; Committee to evaluate program of National Institutes of Health 1964–1965.

President's Task Force on Health, Chairman, 1964–65.

Strang Clinic, Board of Trustees 1964–.

U.S. Conference of City Health Officers, Trustee 1964–65; Chairman of Subcommittee on BCG 1965.

U.S. Public Health Service, Consultant on various public health problems on ad hoc basis, 1960; Bureau of State Services, Committee on Health Education and Communication 1964–.

White House Conference on Health, Executive Committee, Nov. 3–4, 1965.

World Health Organization, Export Advisory Panel on Public Health Administration 1964–69.

Special Lectures:

First Mona B. Scheckman Lecture, Society of Public Health Educators, New York City 1962.

Anniversary Discourse, New York Academy of Medicine, New York City 1964.

First Stuart M. Crocker Lecture, Roosevelt Hospital, New York City 1964.

Delta Omega Lecture, Michigan University School of Public Health, 1964.

Annual Meeting, Ontario Public Health Association, Toronto, Canada, 1964.

Presidential Inaugural Address, National Health Council 1965.

Other Activities:

Havens Relief Fund Society, Almoner 1962–65.

Lasker Journalism Award Committee 1964–65.

Nursing Research, Editorial Board 1960–.

Parents Magazine, Advisory Editor 1962.

Yales Medical Alumni Fund, Regional Chairman 1956–65.

Medical Opinion and Review, Editorial Board 1965–.

Honors and Awards:

Phi Beta Kappa, Columbia 1937.

Alpha Omega Alpha, Yale School of Medicine, 1940 (Honorary Medical Society).

Campbell Gold Medal for highest standing in graduating class, Yale School of Medicine 1941.

Bronfman Award, American Public Health Association 1965.

Gold Medal, Nicholas S. Gesoalde Research Foundation, ('great contribution to the welfare of pharmacy and and its public health aspects') 1965.

Honorary Member, New York University School of Medicine Alumni Assn. 1965–.

Othere Data:

Member, Columbia University Club, 1956–.

Member, Yale Club, 1963–.

Metropolitan Area, Unitarian-Universalist Association, Social Concerns Committee 1963.

Church Affiliation: Unitarian-Universalist Church of Central Nassau, Chairman, Membership Committee 1962–.

Bibliography: Author of about 114 articles in scientific journals.

Mr. ROGERS of Florida. Thank you very much, Dr. James, for a very excellent statement.

Congressman Van Deerlin, questions?

Mr. VAN DEERLIN. I was just wondering, Doctor, is it your feeling that this inability of many of the States to apportion funds fairly stems from disproportionate representation between urban and rural areas in State legislatures?

Dr. JAMES. I am not sure of the degree to which it is based upon political considerations throughout the Nation. As a rule, the budgets are tight in all governmental agencies. The State health departments have limited funds, and when they have Federal funds, they have places to use these funds right within their own programs, and they have their own priorities.

The State health department has priorities which are different from those of the city, and they accept the Federal funds that they get from Federal sources as being for the general support of the State program.

Now when something different happens, when the crisis situations occur at the local area, there is no leeway there. There is no extra fund available, so that if a State had allocated funds, for example, to New York City, during this tuberculosis crisis, they would have had to take it from their existing programs.

Mr. VAN DEERLIN. You do understand, though, that whether it is health expenditures, or education, or blight control, almost anything the Federal Government goes into, there is likely to be opposition,

unless considerable leeway is left to the State in the management of those funds.

So it does pose a political problem for us in Congress.

Dr. JAMES. Yes, I realize that, and the project grant arrangement was one way to get around this partly. I believe that it might be possible to use the project grant approach, and make it more flexible and have funds available to areas of need, whether they be cities or counties, or States, or any subdivisions therein. We should have funds available to met important needs when they arise.

Mr. VAN DEERLIN. Thank you.

Mr. ROGERS of Florida. Congressman Nelsen?

Mr. NELSEN. My question was intended to be along the same line that my colleague, Mr. Van Deerlin, posed. I note that you say on page 6, "Often in the cities, incidents of crisis proportion," and they "will be met by selective attention through a flexible Federal program which need not operate through a State health agency, which has different priorities." Of course the problem, as pointed out by Mr. Van Deerlin, is that we recognize from this level that unless the State agency is interested and cooperating with the Federal Government, lack of personnel on this level would make it almost impossible to do a real good job at State level. Therefore, we have always tried to channel Federal funds through State plans and States agencies, realizing that the State personnel live with the problem. I gather, however, that your recommendation deals more thoroughly with the incidents that are of unusual nature.

For example, you mentioned tuberculosis. If there is an outbreak of such a disease, you feel there should be quicker flexibility than would be true in the usual sense.

Dr. JAMES. Mr. Nelsen, this is, you might say, an unusual instance which proves a general rule. I would think it quite possible for the Public Health Service to require the type of a State plan from each State which would be able to satisfy the Public Health Service that the State was keenly aware of all the priority needs within its boundaries, not only those that you might say they would look at more through the eyes of a State health department. They should be keenly aware of all of the local problems within their State area.

Now if this were done, if the Public Health Service would exercise this degree of leadership and supervision, then I think we might get better State plans, which would in turn be able to meet more of the problems of local areas.

Mr. NELSEN. It is my understanding that the HEW has given considerable thought to plans that move more in the direction of channeling Federal money to a State, and then not binding them too tightly to just exactly how every penny is to be spent, but permitting them to select items that need priority within the State. This would result in greater flexibility, and would meet some of the problems that you suggest.

Dr. JAMES. This would be a good step toward the problem, if the Public Health Service at the same time required a good State plan and took some initiative to see that it was the type of plan that would meet the needs of the State. The flexibility would come in avoiding a sum of money labeled "tuberculosis," labeled "venereal disease" and "cancer."

Mr. NELSEN. Right.

Dr. JAMES. But nevertheless, this doesn't mean that the State should be given, in my opinion, complete freedom to spend it any way they want, without any supervision whatsoever.

Mr. NELSEN. No more questions, Mr. Chairman.

Mr. ROGERS of Florida. Mr. Curtin?

Mr. CURTIN. Thank you, Mr. Chairman.

Doctor, I notice that you say on page 3 of your statement that different demonstrations in the same field by various Federal agencies and even different branches of the same agency cause competition for the same personnel, and I presume from this that you mean there is some confusion as a result thereof, and I would presume that this also results in a waste of money?

Could you give us some specific illustrations of just what you mean?

Dr. JAMES. I am not prepared to give details, but I do know that at the present time, for example, the Social Security Administration has been giving contracts to certain groups to do certain studies relating to the impact of medicare. At the same time, the other branches of Public Health Service are allocating research grants to people who apply to do rather similar types of operations.

Also, other departments in medical schools and universities, through other funds, obtained from other Federal agencies, are engaged in somewhat similar studies.

Now to the degree that these are studies, and pure research, or purer research, you must encourage a certain amount of duplication of efforts, because while we are seeking crucial research answers, you can't put people in too rigid a framework. But these demonstrations, such as the studying the impact of medicare, are exceedingly costly, time consuming, require many very skilled people, and there is competition for such people now. This is just one very current illustration of this.

Mr. CURTIN. You say that this could be avoided by having a greater coordination of all demonstration granting activities by the Federal agencies.

Do you mean by this more coordinating between the Federal agencies themselves, or more coordination of the Federal agencies with the States, or a combination of both, or what?

Dr. JAMES. I think it has to begin at the Federal level. There has to be a study made of the kind of demonstrations which would be particularly fertile, particularly productive of the types of knowledge and experience which we need. Then once these are decided, and they are given priority, then the next step would be for the Federal Government to develop better coordinating mechanisms with the field, so that someone from a Federal agency could go to a State health department or to a university, or to a city, and say, "This is a particular kind of project we would like to have done, and if you will do this, and if you will set it up properly, and use the right people, we will be able to make a grant to you for this purpose."

This would avoid unnecessary competition.

Mr. CURTIN. Well, the Federal Government, and particularly the various branches and programs of HEW are very extensive and numerous. How are we going to get that coordination? Do you suggest one master committee that passes on everything?

Dr. JAMES. Yes. Well, that is a very good question, sir. The arrangement now within the HEW certainly will not make it possible for this to be done easily. It would take a greater reorganization of the existing units which would highlight the importance of service, research, and demonstration, permitting the various units to group around these headings, and permitting much better coordination between them.

Now some of the comments that have been made in the press about proposals that none of us, of course, have had an opportunity to study, in detail, but just by title, the idea of a health resources group of agency activities is very desirable, because health resources or health promotion or health development, or whatever you call it, would be a grouping of those types of activities that relate to the development of new services, which is what the demonstration is.

Mr. CURTIN. That is all, Mr. Chairman. Thank you.

Mr. ROGERS of Florida. Mr. Springer?

Mr. SPRINGER. No questions, Mr. Chairman.

Mr. ROGERS of Florida. I am interested in pursuing this a little bit, too. In other words, you feel that there should be some reorganization in the Department to have one particular agency, perhaps, to handle all of the project grants, or the demonstration grants.

Is this your idea, to consolidate this activity within one, rather than having it divided among the various member agencies of the Department?

Dr. JAMES. If it is too difficult to put it all in one, at least units relating to demonstration in all should work very, very closely together, and be very closely coordinated by some intercommunication mechanism.

Mr. ROGERS of Florida. Now we have been impressed in the testimony we have heard so far, by the fact that most of the people we have heard from have felt that our health programs have stressed activity, rather than results. And I notice you also bear on this by saying Federal officials should accept more responsibility for the way in which these funds are used, and should evaluate the activities more.

Could you expand on that a little bit, as to what you mean?

Dr. JAMES. With the comprehensive approach which has been proposed by the Public Health Service, and with which I agree heartily, with the advent of this, the danger, of course, is that instead of the money being allocated just for a category, and no very careful measure being made of accomplishment, it now will be allocated for total public health with no major effort to measure accomplishment.

I think that it is very important to measure accomplishment. I do not consider that this is any abridgement freedom on the part of a State or a local agency. Now the allocation of funds by a fiscal formula, in my opinion, is not the way to do it. It is an easy way to do it, because you have a formula, you pass out the money, and next year you get more money, you pass it out in accordance with the same formula.

It entails far more in the way of supervision, study of the problems, measurement of the results, if you are going to allocate it on the basis of need and accomplishment.

This means that the Public Health Service would have to have very excellent teams of well-trained medical and other skilled personnel, who would be responsible for studying need, seeing the State plan,

going over the State plan, and also following up the results to see what has been the accomplishment, and if it is found that State has major problems, and is not allocating funds to the control of these problems, then it is fair for the Public Health Service to ask why this is so.

If they find that the money is being spent for things of low priority, I think they can say, "We don't think our money is being very wisely spent."

Now this is a two-way affair. The State and other agencies within it will have an opportunity to talk back, but there should be more concern over the way this money is spent, and the allocation should not be by some simple fiscal formula.

Mr. ROGERS of Florida. Would you say that under the present system, need is a major consideration of the allocation of Federal funds?

Dr. JAMES. Not only need, but what is accomplished with it. We have vast needs, such as in coronary heart disease, with not very much we can do about it, but the need in terms of what can be done about it; yes.

I would say, for example, that New York City should be receiving large sums of money for research demonstration and service, in the field of narcotic control. Here is a city, one city, which has roughly half the narcotic addicts in the Nation. I think it is to the Nation's debit, you might say, that this degree of attention is not being focused on this city.

Mr. ROGERS of Florida. What is the present situation? Do you get funds to carry on your program?

Dr. JAMES. Funds for the city, of course, are obtained from city taxes, 50 percent of which is reimbursed by the State health department. There is a mental hygiene program, too, which has reimbursement from the State mental hygiene department. There are some small amounts of Federal funds for various grants, demonstration programs which are in existence in the city.

Mr. ROGERS of Florida. What about in the narcotics program? Are there any Federal funds for the narcotics program?

Dr. JAMES. A very small amount. A few demonstrations.

Mr. ROGERS of Florida. And yet this is one of your major needs.

Dr. JAMES. Right.

Mr. ROGERS of Florida. I presume that thereby it is a State need, as well, since New York is part of the State.

Dr. JAMES. Right.

Mr. ROGERS of Florida. What can be done to evaluate programs? In other words, you gave the example of TB. Do we have a going TB program that has been funded at all by the Federal Government as far as New York City is concerned? Has the Federal Government participated in that? And yet you have had an increase in TB cases?

Could you expand on that some?

Dr. JAMES. Well, we have some ideas as to why we had the increase in cases. This is something which occurred in many other large cities, with the increasing poverty and overcrowding, and with the decreasing resistance of the population, because more and more people have negative tuberculin reactions, we were due an outbreak of tuberculosis; but once the outbreak occurred, there were certain things that could be done, and the city of New York was called upon to multiply its tuberculosis program rapidly.

In fact, I think we increased it just about by 50 percent. Now this is a great deal of money for a city which has limited tax resources to supply within a given year. The State was unable to give us extra funds, and we did get several hundred thousand dollars from the Federal Government by the roundabout process of testifying before the Congress, getting a major Federal appropriation raise, and after which we could get a small share of it.

Mr. ROGERS of Florida. But there was no machinery where when this problem cropped up, you could get any aid directly from the Department of HEW or the Public Health Service.

Dr. JAMES. No. There were no extra funds available from any source at the Federal Government or State for us at this time, and what I, of course, would suggest, is that if there were evaluations of problems being made continuously by the Public Health Service, allocations could be made for special needs of this nature.

Mr. ROGERS of Florida. In other words, there might be areas or States where the TB problem was minimized, and those funds could be diverted, yet they continually go into the State because of the formula?

Dr. JAMES. That is correct.

Mr. ROGERS of Florida. And this should be changed.

Dr. JAMES. Yes.

Mr. ROGERS of Florida. Now let me ask you just a question or two more, and then we will conclude.

You say that much of the health activity and health functions of the Department are simply based on applications that come in, rather than planning, a reverse action, in effect. Expand on that, if you could.

Dr. JAMES. For research, the present system is excellent. The whole business in research must start with the principal investigator. He has to plan the project. He has to be given the flexibility to move in any direction he wants, so the best way to operate is the way the Federal Government does operate, by having these panels of experts receive grant requests and allocate the grants to the most successful competitor. But in demonstrations, it is something else. These are of longer duration, as a rule; they cost a tremendous amount of money, as a rule; they affect many operating programs, as a rule; and they have an enormous impact on the future programs of the area.

Therefore, you are dealing with something far more extensive, far more close to service programs, and we should not use this mechanism of having the Federal Government sit back and receive requests as much as we should use one of a partnership between the Federal Government and the area doing the study: (*a*) to make it a good study, (*b*) get the best people for it, (*c*) fit a study done in area A into one which is being done in area B. Hence, together you get more than if either one were done separately, minimize competition for scarce personnel, and take steps to see that when the research is completed, its findings are spread more broadly in the country, and applied more broadly in the country.

This is what I mean by a planned approach.

Mr. ROGERS of Florida. So that we do definitely need better planning in the Federal agency now on these demonstration projects.

Dr. JAMES. Yes.

Mr. ROGERS of Florida. Now what is your feeling? I know you say you feel the National Institutes of Health programs are run effi-

ciently. Do you feel there is sufficient planning there, on the in-house work?

Dr. JAMES. The Woolridge Committee made some recommendations that would give the Director of the National Institutes of Health more leeway in making changes between the various Institute programs. I think this would be a step forward, very definitely.

In addition, there were some suggestions made about improving the coordination with certain of the Institutions, so that the Institution would be strengthened in the process of getting research grants, but outside of a very few minor points of this nature, when we studied the National Institutes of Health in the Woolridge Commission, we felt this was a most amazing program, and an enormously successful program, far beyond expectations.

Mr. ROGERS of Florida. Yes, I wonder about this, though; in looking it over, I wonder if more of the budget of the NIH should be allocated to some planned research. In other words, the same objection you are making to demonstrations that come in simply from applications.

Now I realize we have to have the freedom to allow science to operate, but it would appear to me from my study that more of the budget should be used at NIH for a planned activity.

In other words, where your people in the various institutes have seen research done, there may be some area that really needs to be researched, and so by planning it, and saying, "We have so much funds in this area to be planned, and we need this area or field researched," rather than waiting until somebody may come up with it, or they may not.

So what would be your feeling on that?

Dr. JAMES. The NIH, of course, does some. It has collaborative studies, and hence, has done some of this. The question of should they do more is one that I think could be discussed, and perhaps could be defended. I have some feelings that in certain areas, we should be focusing more attention. I think these areas, however, are in that gray zone between where research leaves off and demonstration begins, and perhaps some of these activities would be called by the purer scientist as demonstrations.

However, the general principle that you are pointing out is one with which I agree. I think there should be planning. I think we should look at areas where work has to be done, whether that work be research, service, or administration, and that we have units in the Public Health Service which are capable of isolating these areas for additional study and effort.

Mr. ROGERS of Florida. Thank you very much, Dr. James.

Congressman Gilligan?

Mr. GILLIGAN. No questions.

Mr. ROGERS of Florida. Does counsel have any questions?

Mr. SLOAT. Dr. James, you have indicated that you generally approve of the NIH operation as it now exists. There seems to be general consensus that it has been very effective, in regard to the funding of basic research applications. There is not as much unanimity of opinion, however, that NIH has been as effective in regard to the funding of applied and methodology type of research, which usually

is done, I understand, more by hospitals and health departments, than by universities.

This may result from the fact that the HEW review groups seem to be university-oriented, primarily. Would you care to comment on whether NIH has been as successful in funding this other type of research?

Dr. JAMES. The type of research which relates to application but which is still research, and not a demonstration, is the point to your question, as I understand it. I would say this—and let me preface it by saying that I am a member now of the Health Services Research Study Section, so I am receiving and reviewing just the kind of applications you are discussing.

Yes, I would say we could stand to have sent to us more higher quality applications than we now have, although we do have some excellent ones. I believe that this is primarily the fact that there are very few people, relatively speaking, in the country, who have devoted their careers to this kind of research, and the National Institutes of Health operates only or essentially through principal investigators.

Now what you are suggesting is something that I would warmly support, if I understand that your suggestion is that the Public Health Service take steps to train many more excellent investigators in this field. I feel that there has been far too little attention paid to develop good research people at this area between research and demonstration, or the applied types of research that will help us develop the tools we need to make the fruits of scientific knowledge available as practical health programs.

Mr. SLOAT. The reason for the question is that we have been informed that hospitals and health departments feel that they can't get, or do not have as good a chance of getting, applied and methodology-type research applications funded at NIH, and they therefore go elsewhere, such as to the Vocational Rehabilitation Administration, and there seems to be a trend developing whereby the hospitals and the health departments go elsewhere than NIH for this, while universities go to NIH for their programs, and the question really is whether this is a type of research that NIH should support, or whether it should be supported primarily by somebody other than NIH.

Dr. JAMES. Well, let me just say this: I have yet to see an excellent project come before our group that was not funded. I would feel that perhaps some of the problems you are expressing are due to the fact that these projects are not as well developed as they should be, do not have the proper personnel involved with them, haven't been thought through as accurately and/or perhaps are not of as great significance.

We do not, at NIH Study Sections, wish to give grants to people so they can go through the motions. We want to have good results come out of it.

I do believe, of course, that we need many more well-trained people in this field. I also will say that if a person wants support strongly enough, and he is turned down by the NIH, he may get it somewhere else, and since we are dealing with human beings who review these grants, it is possible that they overlook some good ones, but I do not feet that there is any prejudice in the NIH mechanism against good projects in this field.

Mr. ROGERS of Florida. Thank you very much, Dr. James. We appreciate very much your being present and giving us the benefit of your knowledge.

Dr. JAMES. Thank you, sir.

Mr. ROGERS of Florida. Our next witness is Hon. Marion B. Folsom, former Secretary of the Department of Health, Education, and Welfare, and Chairman of the National Commission on Community Health Services; a citizen who has had, I think, as much experience in this field in surveying the health needs and problems of our Nation as any American today.

We are very honored to have you, Mr. Secretary, and appreciate your making yourself available to the committee.

STATEMENT OF HON. MARION B. FOLSOM, CHAIRMAN, NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES, AND FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. FOLSOM. Thank you, Mr. Chairman and gentlemen of the committee.

I am pleased to have this opportunity to give you my views on the organization and functioning of this most important and fast-growing Department, which affects in one way or another almost every individual in the country.

My views are based upon my experience as Secretary of the Department for 3 years (1955–58) and 7 years' previous experience in other executive positions in the Federal Government—the Defense Department, staff direction of the House of Representatives Special Committee on Post-War Planning, and Under Secretary of the Treasury.

I have also served on several Federal advisory councils, including the original and subsequent social security councils.

Since leaving the Government, I have served on the President's Commission on Heart Disease, Cancer, and Stroke, as Vice Chairman of the 1965 White House Conference on Health, and as a member of the Federal Hospital Council and chairman of the Governor's Committee on Hospital Costs in New York.

In the voluntary field in recent years, I have been chairman of local health planning councils of Rochester and of the surrounding 11-county area and chairman of the National Commission on Community Health Services.

During my more than 40 years' experience with the Eastman Kodak Co., I was often concerned with organizational matters.

In commenting upon the recent appointment of Secretary Gardner, the press carried the statement that former Secretaries had all found this job frustrating. This was not my experience. I found the position no more frustrating than other top Government positions and that it was a most interesting and challenging assignment.

Each program is concerned with the needs of human beings. The programs require constant change to be kept up to date; the need for new programs is constantly arising. The Department has a dedicated staff interested in helping people.

I do not agree with the view that there should be a separate Department of Health or of Education but agree with Secretary Gardner

that the Federal responsibilities in these three fields of health, education, and welfare should be kept in the same department.

I found that there is need for close coordination of the programs in the three fields and that it is valuable to the Secretary in arriving at decisions to have the viewpoints of those working in the different areas.

For example, there is very close tieup between health and education in the training of health manpower, of which there is now critical shortage.

An important concern of the Department is naturally with the problems of the indigent and low-income families and with measures to reduce dependency—with health, education, and welfare measures closely interwined.

The voluntary social agencies dealing primarily with the problems of the indigent and the low-income families have also found out that they must consider the individual as a whole man; and that there is not just one cause for dependency but that the problem is a multiple one.

Probably the most important task which the Federal Government in general faces is the allocation of our resources between the various needs and demands; and the establishment of priorities. As all the programs in the Department of Health, Education, and Welfare concern individual needs, the Secretary should be in the best position to view objectively the various demands and to recommend the proper allocation and priorities.

An individual agency, with the pressure from its special clientele, finds it exceedingly difficult to view the demands objectively. And, of course, a good case for additional funds can be made for almost every program relating to human needs.

Thus, if separate departments were created, additional burden would be placed on the President and the White House staff to make the determinations for the three areas.

The White House staff could not be expected to be as conversant with the real needs as would be the staff of the Secretary of Health, Education, and Welfare. The Secretary is not in the position of special pleader for any one program, but concerned with all matters affecting human needs.

When health, education, or welfare administrators from other countries visited me in Washington, their first question was why we covered in one Department all three fields. I would remind them that the situation in this country is quite different than in smaller countries, with a more homogeneous population.

In most of these countries, the central government has control of the whole educational or public health system, with varying responsibilities delegated to the local communities. Thus, they combine in the national office many of the functions which we handle in the several States.

While Federal expenditures in the health field have increased considerably in recent years, they still represent a small proportion of total governmental health expenditures. The Federal Government is concerned with broad national needs, such as medical and pollution research, and with assistance to State and local health departments in meeting local health needs, through cooperation and grants.

This system has been successful in the past, as illustrated by the practical elimination of malaria and infectious diseases and the substantial reduction in tuberculosis.

With the recent enactment, however, of broad new national health programs with some grants being made directly to local communities and agencies, there is danger that the State health departments may be bypassed and weakened. It is fortunate that your committee is investigating the relationship between Federal, State, and local health departments.

I have a few suggestions for improving that situation but first, I will give you my views on the organization of the Department of Health, Education, and Welfare.

As to the present organization, it is contended by some that the Department is now too large and complex to administer. My answer would be that size is not a deterrent to sound management. The largest Department in the Government is the Defense Department and probably the most difficult to administer; yet it is generally agreed that it is now being well administered. There are other Departments in the Government with larger numbers of employees than Health, Education, and Welfare. Some of the largest business corporations in this country are the best managed and most prosperous.

Other Departments also have a wide divergence of agencies, such as the Commerce and even old line Departments such as the Treasury.

The question is also raised as to how any one Secretary can be expected to be well informed in all three fields and the various programs of the Department. My answer would be that the head of any large organization—whether it be in business, education, or government—cannot be expected to be expert or even well informed in all the activities of the departments in his organization.

The president of a large corporation cannot be expected to have firsthand knowledge in such diverse fields as industrial research, financing, accounting, advertising, selling, legal affairs, industrial relations.

The successful top executive must have the opportunity and capacity to select able assistants; to delegate responsibility and authority to the line officers to carry out designated functions; to have adequate staff personnel to keep the chief executive informed of the operations and to analyze and advise on pending problems.

The executive must have enough general knowledge of the field and the ability to grasp the essentials of the problem presented to him for decision. He must especially have the leadership qualities to inspire loyalty and to obtain cooperation and determined effort throughout the organization to produce results. These qualities are needed, whether the organization provides services or products to consumers for profit or whether it is a governmental department, providing services for the country.

The problem of the Department of Health, Education, and Welfare is not one of size or complexity or diversity of functions, but relates rather to the inadequate top level staff to support the Secretary. The Secretary must administer effectively the programs given the Department by Congress. Many of these programs are concerned with providing incentive and assistance to States, local communities, or institutions to initiate programs to meet vital needs as they arise.

It is important, therefore, that they be kept up to date to meet changing needs and that programs no longer needed for the intended purpose be abandoned so that funds will be available for new and pressing needs.

The present organization does not have a large enough top staff to do the job. I found that it was quite inadequate 10 years ago and the expenditures were much smaller then. The staff has recently been increased by the addition of a number of Assistant Secretaries. While this is a step in the right direction, I understand that all of these Assistant Secretaries will be used as staff assistants and it will still be necessary for the Secretary to be concerned with the administration of 9 or 10 individual agencies.

The Secretary of Health, Education, and Welfare should be able to delegate much of the responsibility for administration and personnel matters to others so that he will have time to devote to broad policy questions. This would enable him to keep in close touch with the key Congressmen and Senators, for their views on existing or proposed legislation; also to consult with other Departments concerned with his or related programs; and what is extremely important, to consult with the leaders of the many voluntary organizations who are concerned with the departmental programs.

He must not depend entirely on his own career people in the agencies for advice. Otherwise, some of these programs are apt to become out of date.

I found out that contacts with educators, health and welfare people on the outside were very valuable. Unless the Secretary can delegate many of his administrative duties, he will not have the time to devote to these important contacts.

I was very much impressed with the manner in which Secretary Humphrey administered the Treasury Department. He delegated to three of us the responsibility for administering specified agencies in the Department, with instructions not to bother him unless it was an important policy or personnel matter.

As a result, he was able to devote a large part of his time to general fiscal, monetary, and credit policies affecting the whole Government and the economy.

As my experience in business organization had been similar, I endeavored to delegate as much as possible to others. I found out, however, that it was necessary for me to devote much more time to study of the important programs which, unlike those of the Treasury, were changing all the time and were constantly being reviewed by Congress.

I delegated responsibility for administration to the agency heads, but with the number and diversity of activities I felt the need of what we call in business "line officers."

Because of his unusual competence and personality, I was able to use the assistant for medical affairs, as such an executive, to keep in close touch with the activities of the Public Health Service, the National Institutes of Health, Food and Drug, Rehabilitation.

While the heads of these agencies could deal with me any time they chose, he kept in much closer touch with their problems and was able to relieve me of much of that responsibility.

As my Under Secretary was in each case an educational man, I used them as line officers not only for the Department as a whole, but espe-

cially for the Office of Education. As I had been active for many years in social security and welfare fields, I dealt with the heads of these agencies directly.

I did not feel that I had enough staff to do a thorough job, especially to participate in the discussions of proposed programs, in checking up on programs to see that they were kept up to date.

Neither did I have adequate time to deal with informed persons on the outside or key Congressmen and Senators, especially those who were not on the committees with which I regularly dealt. It is very helpful to discuss proposals with the key legislators while they are being formulated.

The President's Commission on Heart Disease, Cancer, and Stroke was naturally concerned with the organization of the departments. The following is quoted from the Commission's report:

> The major problem seems to be an insufficient number of high-level policy positions to provide effective leadership and coordination of the Department's many programs which are basic to the internal strength of the Nation. The Department has only five such positions.
>
> These people are expected to provide effective leadership of a Department with over 80,000 employees, with about 130 programs (over 40 in health), and with annual expenditures of $6 billion from budget appropriations and of course it is larger now, and about $15 billion from trust funds.
>
> Even from a casual study of the situation, and certainly in comparison with other Departments of Government, it seems obvious that strengthening of the Department of Health, Eduction, and Welfare at the top is greatly needed.
>
> The Commission recommends that a reorganization of the Department of Health, Education, and Welfare be effected to provide specific high-level policy, direction and coordination of health programs, with adequate supporting policy positions.

I would strongly concur with this recommendation to strengthen the organization by providing more top level officials for general supervision over the many programs handled in the Department.

My specific suggestions are: that a Deputy Secretary be added, following the practice of the Defense and State Departments; that there be appointed an Under Secretary for Health, an Under Secretary for Education, and an Under Secretary for Social Services.

These four top officials would be line officers to whom the Secretary could delegate much responsibility for the activities of the several agencies. In addition, he should have several Assistant Secretaries to serve in staff capacities.

The Deputy Secretary would assist the Secretary in general supervision of the Department, serve as Acting Secretary and attend Cabinet meetings in his absence.

The Under Secretary for Health would maintain general supervision and be responsible for the coordination of the Public Health Service, the National Institutes of Health, the Food and Drug Administration, Vocational Rehabilitation, Environmental Health, and the Pollution Agency.

Under the Under Secretary for Education there should be a Commissioner for Higher Education, a Commissioner for Secondary Education, and a Commissioner for Vocational Education.

The Under Secretary for Social Services would be concerned with the supervision and coordination of the Social Security Administration, the Welfare Administration, the Children's Bureau, and the Aging Bureau.

There could be one Assistant Secretary for Congressional Relations, one for public and press relations, one for relations with voluntary organizations, one for State relations, one for administration, and one or more for program analysis.

To serve the purpose performed by an executive committee in business, the Secretary could meet frequently with the Deputy Secretary and the three Under Secretaries and Assistant Secretaries in order to keep in close touch with the activities of the Department and to coordinate the activities of the various agencies.

It would be understood that the individual agency heads could see the Secretary at any time, but he would, of course, be relieved of many of the administrative and personnel matters which do not require his attention.

With this kind of an organization, the Secretary would have more time to consult with knowledgeable persons without and within Government and with key legislators; and to analyze the important programs. He would then be in much better position to make objective recommendations to the President for the allocation of the funds available for meeting human needs in education, health, and social services.

Regardless of the particular pattern of organization decided upon, a number of improvements could be made in certain of the health functions carried on by the Department, especially in regard to the grant programs, which have increased so rapidly in recent years.

The legislation authorizing these programs should provide for a periodic and objective review by an outside competent group. So that the program can be kept in line with current conditions and abandoned when change in needs warrants it.

Periodic reviews by tripartite advisory councils have been important factors in the success of the Federal old-age insurance program and in keeping it up to date. Such review is now provided for by statute.

The grant system of the National Institutes of Health has been studied repeatedly beginning with Bayne-Jones committee I appointed in 1957. The chief difficulty with the medical schools related to overhead allowances, but this issue has now been settled. There is still a demand for more "block grants" for medical research, and for grants of longer duration—both of which seem to me to be justified.

I certainly agree with Dr. James that the National Institutes of Health is a very successful organization, very well organized, and I would recommend very few changes. It has been studied, and it has been kept up to date.

The greatest need in connection with the other grant-in-aid programs is better coordination in their administration. There have been so many new programs introduced providing grants for demonstration projects, experiments, planning and research into various health and mental health fields that it is very difficult for public health officials, voluntary agencies or individual health people to keep informed or to know to whom application should be made.

A case came to my attention lately—an application was made for a grant and a site team made a visit; the applicant was advised that the team could pass on only one part of the project and some other division—they didn't know which one—would have to review the other aspects.

Fortunately, I was able to get in touch with one of the top officials of the Department to clear up the matter, without the long delay if matters had taken the usual course. Should there not be one point which could serve as a clearinghouse and coordinator for all the small, miscellaneous grant programs, so that everyone would know to whom to go?

Should not a plan also be developed to have local applications clear through the Public Health officer? It would also seem that all applications from a State should clear through the State health officer. Such a system has been successful in connection with applications for grants under the Hill-Burton program.

This program is also a good example of failure to be kept up to date. As far back as 10 years ago when I was Secretary, it was becoming evident that the critical need was no longer for acute, general hospitals but for long-term care and rehabilitation hospitals and for replacement of obsolete hospitals in large urban centers.

Only this year is realistic action being taken. An objective outside group reporting to Congress and the Department might have brought earlier action.

Another suggestion I would offer is that information regarding successful demonstration and experimental projects be given wider circulation for the benefit of health agencies. For instance, the New York Hospital Costs Committee recommended that hospitals should devote much more attention to the recruitment, training and development of personnel, and wanted a successful example to strengthen the recommendation.

It was only after the report was published, did I by accident learn of an experiment financed by a grant from the Public Health Service in one of the largest New York hospitals which had resulted in a reduction of 50 percent in their labor turnover.

While in recent years, great progress has been made in medical research financed largely by the generous appropriation of Congress, very little has been expended for research into improved methods for the delivery of health care. The need for greater effort in this direction was emphasized in the following extract from the summary of last year's White House Conference on Health:

> We spend less on health research than we should. But of our health research expenditures, less than one-half of one percent is spent for research on the organization and delivery of health services.

What is needed is a search for practical methods for applying on a large-scale plans which have been found by demonstration projects and experiments to be successful.

State and local public health departments would be logical places for such research. I would suggest that your committee consider recommending the inauguration of a program of broad grants to State health departments for research in cooperation with local health departments, and incidentally, of hospitals, too, into improved methods for delivering high quality health care.

The State should be given wide leeway so that the effort could be concentrated on the critical problems of the particular State. Such broad grants would also meet the criticism often heard of the narrow specific grants.

One field that warrants special attention by State and local health departments is the health condition in the low-income city and rural areas. Similar to the findings of Dr. James in New York City, we found that the incidence of tuberculosis in certain areas in the center of Rochester was 15 times higher than a suburb, and infant mortality 4 times higher.

Should not the State and local health departments determine the most practical methods for improving this condition?

Another area where a more extensive and systematic program for grants is needed is the planning and coordination of community health facilities and services. Ten years ago when I was Secretary, the Public Health Service advised me that the haphazard planning of hospitals and other health facilities was one of the important factors in the rapidly rising hospital costs.

When, after my return to Rochester, we were organizing a health planning council, the Public Health Service could not give me the name of a single community with a successful council. They and the State health departments helped us determine the actual needs of the community and plan our program.

During the past 5 years, with the cooperation of various community groups, we have made good progress in both the voluntary and governmental fields.

Progress has also been made in a few other communities aided by small grants provided under the Community Facilities Act. The need for greater effort was pointed out in the following extract from the report of the President's Commission on Heart Disease, Cancer, and Stroke:

> Manpower and facilities for the delivery of top quality health care are in short supply in virtually every community. Therefore, the efficient use of existing resources is imperative. Yet in many communities the reverse is actually the case. Instead of coordination, there is duplication of services and facilities in some areas, while serious gaps exist in others.
>
> There may be several large general hospitals, furnishing more beds for acute care than can possibly be utilized by the community, while serious shortages exist in beds for long-term care and programs for those patients who can best be cared for in their own homes.
>
> Several hospitals may possess costly equipment—such as cobalt devices for cancer care, or heart-lung machines—each being used only once or twice a week. Teams of highly skilled people required to work with this equipment are also standing idle.
>
> A beginning response to these problems can be seen in a few of the nation's more progressive and active communities.
>
> Such endeavors are of the utmost importance if we are to realize our aspirations for programs that will have maximum impacts on heart disease, cancer and stroke. Independent and often competing activities of hospitals, health departments, and medical practitioners—each working in isolation and often at cross purposes—are not in the best interest of the consumers of health services, the health profession, or the nation.
>
> The Commission recommends a special program of incentive grants to communities to stimulate the development of a system for the planning and coordination of health activities.
>
> The Commission recommends that greatly increased emphasis and support be given to programs of community health research and research training within the Public Health Service, and that the program of demonstration projects under the Community Health Services and Facilities Act of 1961 be freed from existing appropriations, ceilings, more adequately funded, and more liberally interpreted.

I suggest that your committee recommend a substantial increase in the appropriations for this purpose. Again I would suggest that broad grants be made to the State health departments to help develop statewide coordinated health planning. Present applications from communities must now clear through the State agency, but with the initiative coming from the community, the results are rather haphazard.

As a result of recommendations made by the Governor's committee, New York last year enacted legislation which transferred the supervision of voluntary hospitals to the health department, and provided that no construction of hospital facilities could be undertaken without the approval of the appropriate regional hospital planning council as to public need and the State review and planning council.

The law specifies that the Health Commissioner will not approve the application for additional acute beds until he is satisfied that adequate consideration has been given to construction of long-term care, self-care and rehabilitation units and greater use of outpatient and organized home care services—all with the view to relieving the costly acute beds, and incidentally, provide better health care.

New York could adopt a comprehensive program of hospital planning because it had already established regional councils in connection with Hill-Burton grants. This new law has created considerable interest in other States but regional and local planning councils must first be organized and in operation.

Broad grants to the State health departments for this purpose would be very helpful in obtaining action to moderate costs by the prevention of unnecessary construction and duplication of facilities, and to improve the quality of health care.

Strong local councils can also bring together the various voluntary and governmental health agencies in concerted efforts toward these objectives.

Thank you, Mr. Chairman, for the opportunity to present these views.

Mr. ROGERS of Florida. Thank you, Mr. Secretary, and we appreciate very much the thoroughness with which you have gone into this problem, and your specific recommendations, which will be most helpful to the committee.

Congressman Gilligan?

Mr. GILLIGAN. No questions, Mr. Chairman.

Mr. Secretary, I also would like to add my word of commendation for a very careful and thoughtful analysis of this problem. It is very evident that your own experience in this office contributed greatly to your understanding and to ours of the complexity of the problem and to some of the things that might be done to help in its solution.

I don't have any specific questions. I just would like to say again that I think the members of the committee have profited from your commentary.

Thank you, sir.

Mr. FOLSOM. Thank you.

Mr. ROGERS of Florida. Congressman Nelsen?

Mr. NELSEN. No question, Mr. Chairman.

I do wish to compliment the Secretary for the very fine statement that he made. I noted with interest your reference to organization, and having the various departments headed up by responsible people accountable to the Secretary. Certainly this is an important part of the administration of such a vast department, to have competent people, and quick access to expert leadership in the various branches. Some of us who have had some limited experience in government have learned that this is important, and you have emphasized it very well. I thank you for your very generous application of time and attention to this problem.

Mr. FOLSOM. Thank you.

Mr. ROGERS of Florida. Mr. Secretary, I am particularly interested in your recommendation that the Department not be divided, because there has been great consideration along these lines as well, you know, in discussion over the years, and your suggestion that there be Under Secretaries, for Health, for Education, and for Social Services.

Now I presume that these would operate in an organizational basis somewhat as the Defense Department does now with the three Secretaries.

Mr. FOLSOM. Yes, sir.

Mr. ROGERS of Florida. Do you feel that this is a better approach, rather than just having a number of staff assistants that have no line command, in effect, in the Department?

Mr. FOLSOM. There are several reasons. It is very difficult for a top executive to keep in touch with so many different people. Even in a business organization, you find that the number who should report to the top executive should be limited.

In an organization like this, dealing with so many different programs, it is almost impossible for one man to keep in touch with all of it as closely as he should, and by having these three Under Secretaries who could take care of much of the detail, he can operate much more efficiently.

In part of my statement, I mentioned that when I was at the Treasury Department, Secretary Humphrey—we have a wide variety of agencies in the Treasury, too—he delegated three of us definite assignments to look out for certain aspects. I had charge of the Internal Revenue Service, tax policy matters, Bureau of Engraving and Printing, general administration, and budgets. Mr. Burgess had charge of monetary and credit matters; and Mr. Rose, all the rest—Coast Guard, Customs, Mint, Secret Service.

The Secretary told us, "Now don't bother me with anything unless you think it necessary, and general policy matters. You handle as much as you can. I want to be free as much as I can for general policy questions and financial matters relating to the whole administration."

As a matter of fact, we didn't have to bother him with very much, and he had much more time to devote to the general fiscal and monetary matters, seeing other people in the administration and on the outside. That's the way I felt that this Department should work.

When I got to HEW, though, I found out we had so many programs, and were going to be questioned about so many, I had to spend a lot of time studying these programs, and becoming acquainted with them. I did delegate a great deal. As a matter of fact, I had an Assistant

Secretary for Health and Medical Matters, but I used him as a line officer. He was a very competent man, whom I found out was so well informed that he more or less served as a line officer for me for all the various health activities. My Under Secretary was an educational man, so I used him as a line officer in education as well as the Under Secretary for the whole Department.

And I dealt directly with the social security matters, with which I was familiar. Now that's the way I could operate. Yet I had a very limited staff, and I am sure I could have done a better job if I had had more people.

Now the Department has greatly expanded since that time. It is just impossible to operate unless you have a few key people to relieve you of some of this responsibility.

Mr. ROGERS of Florida. In other words, the Department has grown so large that it is impossible to administer by just one man, I presume.

Mr. FOLSOM. You see, there are eight or nine Assistant Secretaries. I think there are either 9 or 10 agency heads. Thus 10 agency heads and 9 Assistant Secretaries report to 1 man. It just won't work. The Secretary is bound to end up using some of those Assistant Secretaries for line officers.

I feel we had just as well recognize it in the organization chart, and have it understood.

Also, the Under Secretary can have a little more influence with some of the other departments. Now there are other departments in the Government dealing with some of these matters. You can't bring them all together in a Department of Health, and the Under Secretary can have a little more effect in dealing with some of the other departments than an Assistant Secretary.

Mr. ROGERS of Florida. I noticed, too, under the Secretary of Health, you would put the Vocational Rehabilitation, Environmental Health, and Pollution Agency.

Mr. FOLSOM. All those agency heads would still deal with the Secretary directly when necessary, and in matters of broad policy matters coming up, these agency heads would be very much in the picture, but I am talking about the average day-to-day operation.

Mr. ROGERS of Florida. Also, I think your suggestion of having an outside competent group to review periodically the programs, and make recommendations——

Mr. FOLSOM. That is along the lines that Dr. James recommended, too, about evaluation. You see, this outside group can do a much better job of evaluating these programs than an agency directly concerned with them.

Now I have found that to have been very helpful. I have been on these various advisory councils on social security, and that system has been kept up to date, been very successful in my opinion, because we have had these checks from time to time by an outside group, and Congress, has invariably adopted a high percent of the recommendations.

Of course in these councils, we have had representatives from employers, labor, and the general public, and invariably, we reached agreement on a high percentage of the recommendations. When all the facts are on the table, it is easy to reach agreement if the members view them objectively. It seems to me that of the many programs

that we have had, the best demonstration of the need for periodic review is the vocational education program. That was started my way back in 1917, at the time of World War I. Yet until recently there had been very little change since that time in their makeup. A commission that the President appointed on interstate relations, made recommendations for elimination of that program entirely from the Federal Government, but it was kept, and it was only 2 or 3 years ago that the program was really brought up to date.

I say, if it had a periodic survey made by a competent objective group from the outside, they would have told Congress very quickly that that program was really not up to date, because I know you have, your authorizations and appropriations are generally just for so many years, but it is too much of a routine affair, to have them extended, and I would like to see right in the authorization itself a clear statement that there should be every certain number of years, varying with the program, a periodic survey of the program to see that it is up to date to meet current needs.

Now when I was head of the Department, I asked Congress to put such a provision in the social security law. Before that, it was hit or miss, but now we have a provision that a year before any tax increase takes effect, there must be appointed a tripartite advisory council, to report to Congress and to the executive department.

I think these review committees should report to the Congress and to the executive department, not just to the Department head.

Mr. ROGERS of Florida. Informed on how a program is operated.

Mr. FOLSOM. Of course, some of it could be combined. You wouldn't have to have one for each grant, but you could bunch a number of these grant programs together, and have a committee study those.

Mr. ROGERS of Florida. Yes; I think your suggestion, too, that there are so many programs, people don't even know where to make application.

And your solution for that, to have one——

Mr. FOLSOM. Well, one of these Assistant Secretaries, for instance, could be put in charge of that.

Mr. ROGERS of Florida. As a clearinghouse for all of these, where the people would know exactly which agency they should contact, rather than just hoping they would hit the right one.

Mr. FOLSOM. To show you a situation in Rochester where we have a very active health planning council, and I find that individual hospitals, doctors, and others, were putting in applications as for some grant they heard about. Well, they tend to get buried, you see. They get into trouble, and they come to me to see if I can't help them out.

There ought to be some coordination locally through the health officer.

Mr. ROGERS of Florida. Through the State, and it would work very much like the Hill-Burton program, would be your suggestion.

Mr. FOLSOM. The Hill-Burton program has established a very good pattern.

Mr. ROGERS of Florida. Yes, I think it has worked very well, and has brought about some coordination. I noticed that you said that there had been a study which resulted in a reduction of a 50-percent labor turnover.

Mr. FOLSOM. Now I find in going around to various hospitals that they are way behind industry when it comes to training personnel. Of course they haven't paid enough until lately, to get good personnel to start with, and I am not talking about nurses, I am talking about all the other employees.

Mr. ROGERS of Florida. The paramedical.

Mr. FOLSOM. And they come in, are not given the training, and as a result, they soon leave, or they don't do a good job. One of the recommendations of our New York committee was that they adopt many of the practices we have found successful in industry. In the last 30 or 40 years, there has been tremendous progress made in the recruitment and the training, increasing productivity by better utilization of personnel and in developing people for supervisory positions.

Mr. ROGERS of Florida. Yes.

Mr. FOLSOM. And that way, industry has been able to increase productivity considerably. Our New York committee wanted to give illustrations. When we made some suggestion, I wanted to set up an example, of better utilization of personnel. I found out through a meeting of the Federal Research Hospital Council that a study had been made, the hospital hired a consultant with this grant, and they studied the whole system. A number of improvements were made and they found that they could reduce the labor turnover by about 50 percent.

The number of people leaving, compared with the average force, by about 50 percent within 3 years' time. That is quite a contribution.

Mr. ROGERS of Florida. It is a tremendous contribution.

Mr. FOLSOM. I have been on this Federal Hospital Council, and every meeting I go to, I say, we have been making all these grants over the years, and what happens? You have a successful demonstration, it is filed away somewhere, and not generally known.

Now they will generally wait until several years afterward to get all the facts. Now if they know an experiment or demonstration has been fairly successful, why can't we get information out about that now, instead of waiting so long?

And there is no systematic review of it. I wrote the department that we are going to make a number of recommendations in the New York committee as to how we thought hospital costs could be modified, and I would like to have an example in each case of a good demonstration project. I got very few.

Mr. ROGERS of Florida. Yes.

Mr. FOLSOM. And yet I know that there are many successful demonstrations that have been carried on, and you haven't been able to cull them out.

Mr. ROGERS of Florida. In other words, we are doing all this research, but we are not benefiting from it as we could and should.

Mr. FOLSOM. Not benefiting from applied research. That's why I feel, that the State health department should be very effective.

Mr. ROGERS of Florida. Yes. Well, I think your suggestion is good, and rather than keep duplicating, have the State do the same kind of study, if we let successful demonstration projects be known, and have some program to get out the knowledge of research, I feel this really could save a great deal of money.

Mr. FOLSOM. In New York State, almost every one of our regional planning councils have gotten grants from the Public Health Service to improve their agencies. Yet the real need is now in the States where they haven't got any regional planning agencies. So I would say give the grant to the State, just for the general purpose of setting up these planning agencies.

Mr. ROGERS of Florida. Any other questions?

Mr. Secretary, we are very grateful to you, and you can be sure that the committee will give great weight to the testimony you have generously given us today, particularly because of your extensive background in this whole field. We are grateful to you for coming.

Mr. FOLSOM. Thank you. I am very glad to be here, and hope to have been of help.

Mr. ROGERS of Florida. Thank you. We may be in contact with you again. Thank you very much, sir.

Our next witness is Dr. Henrik Blum, who is county health officer in California of Contra Costa County, and I will defer to our California Member here, if he would like to have a comment first.

Mr. YOUNGER. I do not have the privilege of knowing the gentleman. He comes from a district that was represented by our deceased colleague. I do know, however, that Congressman Baldwin, in talking with him prior to his death, said they did have a good record in Contra Costa County. I think that the witness comes with a good background.

Mr. GILLIGAN (presiding). Mr. Blum.

STATEMENT OF HENRIK BLUM, M.D., COUNTY HEALTH OFFICER, CONTRA COSTA COUNTY, CALIF.

Dr. BLUM. Mr. Chairman, members of the committee, I would like to say that your committee has the opportunity of creating what I believe may be the next most important step that is going to be taken in health services for the country, if you can effectuate the kind of thinking that I see you are putting together.

I think this is better than a billion-dollar shot in the arm, to use what we have better, and organization is the key to much of this.

Governor Brown suggested that I amplify his brief statement which he sent on to you, and I shall try to do that, and yet the document that I have placed in your hands is a little too long, so if you don't mind starting on the third page.

Mr. GILLIGAN. Well, sir, you may proceed just however you please. If you want to submit the written statement for the record, it will be included in the record, unless there be objection, and then you can comment extemporaneously on it, or just whatever is most satisfactory to you.

Dr. BLUM. Well, I discovered it was too long, after it was dictated, and it was on its way, so I would just as soon cut it but leave for the record the document that you have.

(The statement referred to follows:)

STATEMENT OF HENRIK L. BLUM, M.D., HEALTH OFFICER, CONTRA COSTA COUNTY, MARTINEZ, CALIF.

Organizational Structure of Health, Education, and Welfare as It Pertains to Health Services

Any statement directed to this subject must be prefaced by what the testifier believes is the federal role in Health Services.

FEDERAL RESPONSIBILITIES

Assuring equal availability of health protection and medical care throughout the union must clearly be a federal responsibility. There are several major elements to this responsibility.

1. Funding for services and facilities

For the fifty years since medicine has had something of consequence to offer, there has been unequivocal evidence that there has been gross denial of services for those with limited incomes in most communities of the United States, and often what has been offered is fragmented and low in quality. Only with federal assumption of responsibility for these services has there been significant improvement. The most important of all federal health measures, Medicare, turns the corner once and for all, and for at least one sizable group it says that they shall no longer in their illness have to go to some separate and rarely equal house of health to be cared for as objects of grudging charity.

There is an inequality of resources, state by state, often inversely proportional to the numbers of persons needing assistance for medical care. When this is combined with the mobility of our people and the (often federally dictated) shift of job opportunities with new technologic breakthroughs and the need to utilize different resources, increasing federal, rather than state or local financing, becomes imperative if all citizens are to have equal protection against hazards to their health and for medical care when they are sick.

2. Funding for training

Training facilities are also not suitably distributed. Trainees in general can have few commitments to the area in which they get their training or to the area from which they come. In other words, training knows no jurisdictions and must receive federal support so that enough skills are developed wherever the training opportunities present in order to serve the entire nation's needs.

It is important that the specific public health and preventive skills not be overlooked and that federal funds be spent to provide this additional training for members of the medical and related disciplines.

3. Funding for research

Much like training, research has value for all our citizens (and for all nations) and has to be undertaken where the capabilities are or where new facilities and subjects for study can attract research scientists. In other words, although local and particularly state governments can participate significantly, the national scope of the benefits make it clear that research remains a major federal responsibility. This is even more true in view of the increasing ability to, and thus cost of, tackling more complex problems.

There is an equal need for funding the area of development and adaptation. The application to health services of ideas and techniques from other fields is sometimes lumped in with research but needs clear cut consideration. The opportunities for field trials may occur anywhere in the nation and usually call for federal funds if they are to be taken advantage of.

HOW FEDERAL AGENCIES PROVIDE STATE AND LOCAL HEALTH SERVICE FUNDING

The bulk of federal funds for service, training, and research are ultimately expended through state and local government channels or to individual agencies and institutions, i.e., not directly by the federal government agencies. Since this is my major concern today, my remarks shall be directed at the federal sources that distribute support to state and local governments and private institutions.

1. The multiplicity of sources

The welter of funding arms and branches at the federal level is a source of grief and confusion at the state and local level for several reasons. There is a tendency for the necessarily highly specialized units at the federal level to desire a counterpart in each federal regional office. The limited nature of specialist interests may often be expressed by detailed restrictions which vary from special fund to fund and from agency to agency. This can result in such mutually exclusive demands as to render the giving of service locally a near impossiblity. In our own immediate experience the Children's Bureau set up such restrictions on three separate funds. What should have been a beautifully integrated service as well as a study and demonstration of some new ways to render maternal and infant care, well child care, and general childhood medical care in a continous one-source-of-care pattern has been left in a shambles. One fund will only tolerate the use of medical specialists (but our area of need has no specialists) ; one will only tolerate clinics as a source of care; and one will only allow us to include patients from certain poverty areas but not for poor persons in the larger general area that would need services from the two other funds.

In other words, even in one part of one county there can be no continuity of care provided for between the three funds for the same people. Nor can the same families receive what they need from pregnancy through delivery (one fund), to well child care (another fund), and inclusive of sick care (a third fund). As a result, we can utilize only one fund but this involves neglect instead of services theoretically available under the other two funds.

At the same moment OEO, through Headstart, is providing short-term services for preschoolers of the same poverty areas and migrant health funds are coming in to the same area for seasonal residents. The mothers in these families can get family planning under the Children's Bureau funds but not through OEO funds. The details, the public confusion, the local policy makers attempt to participate, and the shift from specification to specification according to fund, results in unbelievable agency frustration. Obviously, darn little service occurs. Much of these potential resources are wasted through interminable conferences, detailed plans, and unresolvable conflicts. Often a key element of service may go unfunded for one or several years or even permanently, while the available services allow the patient to go staggering along for lack of one area of service.

I am not prepared to suggest that all health funds be put into HEW or into PHS, or that Congress should never provide special funds for specific purposes. However, several areas needing improvements can be visualized.

The present welter of health serving agencies and divisions at the federal level could be halved. As new areas of health concern or new groups with health needs come into focus, a new agency or institute need not always be set up. Should 'aging' get its own bureau in HEW like the Children's Bureau or should it be put into PHS as a division? Clearly, PHS concerns encompass the area of 'aging' in innumerable ways. If 'aging' is felt to be important enough to get a separate set of funds initially for emphasis, the necessary specialists needed to head the program can be set up in a PHS division of 'aging'. New divisions such as this need not last forever. Once they have achieved the kind of dissemination of interest throughout the nation that is required, their impact dies off anyhow and the skills can be recombined in other ways, e.g., chronic diseases, heart diseases, or blindness programs, etc. These in turn can be restructured in new forms when their immediate 2–5 year purposes have been well launched. The funds can be converted into general funds for public health support.

In other words, we agree that short-term categorical or special funds are needed from time to time for emphasis and that a division may have to be created to concentrate on this area. But, it should not continue forever. Project funds, useful to explore as yet unclarified areas, if seen to be serving a useful purpose, should within a few years also be incorporated into a major general type fund and the special division that was created to explore the area can be dismantled into newer groupings for new areas of concern. In

fact, project type fundings should be restricted to the support of ideas too new to be funded in more routine ways. Short-term project moneys for well documented areas of service serve few purposes.

2. General purpose funding

The backbone of local and state health services will increasingly be coming from federal assistance and should be channeled through a very few major funds such as Medicare which now provides for medical care. For example, as other population groups such as children are considered for coverage (and at least 25 percent of our nation's children desperately need dental care and at least 15 percent need medical care), they too should go into Medicare for funding, not into some new machinery.

If Headstart, for example, is needed as a demonstration (and it is) it should within a year or two go into the long-term more general Medicare funding structure.

In public health we essenitally have no general federal fund, and bits and pieces come on the scene and disappear. Perhaps S. 3008 is the beginning of such a general fund. Vaccination Assistance should shortly go partly into Medicare for the services it provides and partly into the suggested new public health general fund for the health promotion and education functions that it provides.

The integrity of the use of federal general health funds can be guarded simply as by such stipulations that no state or local funds are to be cut back or to be substituted for; that a specified increase in the general federal fund is to be used primarily for "X" services; that a given increase in federal funding is to be used to round out the scope of services in accordance with an approved state plan and that their quality and extent must comply with the accepted state sandards.

3. Strengthening State health departments

A significant requirement attached to the federal general public health funding mechanism should require each state to provide an adequate state health department in the sense of its being a competent source of health surveillance, analysis, planning, standard setting, enforcement and consultation. The state plan should include a determination of how services can best be rendered locally in its state. Where it is decided wisest to provide the direct services from the state level, the state department must then also have an adequately strengthened service arm.

The remarkable success in creating quality local health facilities through the Hill-Burton and Hill-Harris mechanisms illustrate another factor, the strengthening of the facility planning arm of the state health departments involved. In fact, the facility knowledge and ability gained for each state through its role in Hill-Burton and Hill-Harris paved the way in many states for a ready absorption of Medicare responsibilities by the same agency.

Sad to say, the majority of state health departments in the United States are presently incapable of moving effectively in the basic public health areas which hold so many new promises, and when prevention is so desperately needed to minimize the demands make by sick care. The general grant mechanism can call for creation of reasonable state capacities to survey and control their own public health needs with new federal assistance. There is one very pertinent example: California, in its 1947 legislation, provided for a general public health subvention to counties under certain state standards and it rapidly created the strongest local health department network in the nation as a result.

Part of each state public health plan should be devoted to the most appropriate means of locating and providing public health services. Population mobility, urban concentration, needs for regionalization of many medical service and facilities now call for something different from strengthening of each of our nation's county (or city) health departments as California most appropriately did in 1947. Many environmental health hazards can only be handled by regional bodies which must often encompass dozens of local governments and health jurisdictions. Personal health services, particularly hospitals and special services do likewise. If regionalized health agencies are required, and there are parallels with similar needs for transport, utilities, fire and police protection, recreation, etc., the state plan must outline how the new approach can be undertaken.

This is not to say that most of the locally applied public health services to be beefed up by new general federal health funds need be done elsewhere than through those local health agencies that are able to do an effective job. But

the local services must be done under regional planning and standards in a way that make the local services an intelligent and cohesive part of the regional scheme, and in turn, of the state plan.

The hopelessness of ever tackling the public health needs of our big cities, their surrounding autonomous satellite suburbs, and the fringe county areas become overwhelming without the energies that a new generalized public health fund might offer. If the modernization were done on a categorically funded basis no two programs could ever be related in a given region.

The proposed federal aid to states for planning and development, S. 3008, will be a vital beginning. It should then form the base for the general public health fund I am proposing. As soon as the revitalization of the intelligence functions of the state health departments have been initiated, the new general fund can be put to effective use.

4. Improved liaison between Federal health funding agencies and State and local agencies

Federal agencies now have regional offices, each covering many states. They have few generalists and a great many specialists representing various division interests in Washington. Moreover, Rehabilitation, OEO, PHS, Children's Bureau, Social Security all have separate offices in most regions.

It would seem wiser to put a working knowledge of all medical and public health funding for services, training and research into the regional PHS office, doing away with any other federal health representatives in the area. The regional office should have generalists, at least one for each major state and one for each two or three smaller states in the region. The assigned generalist can bring each state knowledge about the full array of resources, how they relate, how they are applied for, or controlled, etc. In this way not only will each state have a comprehensive overview available but the PHS Regional Office will in turn get a composite picture of each state's health needs for transmission to Washington.

Just as I agreed that special federal funds are needed for initiation or emphasis, and project funds for exploration, so the new programs or revitalized old ones may call for a related specialist in each regional office to give the newly funded program a special push. As one special program gives way to another, the regional generalists absorb the last special program, release the old, and get a new specialist for any major new program with which they are as yet unfamiliar.

Presently, not only do local and state governments not know where to apply, but few federal representatives in the regional office know what another agency's regional office may have to offer. This of course has led to despair in the Washington division headquarters which then try to have a specialist, each for their own interests, in the region. They commonly also send out specialists from D.C. who ignore their own agency's regional offices and get into wild antics with states and locals since they know nothing about the regions through which they flit. We have recently had several such merry mixups in California and our regional PHS office was the last to discover the presence of or the confusion being sown by the D.C. division personnel operating in the field.

In our experience the relationships with the federal regional offices has been good but would be immeasurably more effective if all the regional offices' health representatives were generalized and put under the umbrella of the PHS which already has the most diverse coverage. Specialized representatives for new programs could be sent out to work in each regional office utilizing the contacts the generalists have already effected. When the one or two year need for the specialist is over the generalist will assume this field as part of his broad coverage.

5. Desirability of allowing Federal grant moneys to be spent more freely (more suitable to local needs)

For funds justifiably kept apart from the general support funds in order to pursue certain research or piloting efforts in new health programs, there is ample reason to suggest modifications in current restrictions. There is widely felt distress over the parcelling out of funds for such narrow areas that an exciting new approach will be rejected by one division because it is too researchy, while another federal unit will classify it as too service oriented and inadequately exploratory. Neither will, nor perhaps presently can, serve to find a sponsor for what both acknowledge should be extremely valuable. Very commonly the researcher will try to put the pieces together, each to be funded by a separate

agency. Between separate review dates, priority hazards, duration of funding, and starting dates the pieces rarely do get put together.

A more general complaint from the field is the emphasis on meticulous project planning before a project is funded. More importantly, if the project is frozen to size in every detail early, it is pretty clear that we already must know everything that is going to happen, or that if anything unexpected should be encountered (this is inevitable if the project is competently administered and has anything of value to it) it will have to be ignored or the expensively prepared plans will have to be junked. The answers are being designed and predicted by the excessive planning which will not permit new concepts to enter the experimenters design as a result of his encounters with the unexpected realities created by his original innovation.

Another facet of fund narrowness is the matching parochial outlook that often comes with the specialists such a fund recruits and trains to administer the grants. Projects have been hampered by funding personnel insistence that projects utilize certain kinds of advisory bodies or skills that the more knowledgeable researcher knows will hamstring his efforts. The specialist's unawareness of local needs, people and agencies to be contended and cooperated with, to be circumvented and mollified, simply do not justify the specialists insistence on things the researcher is trying to avoid. Either the experimenter has something widely enough useful to offer, or he does not. He should either be assisted or turned down on those terms. The enthusiastic experimenter should not be beaten into line by someone often less capable, less imaginative or less ambitious, someone who is often ignorant of local opportunities, requirements and approaches.

Reviewers of projects rarely spend more than four to eight hours with the experimenter and they can't learn what the facts of life are for his agency relationships, services, personnel, etc. Moreover, by focusing almost exclusively on the project the reviewer is seeing something quite isolated and out of local agency context. By forcing certain modes of approach or operation the reviewer in essence uses the little piece of the agency he controls (the project) to force the whole agency, and sometimes its community into the mold or stereotype which he, the reviewer, holds for such agencies or communities.

Local agency projects both at time of submission and at review periods are often gone over: (1) by the state health department (not necessarily avoiding any of the pitfalls discussed above), (2) by the federal regional office (which may give it a new twist unacceptable to the local or state or both), (3) by the federal D.C. office (which may pose new requirements or demands which may suit no one else). For one project we know about, this resulted in over twenty conferences over a three-year period without resolution. It is now becoming a different project, nearly all the original parties to the negotiation have moved on to other jobs, and it still is not funded or turned down. Another has been amended at three levels in two months and is now unacceptable at all but the last level.

It is not hard to suggest a solution to such usage of expensive manpower and watering down of good ideas. If there is to be detailed review by more than one agency then it should be done simultaneously and the experimenter given only suggestions upon which the multiple agencies can agree. If assembling all the agency representatives to meet with the experimenter is too costly, all can delegate one of the agencies to represent them and be guided in their subsequent actions accordingly.

A NATIONAL HEALTH RESEARCH REVIEW BOARD

In a recent article Amitai Etzioni [1] confirmed our belief that the present pattern of allocation of research and development resources is an accidental happening in a pluralistic setting. There is no one body that even attempts to give priorities either in terms of when or what amounts of dollars should go to which areas of exploration. Great sums may be expended in one program to attempt to exploit what is really a weak technology whereas most of the funding might better go into developing new technology in the particular field. At the same time great sums may be spent for a condition that involves few and creates limited disability, while another disease somehow not gaining popularity may be ignored. The allocation of money may not totally determine direction

[1] "On the National Guidance of Science." Administrative Science Quarterly, Mar. 1966, Vol. 10, No. 4, pp. 466–487.

or numbers of researchers, but failure to allocate certainly will inhibit working in the neglected areas.

We do need a high level body to look at the health research and development funding pattern to point out areas of relative neglect and over-patronage, but not to actually control the distribution. I am sure that not all funding should fall into a few or into a single agency in spite of the tempting economies it might offer. Along with the economies of doing business through a single health funding body unfortunately one can look forward to its development of set beliefs and values and creation of tidy new ways of doing business that might neglect novel or conflicting lines of inquiry and be so restrictive in what was to be funded that the limiting effects of the present confusions and difficulties would appear truly trifling by comparison. However, we can cut back handsomely or the number of existing agencies doling out project funds.

A strong science planning body is needed however not just for orderly evaluations and recommendations but to provide a forum at which special interest can be heard. Presently an appeal for research funds, no matter how valid, has no scientific podium from which to speak and no sounding board or public hearing from which to create support. Although such appeals do now get made in or to Congress, they are so removed from an overall health context that the merits stand truly isolated and unrelated to other health needs. In fact, different committees with different concerns in mind carry the various pieces of health legislation.

We heartily appreciate the opportunity to offer our legislators suggestions based on our experiences and beliefs as to what future needs will require in the way of federal support and organization so that throughout the nation the health needs of our citizens can be reasonably met.

CURRICULUM VITAE (SUMMARY)—HENRIK L. BLUM, M.D., M.P.H.

Born: San Francisco, California, November 11, 1915. No siblings. Married: Marian H. Ehrich, December 25, 1938. No children.

EDUCATION

Grade and Secondary Schools, Napa, California; University, University of California, Berkeley, B.S. 1937, Chemistry; Medical School, University of California, San Francisco, M.D. 1942; Asst. Physician in Medicine, Johns Hopkins, 1944–45; Fellow in Medicine, Stanford University, Palo Alto, 1946–47; Public Health, Harvard, M.P.H. 1947–48.

HONORS

Sigma XI, University of California, 1936; Phi Sigma, University of California 1936; A O A, University of California, 1942; Delta Omega, Harvard, 1948.

DIPLOMATE

American Board of Public Health and Preventive Medicine, 1950.

APPOINTMENTS

Intern, San Francisco Marine Hospital, 1942–43.

Assistant Surgeon, U.S. Public Health Service, 1943–45.

Senior Assistant Surgeon, U.S. Public Health Service, 1945–46.

Chief of Preventive Medical Services, San Diego County Health Department, 1948–50.

Health Officer, Contra Costa Co., California, 1950 to present.

Clinical Instructor in Medicine, Stanford University Medical School, San Francisco, 1950–57.

Assistant Clinical Professor of Medicine, Stanford University Medical School, Palo Alto, 1957 to present.

Lecturer on Public Health, University of California, Berkeley, 1951–63.

Clinical Professor of Public Health, University of California, Berkeley, 1963 to present.

Member, Board of Directors, Tuberculosis & Health Association of California, 1952–56.

Member, Advisory Council, Bay Area Air Pollution Control District, 1956–58.
Member, Committee on Social and Physical Environment Variables as Determinants of Mental Health, National Institute of Mental Health, Washington, D.C., 1956 to present.
Lecturer on Public Health Administration, University of San Francisco, 1958–62.
Member, Board of Directors, Contra Costa Heart Assn., 1958–62.
Member, Governor's State Building Standards Commission, 1959–61.
President, California Conference of Local Health Officers, 1960–61.
Member, Technical Development Board, American Public Assn., 1960–64.
Chairman, Chronic Disease & Rehabilitation Committee, American Public Health Assn., 1960–64.
Vice-President, Contra Costa Rehabilitation Council, Inc., 1961–62.
Member, State Advisory Hospital Council, 1961–65.
Member, Board of Directors, Bay Area Welfare Planning Federation, 1961 to present.
Member, 10 Year Master Plan Task Force, State Department of Mental Hygiene (Dr. Blain), 1962.
Consultant, Ad Hoc Committee, Community Health Services and Facilities—Surgeon, 1962–63.
Chairman, Research Committee, Tuberculosis & Health Association of California, 1962–63.
Member, Special Grants Review, National Institutes Mental Health, Washington, D.C., 1962–64.
Member, Advisory Committee on Public Medical Care for Children, California State Department of Public Health, 1962 to present.
Member, Committee on Diagnostic Skin Testing, American Thoracic Society, 1963–64.
Member, Governor's Committee on Children and Youth, 1964 to present.
Secretary, Section on Preventive Medicine, California Medical Assn., 1964–1965.
Member, Committee on Training in Administrative and Community Psychiatry, State Department of Mental Hygiene, 1964 to present.
Present, Contra Costa Council of Community Services, 1964–65.
President, First of, Economic Opportunity Act, Council of Contra Costa County, Calif., 1964–65.
Consultant, National Commission on Community Health Services, 1964 to present. Member, Board of Directors, Home Visiting Services of Contra Costa County, 1964 to present.
Member, Board of Directors, United Bay Area Crusade, 1965 to present.
Member, Board of Directors; Bay Area Council for Social Planning, 1965 to present.
Member, Technical Advisory, Board, Bay Area Health Facilities Planning Association, 1965 to present.
Member, Board of Trustees, John F. Kennedy University, 1966 to present.

Dr. BLUM. The first point that I would like to make is that I think there is no question that due to the inequality of resources amongst the States, the mobility of population, and the impact that Federal activities have on different parts of States and on different States, that Federal support and equalization of resources in the field of health has to be taken for granted.

I would like to start with that preface, and then go on to say what it is that is going on now in the way of Federal agencies providing States and local health services funding. They put in about 20 percent of what State and local governments spend in public health, but they come from a terrific multiplicity of sources. There are at least 16 special categories of funds and at least 13 project sources of funds besides the National Institutes of Health.

That kind of a multiplicity, and his welter of agencies makes the life of the State and the local government something to behold when it comes to applying for funds and utilizing funds.

I would like also to point out that these funds tend to be administered by people who get very expert and very demanding and very specific. Just in recent times, we have gone through the experience of working with three funds from the Children's Bureau, and found that one of them would not allow us to use anything but specialists, but it is a poor neighborhood and there aren't any specialists, so that is out.

Another one would not allow us to use private physicians, and insisted on clinics, and the tendency in California, of course, is directly away from that, to use the private practitioner as much as possible, and the third one would not allow us to use people who were poor outside of poor areas, but would allow us to take everybody from poor areas, even if they weren't poor.

All said and done, in one case the funds were to be allowed to take the mother through pregnancy and delivery; another was to provide well-child care; the third was to provide sick-child care.

We couldn't put the pieces together for the same families, in the same community. I would like to point out that OEO with its Headstart, and Public Health Service migrant moneys were coming into the same community, at the same time, for other aspects of maternal and child health services.

These are five separate situations coming into one community, all of which offer possibilities that I am sure people in Congress thought were going to create services. Headstart was the only one that really paid off.

The next issue that I would like to approach is, should there be a new category or a new division whenever something new comes into sight? For instance, should aging get another bureau, like Children's Bureau?

I would like to hope that Congress wouldn't see fit to do this very often. I would like to think that the bulk of the funds should go into the general funding mechanism, which has been pretty well abandoned, sad to say, and makes up a very small part of what we get to use, and that new funds and divisions need not be created very often.

Once in a while we think a new one might be created for emphasis and then the specialists could go along with this, too, but the bulk of the funds that we need are certainly going to be for general support.

I would like to give you an example of what happened in California in 1947. The State undertook a general health subvention and in very short order, had, I believe, what was considered to be the best network of local health departments in the Nation. The general subvention was under a general plan, with some general requirements such as monitoring certain kinds of things, and that you must do no less than a minimum of certain things, but they were not categorical funds, and they very rapidly built up a strong network of local health departments. The analogy might well be made at the Federal level, if Federal general grants were utilized. You have a bill in front of you. I believe it is S. 3008 on the Senate side.

That offers to set up general planning grants to make strong State health departments.

The Federal Government would not have to worry about where general fund health moneys go. They would expect a State plan in

advance. They would expect to go back and see that the plan was being worked with, and they would then know that their money was going out in a proper fashion. They would have reassurance at the end of the year's time, each year's time, that work had been accomplished.

The classic example here is the Hill-Burton and the Hill-Harris mechanism. Most of the States using this did create a plan, because it was required, and the very agency that created the plan learned so much, and got so handy at this whole business of hospitals and health care that many of these same agencies were able to take on medicare, because they were already set and rolling. They were used to planning, they were used to evaluating, they were used to handling big chunks of money, they were used to working in this kind of a way, and the Federal Government could depend on them.

But this has never been done in terms of the overall health picture.

One of the things that I would like to call to your attention is the size of the problem around the urban regions, with the suburban autonomous entities, the rural fringes. If they have to be put together through categorical funds, can you imagine ever bringing these kinds of health programs together for the people that live in the general suburban areas, so that they have reasonable kinds of comparable services. It can't be done category fund by category fund, each with different requirements, each with different bases upon which to work.

If you don't have a general fund mechanism, I don't think a broad State plan could ever work. A State plan is not going to be feasible on the categorical funding basis.

Most of our population has moved to the urban or suburban areas. I know Dr. Sox, the city-county health officer of San Francisco, who can't be here, wanted me to say to you that he hoped you would look awfully carefully, at the urban-suburban situation. With the growth of suburbs, what used to be thought of as rural poverty, rural lack of service, has suddenly been transferred over to the city side, and here there are tremendous numbers of problems, really without the tools to work with, certainly not by use of categorical funding.

We would hope that the project type funds, the short-term things, would be reserved for research or special study.

We don't see this mechanism as offering a thing when it comes to regular funding of basic programs. We think projects should be reserved for the things that need clarification, need exploration. They shouldn't be used at large just as another device for contributing money.

I would like to make another point, and that is that I, too, think that a national health research and program planning body is important. We don't have any such thing. This would be a group of people not part of civil service or appointee level in Government, but rather a group of significant people, some of whom might come from the groups mentioned, some of whom might be legislators, to look at the whole picture of what has been done in health, and what has been done in health research. Presently moneys are sometimes spent to push a program when the technology hasn't been developed yet.

The money should be spent in that case for the research and the technology. We have other situations where something important is ignored. Other things are simply deluged with funds.

There ought to be a place where people with special interests about health can come, be heard, get a special podium, not the one in Congress, where you go before a committee, and the committee might very well be doing some part of health only because it has a general concern that accidentally includes one health area.

This ought to be a body that would not make final policy. It would not have the authority to distribute, but would be a place where things could be heard, a place from which recommendations could come to all hands that were concerned to see where allocations ought to go, how things were going, and see that the national health expenditures picture makes sense. Just as much as States should have a plan before they are given significant Federal funds, so the Federal level ought to have a plan, and this kind of a review board could help shape it up.

May I repeat the points that I would like to make. First, I would hope that the Federal Government would be a long-term basic partner, putting in money on general basis to support services, without which many States and many local communities simply aren't going to have any.

Second, that general funds be distributed by such devices as matching, population, poverty, and need. And also tie it to plans and evaluations, so that the general funding gets just as much as any other kind of funding in the way of specific results.

Third. Categorical funds only be used for new emphasis.

Fourth. That projects be reserved for research type things, not any other kind of activity.

Fifth. That the grant and project and fund administration be improved so we don't get the narrow kind of confusion I described for you, such as three conflicting programs out of one division.

Sixth. I would also suggest that we cut the number of agencies and divisions. I think the proposed reorganizaion is sadly needed. There are too many individual arms, all working at different purposes.

Seventh. I would hope that all the regional offices having health activities would be amalgamated into the Public Health Service regional offices. That no other regional offices of the Federal Government do health work. It is much too confusing now. It is broken up too much; you get a plethora of people wandering around, some of whom even come directly from Washington, ignoring their own regional people, who then hear in surprise that something is going on.

Eighth. We hope State health departments would be strengthened through the basic planning grants, and then be a suitable vehicle to see that Federal grant moneys are really distributed locally, so the Federal Government wouldn't have to pursue everything right out to the end, because there isn't in many cases, a strong State health department.

Thank you.

Mr. GILLIGAN. Thank you, Doctor.

Mr. Younger?

Mr. YOUNGER. No, I thank you for the recommendations. Apparently all of you are pretty much in accord that these categorical grants are not satisfactory, and are not designed so that the money can be

used to the best advantage, either in the State or in the community. Is that correct?

Dr. BLUM. Yes, I am sure that just as there must be one particular plague in your kind of work, this is the particular plague, I think, in our kind of work.

It is the thing that we just seem to beat our heads against.

Mr. YOUNGER. Thank you.

Mr. GILLIGAN. Mr. Nelsen?

Mr. NELSEN. No questions.

Mr. GILLIGAN. Doctor, I have a couple of questions of an exploratory nature. You referred to an equalization formula, the use of general grants rather than the categorical grants, and then you had some comments which echoed some other comments we had earlier from Dr. James about the concentration of the problems of public health in the great urban areas.

He pointed out, for instance, that the tuberculosis rate in New York City was up 10 percent in a year's time, whereas in the rural areas it was dropping quite sharply, and had been for some period of time.

In the effort on the part of the Federal Government to deal with these problems of public health, have you some suggestion as to the kind of equalization formula which could get the money into the main problem areas, whether we are discussing division of the funds between the States, or division within the States of the funds between, let us say, rural areas and urban areas?

Dr. BLUM. Well, I do think there is a precedent. I like what the Hill-Burton Federal mechanism has required. They require the States to come up with a plan. They have encouraged the States to take a look internally, not just on an individual place-by-place basis, but on a regional basis, of region versus region, so that the whole situation is looked at every year, and continually during the year. When the State gets through with its plan for next year, which it must turn in for approval before it gets its next allotment for Hill-Burton funds, they have looked at the facts.

They suddenly need a lot of nursing homes; the population has changed, or they need more beds. They are staying on top of these situations, either of movement of people, special health needs, or new technology which calls for new facilities. Every year they wrap this up and shoot it back—each State does that—so that the Federal Government has a picture of what the Nation's problem is in this one area of facilities, and the State has a picture of what its internal problem is.

This is not done in other areas of public health, and I think the mechanism is very sweeping, and really works.

Mr. GILLIGAN. Well, within the Hill-Burton program, as I understand it, and I don't intend to think that my understanding is by any means complete—the equalization formula applies by assuring each State a minimum, at least a minimum allocation of the funds made available in the national program. Is that correct?

Dr. BLUM. I believe that is correct.

Mr. GILLIGAN. And it would be your thought, then, that something of this approach be used in assuring each State, for instance, a minimum of general funds for the general improvement of their public health setup, but with sufficient flexibility to throw some Federal

emphasis and Federal money into special problem areas as they seem to develop?

Dr. BLUM. I would like to think a few more criteria would be added. In other words, you have the 50 plans coming in, and you see what the need is versus what they have, and right away you get an idea of where you stand.

The Hill-Burton funds do one other interesting thing. They sort of reward the aggressive persons, I think, in a way, and this is all right, that is, the States that have higher aspirations. I see nothing against it, but there should be enough funds to underwrite what would be called a reasonable national minimum or adequate standard, so I would think that needs would be taken into account in terms of not just population, but age distribution, and assessed or assessable wealth, or other income criteria.

I think growth is a critical thing. For instance, in California, where we regard ourselves as wealthy, and we are regarded as a wealthy State, we are continuously a year behind on taxes, on the growth situation. It is really a calamity every year. You have all these new people, but there is nothing coming in on their behalf for a whole year, and every year this goes on; you can't get ahead of it.

Mr. ROGERS of Florida. Well, I am somewhat more familiar, because I spent some time in a city council, with the operations of the Urban Renewal Act and program, and during the course of that program, for some 15 years, there gradually evolved, and finally was developed within the act, and within the program, what was known as the seven-point workable program.

Each city was required to certify each year or to submit each year a review of what had been accomplished in the previous year, and state some objectives for the coming year, maybe the long-range objectives, as well. Theoretically, at least, if they were not keeping up with all phases of the seven-point program, their certification by the Federal Government, or by the Department of Housing and Urban Development, could be withdrawn and the Federal funds shut off.

Do you see the possibility of a parallel development in the field of public health? Is it practical to think in terms of the States submitting not just a report of how they spent the money last year, but of what they see their problems to be in a number of other, let us say, categories of various kinds of disease control, and so forth, and in touching all bases within the report, and if they drop back in any one or two of them, the funds can be withheld?

Dr. BLUM. Yes. I left a meeting last evening in Sacramento with a group of people, including the director of our health and welfare agency, and this was very much the proposal: on one hand that the counties be prepared to do this, so that the State would know wherein the problems lay, and when they hand out general funds there could be some real control to see that standards were met, and the State would know where assistance had to go, especially what the special problems were, and I think that they were perfectly prepared, by the same token, to say that health matters ought to be cleared at the Federal level in the same way when Federal funds were being used.

Health officers were proposing it, and I say local people were proposing it to the State, and the State people were buying it.

Mr. GILLIGAN. Thank you, Doctor. I think the counsel has some questions for you.

Mr. SLOAT. Dr. Blum, in the early part of your statement, you mentioned that the multiplicity of specialized Federal agencies involved in funding health programs for the States and the local communities has resulted in not only detailed restrictions in the programs, but also even mutually exclusive demands with regard to eligibility for available funds, so as to render the giving of service locally a near impossibility.

Have you ever tried to point out these inconsistencies to the proper HEW officials, and what results have you had?

Dr. BLUM. The people whom we have had to point them out to have tended to be the specialists representing the particular fund or funding mechanism, and they are usually sympathetic. They are often unable to move, and say, "But this is the way it is," and they are not generalized enough to be able to see how to put all the pieces together, or how to combine two or three things and make a go of it.

They sometimes get together and try to help out. It is not altogether a lack of trying. I think the vehicle is tremendously cumbersome. It comes with so many strings that neither they nor we can overcome it.

They have often tried to go to bat, and succeeded. We had such a thing in the TB subsidy. It originally came out with a demand for specialized public health nurses. There isn't a county in California that has a specialized public health nurse and I suspect, not too many in the Nation. After that approach had been given up for 20 years, by and large, it came out. None of us could use the funds; we would have had to reorganize our departments to do it. Yet, if this had come as a segment of the granting agency funds requiring that you have to meet certain TB standards, if you don't already have them, I believe we could have used those funds, and we would have used our customary nursing staff.

The problem isn't whether we use specialized or generalized nursing it is that we don't have enough money to get enough nurses.

Mr. SLOAT. Does this restriction come from the statute, do you know, or the HEW regulations, or the regional office regulations?

Dr. BLUM. I wouldn't want to guarantee, but it is my understanding that this is a restriction placed by HEW, not in the legislation, but I am not sure.

Mr. SLOAT. On page 5 of your statement you state that the present number of Federal health agencies could be halved. How do you feel this should be done, and which agencies would you combine or eliminate?

Dr. BLUM. Well, I think that the present grouping of services and divisions in PHS finds us on occasion apparently dealing over the same thing with several arms, and I think they could be pulled together, two or three at a time, right in PHS. I believe that the present reorganization proposal envisions this, so that you get things that are somewhat alike to really be together.

Besides, I don't think we always need all the divisions; some of them are anachronisms. They were important once to get something going, to give it a lot of national visibility and emphasis and strength.

They aren't necessary any more. Some of these things are holding operations now; they could go into a more general kind of service.

We see health services coming to us through OEO, through Rehabilitation, through PHS, Children's Bureau. We see them trying to do the same things, and I just can't see that Headstart is so different from the very programs the Children's Bureau or PHS migrant money or other funds are trying to do. In fact, medicare will also do some of these things.

I am not prepared with the answers, but surely these things that are working on the same clients, on the same day, would seem to be better meshed here in Washington, rather than having us try to put them together.

Mr. SLOAT. You feel that the Headstart program is duplicating programs of the Children's Bureau, at least to some extent?

Dr. BLUM. I would say that Headstart, because of its emphasis, is really very worthwhile right now, but I don't see it continuing as such very long. Maybe it is a period for emphasis, but even then, it should have been in a health agency, I would think, and then it could be absorbed into a general program. I like the emphasis it is giving right at this moment, but I can't see it coming from another source, another world, so to speak, one we don't know.

We don't quite know who to deal with. Yet we are called upon to make it work, you see, organize it, out where we are.

Mr. SLOAT. On page 8 of your statement you state that a majority of State health departments in the United States are presently incapable of moving effectively in the promising new areas of basic public health. Could you explain what are the causes of this situation, and what, if anything, the Federal Government could help to do about it?

Dr. BLUM. I get around a fair bit to the various States, and I find them suffering from very, very serious disabilities. Something as simple as the licensing of laboratories, for example, only a handful of States are doing this, to assure that the kind of laboratory work performed meets a reasonable standard that the doctors would like to have for their patients.

This is a basic historic function, theoretically, and yet it isn't really done. The motions are gone through in a few more places. I think that the chronic disease program is nonexistent in a high proportion of all the State health departments. There are environmental areas that are really not touched worth a darn in many State health departments.

Such simple things as air pollution and water pollution—nobody is doing it, in some States. I think here is where a strong Federal plan, talking in terms of being an aggressive partner in funding, and requiring the State plan then to meet at least simple basics of the safe environment, safe water, et cetera.

I have been in States where the water isn't even inspected. Water systems for cities are literally running in ditches, and I know, because once I got dysentery in such a community. All of us did who were visiting. We decided to check it out and discovered that these communities in this area didn't even have controlled water supplies. They were just taking raw water supplies out of a ditch.

This is the simplest kind of basic control, and if there were a Federal plan that required each State to have a State plan and the Federal to be a basic aggressive and funding partner with some leeway for

means and resources in accordance with the State's ability, I think we could make a tremendous improvement nationwide.

Mr. GILLIGAN. Doctor, if I could interrupt you just a moment, the example that you have used just a moment ago is an interesting one, when we get into the question of at what point the Federal Government is interfering with the prerogatives of the State.

For instance, just recently I was approached by some people in my district, several of whom had been conducting laboratories for doing blood tests and that sort of thing. One fellow had been in business for 15 years. Now, under the new Medical Care Act, regulations have been laid down as to who may be compensated under the Medicare Act for doing this kind of work. He can't match the requirements laid down by the Department of HEW, and he says, in effect, "I have been performing a service in this community for 15 years, and all the doctors used me and referred their patients here, and so forth, and the State has never bothered me. Now, all of a sudden, you people come waltzing in here and you are going to put me out of business."

So while I would agree that with some judicious use of regulation and grants the general quality of public health performance can be elevated, it may eliminate one kind of friction and one kind of difficulty for local authorities, and raise a whole new host of problems during the transitional period when these various programs are coming into being.

Dr. BLUM. That is a beautiful example, really, though, in a way, of what I am advocating. For instance, in California, which has for many years gently but definitely gotten this job done, all the laboratories in California that are licensed, as I understand it, are eligible to provide medicare services, and so the State that has had a long-standing agreement with its laboratories, and has given them check samples, has supervised in a very definite way the quality of their work, there are no problems. Medicare, as I understand it, is accepting the State-licensed laboratories.

The point is, there is a tremendous jump from rather high Federal standards to nonexistent State standards in all but a handful of States. This will happen again and again if we don't nationally underwrite a basic, general State minimum of adequacy, and I think the Federal moneys could be used to do that.

As a partner, you have certain things you get out of the partnership. When you put your money in, you expect a plan, and you expect an evaluation, and you wouldn't have even had this laboratory fight on your hands, because it would have been settled some years ago if the States had been performing, so it is a good example. Now it is a problem and it can't be rectified in a day, either.

Mr. GILLIGAN. Counsel?

Mr. SLOAT. Dr. Blum, one of the most significant features of the present HEW structure is the separation of mental health activities from those of general physical health. Do you have any views as to the advantages or disadvantages of this type of division?

Dr. BLUM. Since both of these services—and I assume you are speaking of the Federal level—are really in the same basic agency, I think for some years to come, considering the newness, in a way, of some of the basic knowledge about much of mental health, I would certainly have no objection to seeing a major segment of what is going on in health in HEW to be devoted pretty clearly to mental health.

There will commence to be overlaps, more and more. I might not say that 10 years from now. I don't regard that as a serious drawback at this time. Sometimes, however, it is fragmented pretty badly locally, but that is not your fault. Local people, in their own way, decide they want to separate things very arbitrarily, like one agency will deal with alcoholics, and another with addicts of narcotics, and another with people with emotional ills, and still another will do suicide work.

These same sick people may show up time and time again across the board. This is not something I think that concerns the Federal Government's structure. It is sometimes not done well locally, but the Federals do not make a problem for us, as I see it.

Mr. SLOAT. Do you know approximately what percentage of your total health budget is composed of Federal funds, and what percentage is State funds?

Dr. BLUM. Well, it has varied from about 8 to 12 percent, combining the two. The Federal share comes through the State, and both combined average around 10 percent of our total county health department expenditures, and which run about $4 per capita, for basic public health services. The Federal share of that is about a fourth of that 8 percent this year.

We don't see Federal funds directly. Now we are getting new special programs, like C.I. & A. moneys and maternal and child health moneys, categorical new funds. We do see those directly, but they are very tiny. So far they don't make up even a percent.

Mr. SLOAT. I have no further questions, Mr. Chairman.

Mr. ROGERS of Florida. Thank you very much for being here today, Dr. Blum, and giving your testimony to the committee. It has been most helpful.

Dr. BLUM. I appreciate the opportunity to come.

Mr. ROGERS of Florida. Since the House is about to go into session now, if it would be convenient for the other witnesses to meet at 2 o'clock, we will try to hear your testimony this afternoon. If there is any difficulty, you can see counsel, and we can try to arrange another time, but if convenient, we would prefer to continue this afternoon at 2 o'clock, providing we can get permission of the House to sit, and I think we can, so we will adjourn now until 2 o'clock this afternoon.

(Whereupon, at 12 noon the subcommittee recessed, to reconvene at 2 p.m. the same day.)

AFTERNOON SESSION

Mr. ROGERS of Florida. The committee will come to order, please.

We will now be glad to hear from Dr. Mack I. Shanholtz, who is the commissioner of the Department of Health, Commonwealth of Virginia. Dr. Shanholtz, we appreciate your presence here today and we will be delighted to receive your testimony.

STATEMENT OF MACK I. SHANHOLTZ, M.D., COMMISSIONER, DEPARTMENT OF HEALTH, COMMONWEALTH OF VIRGINIA

Dr. SHANHOLTZ. Mr. Chairman and members of the committee, you will be glad to know that I have boiled my remarks down to about 8 to 10 minutes. Also, I noted that previous speakers have made almost every point that I have to make and I think this is good that we seem to be together about it.

Mr. ROGERS of Florida. This is good. Would you like to put your statement in the record at this point and then just comment on the points you think need emphasis? Whichever you prefer, or if you prefer to read it.

Dr. SHANHOLTZ. It is very short and if you don't mind, I will present it.

Mr. ROGERS of Florida. All right, you proceed.

Dr. SHANHOLTZ. The 20th-century method of delivering health services to the people is divided into two main parts. In part I, at the Federal level, health services are fragmented into many different and often grotesque pieces. In part II, at the point of delivery, an attempt is made to put the pieces back together again by means of coordinating committees and various cooperative arrangements.

One justification or explanation for fragmentation is that more money can be raised through a multitude of smaller requests than through one large, all-inclusive request. Whatever the true reasons are, and it has been suggested that these may arise from personal, political, or special interests and pressures; we all know that health services are fragmented.

Some of the main Federal agencies which maintain separate, parallel pipelines carrying health funds to the States and localities are: The Public Health Service, the Children's Bureau, the Welfare Administration, Vocational Rehabilitation, Social Security, Office of Economic Opportunity, Department of Agriculture, and the Office of Education.

The effect of this fragmentation may be summarized as follows:

1. High administrative costs;
2. Duplication of effort;
3. Waste of trained personnel;
4. Confusion;
5. Establishment of multiple health standards;
6. Establishment of variable payment plans and amounts for the same service or commodity; and
7. Lowering of proper standards of care.

The high cost of establishing and maintaining such a complex system is self-evident, and duplication, overlapping and confusion are inherent and unavoidable. Many examples might be cited, such as the entering schoolchild who is given a physical examination in a Headstart program of OEO and who gets the same examination in the preschool clinic of the local health department. The program of the local health department includes all beginning schoolchildren; that of the Headstart program, only those included in the special project.

A child with a clubfoot might have it corrected through welfare if he is on welfare rolls, through a special comprehensive child health care project of the Children's Bureau and the local health department, or through rehabilitation, or through the State health department's bureau of crippled children.

I know of no better opportunity for variable standards of care, payment schedule, and so forth, than exists in titles XVIII and XIX of the Social Security Amendments of 1965. On the Federal level, title XVIII is administered by Social Security, and title XIX by the Welfare Administration.

On the homefront, as a general rule, title XVIII is administered by the State health departments and title XIX by welfare departments. A few bold States, including Virginia, have ventured to put title XIX under the State health department. Only one of these programs, or title XVIII, is called medicare, although title XIX, which is an extension of the Kerr-Mills program, is just as much medicare as is title XVIII and potentially even more so.

There are those who feel that if a person is on the welfare rolls, then the welfare department should look after his health needs. These same persons, however, still permit the education department to look after educational needs. A welfare patient should receive the same services and the same standards of care as anyone else. His tuberculosis should be handled like anyone else's tuberculosis.

For example, in Virginia the only tuberculosis sanatoria are those supported by the State and operated by the State health department. There are no private, municipal or welfare-operated tuberculosis hospitals. All patients with tuberculosis and in need of hospital care are admitted.

Patients able to pay all or part of the per diem costs pay all or part. Those able to pay nothing pay nothing. The service is the same for all. If an acutely ill patient needs a private room, he gets a private room regardless of whether he is indigent or on welfare, medically indigent, or able to pay for it. These hospitals demonstrate several important principles of care that should apply to all health services:

1. Health services are administered and provided by competent health and medical people.

2. Responsibility is placed in a single health agency, thereby minimizing waste, duplication, and confusion.

3. There is one standard of care.

4. The standard of care is high. Each of the four tuberculosis sanatoria in Virginia is fully accredited by the Joint Commission on Accrediation.

The Federal Government frequently bypasses the official State health agency with certain community health projects, such as those sponsored by OEO, the Elementary and Secondary Education Act of 1965, and some special or categorical projects of the Public Health Service. Of course, this is also true of National Institutes of Health research grants, but because of the nature of these awards, this usually is not objectionable. However, as NIH gets into programs such as that for heart diseases, cancer, and stroke, they should coordinate these plans with State programs administered by official health agencies.

The need for more flexibility in the use of Federal funds has long been recognized by State health officers. For this reason, State health officers individually, and collectively as the Association of State and Territorial Health Officers, are supporting S. 3008, sponsored by Senator Hill, and H.R. 13197, by Mr. Staggers.

A closer Federal-State-local relationship should be encouraged, but to do this reorganization of the Department of Health, Education, and Welfare along the lines submitted by me to this committee on September 15, 1965, will be necessary. The reorganization would create directly under the Secretary and Under Secretary a National Health

Administration with an Assistant Secretary of Health who would also be the Surgeon General of the Public Health Service.

Next, the new National Health Administration would establish a policy, which is lacking now, for dealing with the official State health agencies. It should also provide basic financial support for State and local health programs such as is suggested in H.R. 13197.

The policy also could set forth minimum standards of staffing and content of State and local health programs, thus providing assurance that quality health care and health services are made available to the people.

In Virginia the State health department is an efficient mechanism through which the Federal Government can assist the people in local areas of our State. Even though the present method of piecemeal allotment of categorical grants is difficult to administer, we do manage to funnel most of the Federal funds down to the local areas through our network of local health departments. In Virginia we keep only 5.2 percent of the Federal funds for administrative purposes in the central office. All of the rest is spent locally on direct health services.

For the committee's information, here is an outline of the plan for coverage of the State of Virginia with full-time local health departments. All counties and cities in Virginia, with the exception of a few larger cities and two counties, operate their local health departments under our State-local cooperative plan. The majority, if not all, of these independents plan to join the cooperative plan in the near future.

Financial support of the local health department is shared by the State and the locality under a formula based on the locality's ability to pay. In addition, two or more counties or cities may, on the basis of population and area covered, combine into a district for the operation of the local health department.

The primary benefit obtained from the State-local cooperative plan is the provision of health services on a statewide basis. Through the formation of districts and regions, supplemental and specialized services are also made available. The central office in Richmond provides consultation and general supervision in order to assure the localities of public health programs which are consistent with recognized State and national standards.

Some States are not so far along as Virginia in the development of local health services. The provision of basic health grants, as provided in H.R. 13197, would be a real impetus for the States to improve their services.

In any reorganization effort certain basic principles should be kept in mind. One important principle is that if a special health function is to be undertaken, the responsibility should be given to one agency to serve the whole community needing the health service and not, as is presently done, to several agencies for different segments of the community. Furthermore, the agency given the responsibility should be the one most competent to carry out health services; its staff should be educated, trained, and experienced in the health field.

With these principles in mind, the Department of Health, Education, and Welfare could best be reorganized by placing all educational services in the Office of Education, all welfare services in the Welfare Administration, and all health services in a new Health Administration. This would establish a highly competent, well-staffed health

agency which could provide, through interagency cooperation, quality health services for our citizens.

The Federal Government never has seriously supported the State and local health services, certainly not in a manner comparable to its support of education and welfare. The development of a strong Federal health agency and the enactment of H.R. 13197 would put the Federal Government and the States on a real partnership basis. All the State health officers of the country stand ready to cooperate in the development of a plan for the provision of better health services for our citizens.

CURRICULUM VITAE—MACK IRVIN SHANHOLTZ, M.D.

Date of Birth: December 11, 1905.
Place of Birth: Cold Stream, West Virginia.
Present Address: Virginia State Health Department, Richmond, Virginia 23219. Telephone: Milton 4–4111, Ext. 3073.
Education: Handley High School, Winchester, Virginia, 1926. B.S., University of Virginia, 1930. M.D., School of Medicine, University of Virginia, 1934. M.P.H., School of Public Health and Hygiene, Johns Hopkins University, Baltimore, Maryland, 1938.
Positions:
1934–35, Intern, University of Virginia Hospital.
1935–36, Resident Physician, West Virginia Tuberculosis Sanatorium.
1936–38, Health Officer, Washington County, Virginia.
1938–46, Director of Commonwealth Fund demonstration, Seminole County Health Department, Wewoka, Oklahoma.
1946–51, Director of Preventive Services, Oklahoma State Department of Health; Assistant Professor of Preventive Medicine and Public Health, University of Oklahoma School of Medicine, Oklahoma City, Oklahoma.
1951—, Commissioner of Health, Commonwealth of Virginia; Lecturer in Preventive Medicine, School of Medicine, Medical College of Virginia; Guest Lecturer, School of Medicine, University of Virginia; and member of Advisory Council, School of Public Health, University of North Carolina.
Principal Organizations:
Diplomate, American Board of Preventive Medicine and Public Health.
Fellow, American Public Health Association.
Member, American Medical Association.
Member, Medical Society of Virginia.
Member, Richmond Academy of Medicine.
Member, Rotary Club; Past President.
Member, Association of State and Territorial Health Officers, Secretary-Treasurer, 1956–59; Vice President, 1959–60; President, 1960–61.
Member, Conference of State and Provincial Health Authorities of North America; Vice President, 1963–64; President, 1964–65.
Member, Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities, Vice President, 1963; President, 1964.
Federal Advisory Groups:
Advisory Committee to the Cancer Control Program, USPHS, 1957–65.
National Advisory Health Council, 1952–56.
Food Establishment Sanitation Advisory Committee, USPHS, 1960–62.
United States Delegation to World Health Organization Assembly, New Delhi, India, 1961.
Advisory Committee on USPHS Quarantine Activities, 1965—.

Mr. ROGERS of Florida. Thank you very much, Dr. Shanholtz, for a very concise and effective statement.

Congressman Van Deerlin?

Mr. VAN DEERLIN. No questions, thank you, Mr. Chairman.

Mr. ROGERS of Florida. Congressman Younger?

Mr. YOUNGER. No questions. Thank you very much.

Mr. ROGERS of Florida. Doctor, I was interested in your statement that all of this fragmentation actually is increasing the costs, duplicating effort, and lowering standards of care.

Could you give me an example of how this happens?

Dr. SHANHOLTZ. Examples of fragmentation?

Mr. ROGERS of Florida. Yes, and the lowering of standards of care, and the duplication of costs.

Dr. SHANHOLTZ. Yes.

I have been a State health officer in our State now for 15 years and I have watched these new programs develop, and we have tried to work with the various groups that are interested in health and tried to help in any way we can, but it seems like there are so many of them sometimes unbeknown to us that will spring up.

For example, a school board can put on a nurse under this new Elementary and Secondary Act that we have no knowledge of. Still, the local health departments we support do provide school health services. They may be purchasing some services of the dentists.

In the State of Virginia, by law I am the official adviser in health matters to the Governor and the legislature. Now, I try to propose a program to meet the needs, and it has to be financed.

Now, if one of these newer agencies is providing services to some segment of the population and I don't know it, I will be figuring it into my overall costs, which will be a duplication and overlapping, and this does happen. If they are going to run a program, particularly if they are going to make it a permanent type of program, we could figure that in and make allowance for it when we ask for appropriations.

Many times we don't know, and I think this has been brought out before this committee by the local health officers until one day you find that they have started a program. This sort of things happens—the mother in the prenatal clinic is followed as a prenatal patient before a child is born. The child is born, comes to the health clinic perhaps once a month, has been under their constant supervision, and along comes a Headstart program, picks that child up and gives it an additional examination.

Maybe it just had an examination, maybe a series of them. There is no coordination.

Mr. ROGERS of Florida. Well, I would agree. And you say now, because of the education bill they are now duplicating what many States are already doing in providing health care for the schoolchildren?

Dr. SHANHOLTZ. Yes. And another thing is that we have formulas based on ability to pay; take Hill-Burton, for example, in our State. We use 55 percent of the Hill-Burton, 45 percent, but if you want to build a hospital in the Appalachian region, you may get a better match than this.

We had an example of one town that had already made application, been approved, ready to build their hospital, then they found out there was a better deal. And now they want to see if they cannot change around and get the better match.

In hiring a school nurse our matching formula would be say 60 percent, the locality's share 40 percent, but under the Elementary and Secondary Education Act of 1965—and I think I am correct in

this—the locality would only have to put up 25 percent. Naturally they would want to hire the nurse under the better matching formula.

Mr. ROGERS of Florida. Should mental health be separated from the general physical health in your approach to the problem?

Dr. SHANHOLTZ. You know, I have often heard it said that a patient is all in one piece. We may fragment him by programs and IBM cards and all. I think literally you cannot separate a person's physical from his mental ailments, but I think maybe that it takes different types of specialists to handle mental disease than it takes to handle a physical disease. These things have to be taken into consideration in a program to fit the need.

Mr. ROGERS of Florida. Have you any more questions?

Mr. VAN DEERLIN. No, thank you.

Mr. ROGERS of Florida. Thank you very much. We appreciate your being here and letting us have the benefit of your experience. It is very helpful to the committee and we are grateful.

The next witness the committee would like to hear from is the secretary of health of the Commonwealth of Pennsylvania, Mr. Charles L. Wilbar.

Mr. Secretary, we are pleased to have you with us this afternoon and we will be glad to hear your statement.

STATEMENT OF DR. CHARLES L. WILBAR, JR., SECRETARY OF HEALTH, COMMONWEALTH OF PENNSYLVANIA

Dr. WILBAR. You are hearing two Commonwealths in a row. There are only four of them in the country.

Chairman Rogers and members of the subcommittee, I am Dr. Wilbar, secretary of health for Pennsylvania and I am here before you as the representative of Gov. William W. Scranton.

Pennsylvania is the third largest State of the Nation populationwise and we have within our State a variety and complexity of health problems which we are attacking with vigor in order to bring them under control to an even greater extent than is now true.

Starting with the passage of the Social Security Act some 30 years ago, but greatly accelerated in recent years, our State, as well as the other States, has come to be aided to a major degree by Federal laws, funds, and personnel in developing and improving our public health programs. On the whole, this Federal participation and partnership with the State for improving health conditions of the people of this Nation has been very beneficial. Some major difficulties regarding efficient operations and communications have arisen, however.

I have spent nearly 27 years in governmental public health administration and during this period have seen some marked changes in the public desires and approaches to public health practice and in the Federal-State-local relationships in administering the public health programs. Changes have, I believe, been more dramatic and extensive on the part of the Federal Government than on the part of the State and local governments.

All of us working in the public health field have stressed the primary and paramount importance of public education in advancing improved health among our people. By far the major activity of a health department is attempting to close the gap between scientific knowledge

as to how to keep well and prolong life and the popular application of that knowledge.

Chronic diseases, accidents, and environmental health problems are the main public health challenges of today. There is considerable evidence that good public health practice is now becoming popular in a number of aspects and that the majority of the people want to do something drastically and quickly about putting scientific knowledge into effect in a widespread manner.

When public interest is high, people become impatient to obtain results. There is evidence that many people now want all the pollutants removed from our streams in a short period of time. They want their air clear and clean within a few months. They want immunizations for communicable diseases taken by nearly everyone. They want everybody to have high-quality medical care readily available and economically reachable.

They want all known precautionary measures built into machines, roads, and buildings to prevent accidents. They want the chronic diseases prevented from occurring or from shortening life or from causing serious disability. The large number of laws enacted by the Congress and various State legislatures and local governmental bodies in the health field in recent years, with considerable increases of funds being made available for public health practice, is clear evidence of this increased popular interest.

This popular interest, with passage of laws and appropriations of funds to improve health conditions is certainly highly desirable. As we see it, major difficulties have arisen, however. Splintering of governmental health administration has been brought about in the desire for quick action. Attempts to charter new and untried channels have often led to poor communications and a bypassing of agencies already accomplishing a good deal in a given health field.

From the standpoint of State government, we see a considerable tendency to bypass the States in giving Federal assistance to local communities. In some States and even in some local jurisdictions there has been some diversification or splintering of health administration, but other States and local areas have worked toward consolidation in this field.

At the Federal level, however, which is the major concern of this committee, there has been a marked tendency to continuously splinter health administration. Entirely new channels have been set up for the public health aspects of the Economic Opportunity Act and the Appalachia Assistance Act as well as the Heart, Cancer, and Stroke Act.

Then, there is a movement, after shifting responsibility for water pollution control from the office of the Surgeon General to the office of the Secretary of Health, Education, and Welfare, to move this program, which in my opinion is essentially a public health program administered by public engineers, entirely out of the Department of Health, Education, and Welfare.

Even within the Public Health Service, the major public health operational organization of the Federal Government, there has been some tendency to scatter responsibility rather than to consolidate it. There was some tendency for the National Institutes of Health, for instance, to become more and more autonomous from the Surgeon General, but

it is to be hoped that the present changing patterns within the Public Health Service will draw the National Institutes of Health closer than ever to the total administration of the Public Health Service.

Within the Department of Health, Education, and Welfare, State health departments need to deal intimately with all branches of that Department on public health matters with the possible exception of the Office of Education. When these are consolidated into one department, it is not so confusing or difficult.

Let me just list other units of the Federal Government outside of the Department of Health, Education, and Welfare with which we must deal regularly on public health matters, each of which seems to have a different set of policies, rules, channels, and organization. The list which follows is probably not complete: The Office of Economic Opportunity, the Appalachian Regional Commission, the Department of Labor, the Department of the Interior, the Department of Agriculture and the Office of Emergency Planning.

While the health functions of these agencies, in some instances, are so intimately tied in with other functions or are such a small part of the total agency's functions as to make their transfer to the Department of Health, Education, and Welfare or to a newly created Department of Health difficult or impractical, it has been our feeling that a number of these health functions could well be transferred to the Department of Health, Education, and Welfare with an increased efficiency of operation and improved Federal-State relationships in administering public health programs.

Actually, at times we discover a new federally financed and sponsored health program already operating in some locality within the Commonwealth of Pennsylvania before we even knew it was contemplated. This is more apt to happen under the Office of Economic Opportunity than any other program.

There has been a considerable tendency in recent years to utilize Federal funds through project grants rather than program grants to State and local communities and have such project grants go directly from the Federal Government to a local agency, which may or may not be a governmental agency, with little or no coordination or planning on the part of the States.

This trend has helped to channel more funds into the urban areas, which is probably needed in most of the Stats, but has led to a haphazard type of planning with some proneness to overlapping and a spotty method of meeting some of the major health problems.

It must be kept in mind that in spite of the growing magnitude of Federal funds in the health field, it is still true that many more health activities are administered by State and local government than by the Federal Government. State governments now employ about seven and a half million employees compared with two and a half million Federal employees in this area of endeavor.

The Bureau of State Services of the Public Health Service has, over the years, shown a sympathetic understanding of State needs and problems with a desire to work cooperatively with State health departments and other State agencies with health programs. This unit, however, has not grown much compared with the growth of other units of health administration such as the National Institutes of Health.

The regional offices of the Department of Health, Education, and Welfare, particularly the Public Health Service and Children's Bureau components, have valiantly attempted to be helpful to State and local public health administration. However, they are understaffed and also are overwhelmed by the inclination to splinter administration at the Federal level and to break down grant money into a multitude of individual relatively small project grants.

Thus, in spite of themselves, the regional offices have become, to a large degree, channeling devices and program reviewers with little time for aid in planning and advising State and local health departments. Unfortunately, from a State's viewpoint, the regions of the Food and Drug Administration do not have the same boundaries or headquarters as the Public Health Service and Children's Bureau regions.

The National Institutes of Health have such a large number of requests for grants that they must have many reviewing committees consisting of persons who are not employees of the Public Health Service, but serve on a parttime basis. Most of these reviewing committees are made up of university-oriented and clinical or basic science-oriented persons. Consequently, nonuniversity organizations, such as hospitals or health departments, do not seem to receive the attention, as far as research grants are concerned, as they might from a group of reviewers who are not primarily university-oriented.

Also, it seems to us that badly needed applied and methodology type of research has received little backing from the National Institutes of Health. This research concerned with methods of obtaining popular application of the findings of clinical and basic scientific research is extremely necessary to help bridge the gap between scientific knowledge and its widespread use.

The regional offices of the Food and Drug Administration have worked closely with our State department of health which administers the Drug, Device, and Cosmetic Act of Pennsylvania, including narcotics and dangerous drugs. There has been a tendency for the Food and Drug Administration to make determinations on a national basis without much mutual planning and discussion with State counterparts.

Much of the determinations in this field needs to be done federally, in my opinion. Nevertheless, determination of needs and carrying out of adopted standards administratively in the field of drug, devices, and cosmetics control are largely done in our State, as in a number of others, by State government.

Thus, intimate mutual planning is desirable. Federal administration of one group of dangerous drugs, narcotics, is not within the Food and Drug Administration, not even within the Department of Health, Education, and Welfare. Having this administered in the Treasury Department because of the revenue aspects does not seem in keeping with modern knowledge of these dangerous drugs. I believe this narcotic program could well be included under the Food and Drug Administration.

There is a movement for more and more Federal aid toward training qualified health people and to some extent toward helping to recruit people into the health sciences. In spite of this aid, in general the ratio of qualified trained health persons to population continues to decrease. Also the problems are constantly changing.

As an example of change, with the passage of the recent amendments to the Social Security Act, known generally as medicare, the demands for such personnel as home health aids, hospital aids, and certain other similar positions which might be called auxiliary health positions are apt to increase rapidly and, therefore, call for some change of emphasis as well as acceleration of health manpower training programs. This training is needed to increase both the quality and quantity of human resources in the health field. Consequently, Federal funds, planning, and consultation in this area of training health manpower is one of the greatest areas needing attention and acceleration.

I will touch very briefly on the problem of flexibility of Federal health grant-in-aid funds, since bills which are identical are being considered on this matter in both the House of Representatives and the Senate at the present time.

Strict and inflexible categorizing of these grants has led to considerable difficulty in administering them throughout the nation with the complexity and diversity of health problems in different areas of the country. Well-planned, well-balanced, and well-consolidated public health administration is needed at the local and State levels, as well as the Federal level.

The present system of health grants-in-aid tends to prevent this desirable approach. I believe that H.R. 13197, if enacted, would go a long way toward permitting a flexible and balanced public health program in the Nation and improve Federal, State and local relationships in this major field of endeavor. The planning of the legislation embodied in H.R. 13197 has been studied and worked upon for a number of years by Federal and State health personnel. I believe the bill is well worded to accomplish the desirable ends except for the portion dealing with the State advisory planning board.

Rather than have two total advisory committees in a State, the one included in this bill and the State board of health, there should be, I believe, only one planning and coordinating board; namely, the State board of health.

To tie together what I have said, may I suggest that this honorable committee would wish to tailor the health program for the public, as managed by the Federal Government, in such a manner as to expressly and effectively fit the health needs of our time. This means working cooperatively and effectively with the State and local health units of government. I believe it also means working with local units through State health units.

This relationship can be improved and a more effective health program for the people of our Nation brought about by having more flexibility of grants-in-aid to the States as would be authorized in H.R. 13197, by turning more to program grants than project grants or at least having the States be a major partner in coordinating project grants, and by consolidating most of the health activities of the Federal Government into one place.

In this latter regard, I cannot help but feel that the health field has become so large, complex, and popular that it is necessary to have a separate Department of Health in the U.S. Government. Most of the nations of the world have separate departments of health, as do all but a few of the States of this Nation.

The preventive aspects and treatment aspects of health, as supplied by Government, need to be closely intertwined. The health of the body and mind can hardly be separated. Any one aspect of health is apt to affect all other aspects. If a separate Department of Health of the Federal Government cannot be arranged, at least it would seem advisable to have all the health functions of the Federal Government incorporated into a major branch of the Department of Health, Education, and Welfare with an Under Secretary of Health in charge.

Such a coordinated Federal health unit could and should, I believe, work closely and cooperatively in planning with the State and local jurisdictions in effectuating a more coordinated and more effective public health pattern and program for this Nation.

BIOGRAPHICAL SKETCH OF CHARLES L. WILBAR, JR., M.D.

1907: Born June 8, Philadelphia, Pennsylvania. Attended Henry C. Lee School and West Philadelphia High School, both in Philadelphia.

1928: A.B., University of Pennsylvania.

1932: M.D., University of Pennsylvania.

1932–1933: General Intership, Abington Memorial Hospital, Abington, Pennsylvania.

1934: Residency in Pediatrics, Mary Drexel Children's Hospital, Philadelphia, Pennsylvania.

1935: Residency in Medicine, The Queen's Hospital, Honolulu, Hawaii.

1936–1939: Director, Ewa Health Project, Ewa, Hawaii. Private practice, mostly in pediatric field, during this period.

1939–1941: Chief, Bureau of Maternal and Child Health, Hawaii Department of Health.

1940–1941: Residency in Pediatrics, The Children's Hospital, Cincinnati, Ohio.

1941–1943: Medical Corps, U.S. Army (Captain and Major). (Duties: Medical Inspector of 24th Division; County Health Officer of Maui County, Hawaii; C.O. of small Station Hospital).

1943–1953: President, Board of Health, Territory of Hawaii.

1953–1957: Deputy Secretary of Health, Commonwealth of Pennsylvania (April).

1957–date: Secretary of Health, Commonwealth of Pennsylvania (November).

1943–1953: Lecturer, School of Public Health Nursing, University of Hawaii.

1953–date: Lecturer, Graduate School of Public Health, University of Pittsburgh.

1958–date: Visiting Professor of Public Health and Preventive Medicine, School of Medicine, University of Pennsylvania.

1965–date: Associate Professor, Department of Public Health Administration, Johns Hopkins School of Hygiene and Public Health.

Married to Mildred Irene Robinson in 1935—two daughters: Irene and Charlotte.

Member, Dauphin County Medical Society, Harrisburg Academy of Medicine, American Medical Association.

Diplomate, American Board of Pedriatrics, 1941.

Diplomate, American Board of Preventive Medicine and Public Health, 1949.

Fellow, American Public Health Association.

One of two observers for United States at first meeting of the Western Pacific Region of World Health Organization (Manila, 1951).

Member, U.S. Delegation to World Health Organization (May, 1963).

President, Conference of State and Provincial Health Authorities of North America (1951–52).

President, Association of State and Territorial Health Officers (1962–63).

Chairman, Program Area Committee on Public Health Administration, American Public Health Association (1959–62).

Chairman, Health Officers Section, American Public Health Association (1962–63).

Member, Board of Directors of National Health Council (1959–61).

Member, Governing Council, American Public Health Association (1965–date).

Member, Board of Directors of National Multiple Sclerosis Society (1962–date).

Member, Board of Directors of American National Council for Health Education of the Public, Inc. (1951–64).
Chairman, Ohio River Valley Water Sanitation Commission (1961–62).
Chairman, Interstate Commission on the Potomac River Basin (1963–65).
First Vice President, Pennsylvania Health Council (1959 and 1960).
Member, Board of Directors and Executive Committee of Pennsylvania Tuberculosis and Health Society (1957–date).
Chairman, Central Pennsylvania Chapter of National Multiple Sclerosis Society (1958–60).
Lions International—President, Honolulu Club (1952); District Governor, District 14–G, Pennsylvania (1957–58); 100% District Governor's Award (1958); International President's Award (1959).
Recipient of Pennsylvania Public Health Association Award of Merit for outstanding achievement in the public health field in Pennsylvania (1961).
Recipient of McCormack Award for 25 years' work in the field of public health, ten of which have been as a State Health Officer (1962). This award is given by the Association of State and Territorial Health Officers.

Mr. ROGERS of Florida. Thank you very much, Dr. Wilbar, for an excellent statement. You have pointed up, I am sure, some of the major problems that we are seeing develop so rapidly today with the expansion of the Federal Government in the health field.

Congressman Van Deerlin?

Mr. VAN DEERLIN. I think this is the most provocative statement we have had today, most thought provoking. On just a minor point—on page 6, do you not have some erroneous statistics in there? Are there 7.5 million State employees and 2.5 million Federal employees in the health field?

Dr. WILBAR. In the health field, of course, I am including in the States the local employees by city and county health departments, too.

Mr. VAN DEERLIN. Well, but the figure for the Federal employees is——

Mr. YOUNGER. All the States.

Dr. WILBAR. This is all the States together, not just our State.

Mr. VAN DEERLIN. Even so, 2.5 million Federal employees would be all the employees of the U.S. Government in all the categories, not health. I think that somebody must have picked up some wrong figure there.

Dr. WILBAR. Maybe you are correct.

Mr. VAN DEERLIN. I can't believe there were ever 7.5 million, but again this is a detail.

Dr. WILBAR. I got this from a statement in the Congressional Record, but I will check it back.

(The following letter was received from Dr. Wilbar:)

DEPARTMENT OF HEALTH,
COMMONWEALTH OF PENNSYLVANIA,
Harrisburg, Pa., April 28, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Rayburn House Office Building,
Washington, D.C.
(Attention: J. W. Sloat, Esq.)

MY DEAR MR. ROGERS: In response to a question from Congressman Van Deerlin about the statistics I presented on state employees versus Federal employees, I should like to make a correction of my statement as I promised at the April 19 hearing. The statement was taken from the Congressional Record of February 19, 1965, Vol. III, number 33, from remarks made by Senator Karl E. Mundt of South Dakota, quoting former Governor John Anderson of Kansas. The statement, which is item 3 of Governor Anderson's remarks, is as follows: "State and

local government employment is rising steeply. These governments now have about 7,500,000 employees, compared with 2,500,000 Federal employees." It is clear from the statement and from the total context of Governor Anderson's remarks (made as a member of the Advisory Commission on Intergovernmental Relations) that the figures given are for total employees of state governments and of the Federal government and not, as I had stated in my testimony, employees "in this area of endeavor" meaning in the health field. I am sorry for my error of interpretation and hope that this will be corrected for the record.

As to further questions of elaboration of my testimony handed me on behalf of the Subcommittee by Counsel J. W. Sloat, may I submit the following:

Question: Doctor, on page 3 of your statement, you state that attempts to charter new and untried channels have often led to poor communications, and a bypassing of states in giving Federal assistance to local communities. Could you give some specific examples of such bypassing and elaborate further as to its effect on your state health program?

Answer: (1) Most of the examples of this bypassing of the Pennsylvania Department of Health are in connection with the Economic Opportunity program.

No funds have been made available, in spite of requests, to the Pennsylvania Department of Health to employ personnel who could mobilize the skilled professional public health staff at the local level to influence the inclusion of sound health projects in Community Action Programs. As a result, very few of the Community Action Programs in Pennsylvaia have siginficant health content. Where health activities are included, they have not been produced, as a rule, with professional guidance. Local citizen groups, acting independently of each other, submit their community action applications to the Office of Economic Opportunity in Washington. If approved, copies of the approved application are sent to the Governor who can veto them. Those portions of the applications dealing with health are sent to the Pennsylvania Department of Health for review. The description of health activities, in general, are too incomplete to permit a useful analysis and no personnel has been made available to permit on-the-spot review. The result has been the omission of many preventive health activities in local Community Action Programs that could have benefitted the underprivileged. Several specific examples follow:

(*a*) *Greater Erie Anti-Poverty Action Committee.*—The Board of Directors of Greater Erie Anti-Poverty Committee, the officially recognized organization for conducting anti-poverty programs under the Office of Economic Opportunity, has no representation from the Erie County Health Department or the Pennsylvania Department of Health. This project, designed to provide caseworkers with knowledge needed to meet the needs of impoverished families, offers no training designed to recognize or cope with problems stemming from ill health.

(*b*) *Allegheny County Office of Economic Opportunity.*—The programs developed for the poor in Allegheny County, while excellent in many respects, have not recruited substantially from the reservoir of trained public health workers on the staff of the Allegheny County Health Department. A letter integration of the health components of the anti-poverty programs and the on-going official public health programs would substantially improve their health content.

(*c*) *Community Action Program in Clearfield County—Multi-Purpose Development Center.*—This $32,354 project will be operated by a local non-profit corporation divorced from official health and welfare departments. This center "would be necessarily related directly to every facet of this region's poverty." The only health-related component project is for "arranging for or providing health examinations and health education for school children." This project is in direct conflict with Article XIV of the School Law of Pennsylvania which places this responsibility upon school districts.

(*d*) *Bedford-Fulton-Huntingdon Tri-County Community Action Agency, Inc.*—This proposal involves the allotment of $83,130 for a multi-purpose community center—"the initial point of departure from self-help local development and activation of social, *medical*, physical, educational, and employment opportunities . . ." In this project some aid was obtained from a sanitarian supported in the area by the Pennsylvania Department of Health, but he could not conceivably develop *medical* opportunities for the poor, as noted above.

(*e*) *Mayor's Committee on Human Resources—Pittsburgh.*—This $604,335 project or series of projects includes such ambitious component projects as: providing for home health aides, family planning, and maternal health services. These are the types of services normally provided by the full-time county and

city health departments under the leadership of trained and experienced professional workers. The primary reason more health services have not been provided to the poor has been that adequate funds were not made available in the City-County budget. But the Federal supplementary funds that could have gone through professional channels went, instead, to an independent lay-dominated corporation.

(2) Farmers Home Administration funds are provided to rural communities for planning and for the development of water supply resources. Funds may be used for treatment and distribution systems. No provision has been made for clearing these projects with the Pennsylvania Department of Health except that, after the fact, the community must apply to the Department for a license.

(3) Air pollution grants have been made to communities with or without consultation with the Pennsylvania Department of Health. The Department may comment, but has no authority to approve or disapprove applications.

In the discussion after my presentation, some questioning was concerned with further elaboration of the statement that due to university-orientation of most of the National Institutes of Health reviewing committees, non-university organizations, such as hospitals and health departments, do not seem to receive as favorable consideration for their research applications as they might.

In addition to my answers to those questions, I would like to point out the following as far as Pennsylvania is concerned: In 1965–66, the National Institutes of Health gave 1,061 research grants in Pennsylvania amounting to $37,838,332. Only one of these grants was awarded to a researcher in the State Health Department and one to a researcher associated with a local health department nonprofit research corporation. The total amount of these two grants was $32,936. For several years the Association of State and Territorial Health Officers and the Association of State and Territorial Directors and Coordinators of Research (in the public health field) have recommended that impetus be given to the development of greater research competency in State Health Departments by providing a $25,000 a year base grant for public health research to eligible departments. Such grant support now goes to medical and dental schools and has been instrumental in encouraging the development of better research programs there.

Two questions were asked about health activities of the Federal government in departments other than the Department of Health, Education, and Welfare, which I believe should be coordinated either in a separate Department of Health or in a major health unit of the Department of Health, Education, and Welfare under an Undersecretary of Health. Some of the more obvious include the program for health protection of workers now in the Department of Labor, the Veterans Administration hospitals, the Food and Drug Administration, the Office of Water Pollution, the health programs of the Children's Bureau, the Office of Vocational Rehabilitation, the "medicare" program other than the portion administered by the Social Security Administration, and the health and medical aspects of civil defense and disaster control. In regard to the last item, a portion of this is in the Office of Emergency Planning, some in the Office of Civil Defense and some in the Public Health Service at present. It would seem logical that all of these civil defense health functions would be better combined in an agency primarily interested in health, namely the Public Health Service. Included here would be the medical aspects of both nuclear and natural disaster; the procurement, storage and maintenance of necessary supplies and equipment; all training involving professional and lay personnel in the health field; the research incident to planning and preparing for better management of disasters and the actual management, direction and operation of all phases of disaster medical care and public health, both before and at the time of disaster.

Question: Near the end of your statement, Doctor, on page 9, you mention the importance of the Federal government working cooperatively and effectively with the State and local health units of government. What do you feel are the proper roles of the State and local health units respectively, both in dealing with the Federal government, and with each other? What do you feel are the distinctive responsibilities which should be lodged in each of these levels of health administration?

Answer: Ideally, public health should be administered close to the people; therefore, it is best administered by local health departments small enough to have intimate day-by-day contact with the people served, but large enough to be able to employ a qualified staff of trained persons. Both State and Federal governments should aid local health departments financially and through competent consultants and advisers. Where local health departments do not exist,

State Health Departments must supply these direct to the people services. Of course, voluntary health agencies help in health programs, but the major responsibilities lie with governmental health agencies. When it comes to laws and regulations, the sovereign powers in this nation, as written in the Constitution, lie within the States and powers are delegated by the States to the Federal government or to local jurisdictions. States, therefore, make basic health regulations which should not, in my opinion, be overthrown by the Federal government or local units, but local units should, and often do, participate in making more detailed and sometimes more stringent local regulations. It is necessary for the states to bring about some coordination and some uniformity of health administration within the local units, but in cooperation with the local units themselves within each State. In the case of broader health problems, such as river basin cleanliness, interstate compacts are needed, with the Federal government a partner in such contracts. From the standpoint of the Federal government, I believe it leads to much confusion for the Federal government to deal directly with local health units without having the State Health Departments involved. Ideally, the channel should be through State Health Departments in nearly every instance. At least, State Health Departments should have a major role to play in planning and determining health programs at local levels which are aided by the Federal government. This is important in avoiding gaps and overlaps and helps to keep a balanced program to meet health needs in accordance with their priorities within the State. The role of the Federal health agency should be mainly national planning, providing consultation and advice to the States and, through the States, to local units and providing financial grant-in-aid assistance, preferably on a program grant basis rather than on a project grant basis. Certain health conditions are so widespread and cross State lines to such a degree that Federal laws and regulations are necessary. An example of this would be requirements for automobile exhausts in the air pollution field.

Question: Doctor, on page 7 of your statement you state that there has been a tendency for the Food and Drug Administration to make determinations on a national basis without much mutual planning and discussion with State counterparts. Could you recall for us some examples of this? In what areas do you think it is important for the FDA to work closely with its State counterparts?

Answer: There have been instances in the past where one might have expected extended discussions between the Food and Drug Administration and the State Health Officers for mutual planning of the future. One such example is the contamination of eggs and egg products with salmonella. Contaminated tuna fish, lead paint on toys and the occasional use of nitrites to increase the shell life of fish, are other examples where such dialogues would have appeared desirable. It is to be hoped that the new administration of FDA would take this into account but this has not occurred in the past.

Sincerely yours,

C. L. WILBAR, Jr., M.D.,
Secretary of Health.

Mr. VAN DEERLIN. I feel certain that a couple of other points you have raised are going to lead to some lively discussions.

I will yield at that point, Mr. Chairman.

Mr. ROGERS of Florida. Congressman Younger?

Mr. YOUNGER. The States now employ about 7.5 million employees, just in health, and 2.5 million Federal employees. But that means both——

Dr. WILBAR. Perhaps it is the total employees of State against the total employees of the Federal Government. I will check that and correct it.

Mr. YOUNGER. That was a very good statement. All of you agree that the way the moneys are handed out does not promote the best administration, the best treatment. Everyone seems to be agreed on that.

Dr. WILBAR. Yes, there are now major gaps and major duplications, I feel, with the present system.

Mr. YOUNGER. Do you believe that it is better for the Federal Government to make a return to the State of a certain percentage of the Federal tax on some adjusted allotment and then let the State disburse it and handle it whichever way they want to?

Dr. WILBAR. I think that would be a more helpful system than we now have. Not only for health, but for some other aspects of governmental administration, particularly for health.

Mr. YOUNGER. That is all.

Mr. ROGERS of Florida. Doctor, I was interested in the fact that you felt that all health activities should be pulled into one department so that you would know with whom to deal.

Dr. WILBAR. Yes, sir.

Mr. ROGERS of Florida. Secretary Folsom, former Secretary, as you know, of HEW, suggested that there should be an Under Secretary for Health as well as one for Education and one for Social Services. Your second preference, as I understand it, would be this approach. You would prefer to have a separate department as your first choice?

Dr. WILBAR. Yes, I think Health is becoming so complex and popular and there is a desire for moving ahead very fast on these programs that it is worth a separate department, but if this is not possible administratively, then at least it seems to me there should be a major unit of the Department of HEW dealing with health and, if possible, drawing in some of the health matters that are administered now in other departments of the Government.

Mr. ROGERS of Florida. Now, I was also impressed with the statement you made about the National Institutes of Health. First, that they are so university oriented that they are not using the facilities of our hospitals and State health organizations which could do research and effective research.

Dr. WILBAR. Yes, the gap between scientific knowledge and its popular application is getting so big and getting wider, as I see it, that we need a good deal of our research directed toward methods or applied research, as to how to reduce this gap, how to get people to understand and use this scientific knowledge, and it is very difficult under the present circumstances to get money for health departments, in some cases hospitals, to do this type of research. And the reasons seem to be what I have stated.

Mr. ROGERS of Florida. And tying in with that the fact that they have put most of the emphasis, of course, on research itself, on trying to find cures, supposedly, without putting proper emphasis on the delivery of knowledge already obtained to treat the public?

Dr. WILBAR. Yes. It has been estimated, for instance, that about a third of the cancer deaths today—and cancer is the second leading cause of death—are preventable if people just knew what to do, what the early symptoms of cancer are, and where to go to get proper treatment.

Mr. ROGERS of Florida. We are not getting that out, is that right?

Dr. WILBAR. This is not being done, so here a third of these cancer deaths are happening which need not happen.

Mr. ROGERS of Florida. Useless deaths, really.

Dr. WILBAR. Yes, sir.

Mr. ROGERS of Florida. With present knowledge.

Dr. WILBAR. That is it.

Mr. ROGERS of Florida. Thank you very much, Dr. Wilbar. You have been most helpful and we are going to follow up some of the points you have brought for us. Thank you very much.

Now, we would like to hear, if we may, from Dr. Stanley P. Mayers, who is the health director of the Arlington County Health Department, Virginia.

We are particularly pleased to have you here, Dr. Mayers, to get another viewpoint of the health programs.

STATEMENT OF STANLEY P. MAYERS, M.D., DIRECTOR OF PUBLIC HEALTH, ARLINGTON, VA.

Dr. MAYERS. Thank you, Mr. Chairman.

I think some of the things I may say may give a slightly different viewpoint in that I am at the local level here and sometimes we at the local level don't always agree with those at the State level.

In the recent past, local health departments related to State health departments, which in turn related to the Public Health Service. This was the established legitimate chain of communications. The State health department, which served as the interface between the local and Federal departments, developed certain skills as interpreters. There were various staff or categorical program people in the State health department who were skilled in communicating with their counterparts at the Federal level.

At the same time, the division or bureau of local health services of the State health department was staffed with generalists skilled in working with local health departments. So-called illicit relationships between local departments and the Federal agency were discouraged, if not actually barred.

This system, as cumbersome as it may appear to be, did provide for an orderly development of local health programs in many parts of the country, particularly in the more rural areas of the States. Funds were channeled into the programs which deal with the most pressing problems: tuberculosis, venereal disease, control of other communicable diseases, water purification, food and milk control, et cetera.

But while progress was being made, new problems emerged, particularly in relation to chronic diseases and environmental pollution of all kinds. These new problems were particularly pressing in the large urban and suburban concentrations of populations. The old Federal-State-local relationship was never entirely satisfactory in these urban areas at best.

With the emergence of the new problems, an increasing dissatisfaction with the lack of speed in progress under the old system led to a number of experiments in direct communications between the Federal and local level. The Community Health Facilities Act of 1960 was the first attempt at such a breakthrough. Since then we have seen a great variety of Federal programs established, mostly of the project grant type.

In many ways this represents a revolution in Federal-State-local health relationships. As with any revolutionary change, a great deal of confusion has been generated. This confusion has been compounded by the host of scientific advances in recent years, by the rapid proliferation of Federal health programs and agencies, and by the great public

impatience for quick action to solve the many complex health problems which beset us today.

I do not consider this confusion to be an entirely bad thing. I believe that the old system of relationships needed some shaking up and that a new system, which is in the process of development, will be needed to meet the problems of today and, more important, tomorrow. I do feel that it is necessary that we try deliberately to create a new system which will better serve the future.

One of the real problems confronting a local health department today is the tremendous proliferation of Federal programs and agencies. Not only are health problems divided in a categorical fashion—for example, heart disease, mental retardation, tuberculosis—but there is also a functional or what you might call a horizontal division—for example, research, facilities, service programs.

A local health officer can spend quite a bit of time looking for the proper place to apply for funding of a project. This problem is growing worse all the time. I recently read that the Federal Water Pollution Control Act would be transferred to the Interior Department, but that those activities with respect to the health aspects of pollution would remain in the Department of Health, Education, and Welfare.

This tendency toward fragmentation of services and multiplication of agencies at the Federal level is likely to get worse rather than to improve. Increases in knowledge, pressure groups interested in a problem or a specific part of a problem, the continuing growth of Government all push toward this result. Sometimes this setting up of a separate program or agency is the best method of getting quick action in relation to a vexing problem. A conscious effort to resist this tendency whenever possible is maybe the best that can be hoped for at the Federal level.

Because of the increasing communications directly between Federal and local levels, I believe that there is a real need for the development of a strong group of "line" officers or "generalists" in the Public Health Service.

Under the old system this was a function of the State health department, so that there was no great need for many such individuals at the Federal level. These people would serve several purposes. They would be familiar with the many Federal agencies and programs so that they could serve as a synthesizing force as consultants to State and local health departments. They would also provide feedback to the various Federal agencies and programs so that modifications and changes could be made to make the Federal programs more effective.

The area in which I believe the greatest improvements in intergovernmental relationships can be made is in the area of the Federal grant programs. I think all will agree that there is great need for continuing Federal assistance in the support of health programs at the State and local level. Most health problems are not confined to one particular locality or even one State.

With the limited tax funds available locally and the competition from schools, public service, and other more visible needs, the local health departments are not likely to receive the increased appropriations necessary for the more complex programs visualized for the future from local sources alone. It is of great importance that the

various grant programs be updated and adapted to meet these new needs.

At present there are three types of grant programs being utilized: The general support grant, the categorical formula grant, and the project grant. Each one has certain advantages and disadvantages.

The general support grant provides money for the overall support of health services, as the name implies. This type of grant is the most useful to health departments in that the funds can be used with considerable flexibility to meet the needs and priorities of the health department receiving them. They are usually distributed on a formula basis to take into account the need from a financial and a size-of-problem standpoint.

At present, these funds are the smallest of the grant funds available and are not awarded to local health departments except as they trickle down from the State health department.

Categorical formula grants provide funds which are earmarked for specific programs. They can be used only for the specified program. These grants are most useful in encouraging the development of new programs which have been shown to be worthwhile and in shifting emphasis in existing programs where new knowledge has indicated the need.

The funds available in these grants can be used only for the specified program and, therefore, provide no flexibility for the department receiving them. Worse still, if matching money is needed to receive them, money may be pulled from other programs or other programs may not be started, in order to provide the matching funds for the categorical grants.

Project grants are usually grants for specific programs for which an application must be submitted. The health department is required to develop a plan for a project which will demonstrate the value of a particular program or service. The department receiving these funds must use them for the specific program and thus has no flexibility in using them.

These funds are most useful in providing for experimentation in the development and provision of health services. There is a definite need for this kind of "risk money" to explore newer services and programs. This is one of the ways in which the gap between new scientific knowledge and the practical utilization of this knowledge can be shortened. But only the well-developed, already strong health departments have the knowledge and skill to apply for these grants and are able to use them effectively.

At the present time the project grants are the ones most available to local health departments. In most cases they are the least useful for most local departments. On the other hand, the grants which would be most helpful in providing a continuing base for the rational development of well-balanced local health programs—general support grants—are virtually nonexistent as far as local departments are concerned.

I believe that the emphasis in Federal grant programs should be shifted from the categorical type of grant to the general support grant. This should be done by greatly increasing the amount of general support funds and by making them more directly available to local health departments. There is still a need for the categorical

grants, both on a formula and a project basis, but these should not be used as the main source of Federal funds.

As I see it, a project grant might be used to experiment with a new method of delivering services in a particular program. Once this has been proved to be effective, a categorical formula grant might be used to encourage all health departments to incorporate it into their programs. Once this had been accomplished, the funds would be provided through the general support grant. The project grant would require very little matching funds, the categorical formula grant would require more, and the general support grant would require more still.

The general support funds should be provided on a formula basis, taking into account the ability of the community to afford the service and the size of the problem. Safeguards should be provided to see that the community meets its responsibility in providing its share of the costs and that the funds are used for recognized public health services which are designed to meet reasonable standards of performance.

It is encouraging to see the recognition by the Federal Government of the metropolitan nature of many of our most vexing health problems today. In many cases, communities making up a metropolitan area are more closely bound to each other in their health problems and needs for services than they are to the rest of their State.

A metropolitan area frequently involves two, and sometimes more, States. When this occurs, the old system of the Federal Government dealing only with States produces serious barriers to the solution of such problems.

The heart disease, cancer and stroke legislation introduces the concept of regional solutions to regional problems without being concerned with political boundaries. This is a giant step in preparing for the future in health services. It is hoped that this concept will be extended to other health problems and programs.

CURRICULUM VITAE

STANLEY P. MAYERS, JR., M.D., DIRECTOR OF PUBLIC HEALTH, ARLINGTON COUNTY HEALTH DEPARTMENT, ARLINGTON, VIRGINIA

Born November 9, 1926, in Philadelphia, Pennsylvania.
Education:
Public schools of Philadelphia.
A.B.—University of Pennsylvania—1949.
M.D.—University of Pennsylvania School of Medicine—1953.
M.P.H.—Johns Hopkins University School of Hygiene and Public Health—1958.
Internship: Philadelphia General Hospital—1953–54.
Residency in Public Health: Arlington County Health Department—1954–55.
Experience:
August, 1955–September, 1957—Director, Henry-Martinsville-Patrick Health District, Virginia.
June, 1958–July, 1959—Regional Director, Virginia State Department of Health.
August, 1959–March, 1962—District State Health Officer—New Jersey State Department of Health.
April, 1962–June, 1965—Assistant Professor, Public Health Administration and Assistant Dean, Johns Hopkins University School of Hygiene and Public Health.
July, 1965 to present—Director of Public Health, Arlington County, Virginia.
Further Qualifications:
Diplomate of American Board of Preventive Medicine—1960.
Fellow of American College of Preventive Medicine.
Professional Organizations:
Member of: Arlington County Medical Society, Medical Society of Virginia.

Member of: American Medical Association, American Association of Public Health Physicians.
Fellow of American Public Health Association.
Publications:
Mayers, S. P., Jr. and Beachley, R. G.—"A Survey of Dog Bites in Arlington"—Virginia Medical Monthly, Vol. 82, pages 317–319, July, 1955.
Mayers, S. P., Jr.—"An Evaluation Schedule for Local Health Services, Public Health News (N.J.), Vol. 41, No. 6, pages 198–200, June, 1960.

Mr. ROGERS of Florida. Thank you very much, Dr. Mayers.

This gives us a different viewpoint which we need to consider.

Congressman Van Deerlin?

Mr. VAN DEERLIN. No, thank you.

Mr. ROGERS of Florida. Congressman Younger?

Mr. YOUNGER. No, thank you.

Mr. ROGERS of Florida. I was interested in the fact that you feel we should develop, as you say, mechanisms on the Federal level to deal with metropolitan areas, in effect. What function would you then have the State health officer perform?

Dr. MAYERS. Well, I think that this really gets into a problem. I realize that there is no easy answer to this, and I think that probably to be realistic in our present system of government, there will have to be a relationship with the State, too.

But I feel that many of the States as it stands at this time are not in a position to really deal with these metropolitan problems.

Now, there is another way of doing this if the Federal Government doesn't do it directly. This would be to strengthen the State health departments so that they would be able to deal with these metropolitan problems.

Mr. ROGERS of Florida. Yes.

Dr. MAYERS. In other words, I think that there would have to be agreement of the States involved to allow the Federal Government to get directly involved in these metropolitan area problems.

I am really confronted with this in Arlington in that we are in a two-State and District of Columbia situation.

For example, as it stands right now, if a child in Arlington is found to have a congenital heart condition, there are funds that are available to provide complete care for this child—diagnosis, treatment, followup, and so on.

Now, if this child is going to get this care through the Virginia program, he has to go to Richmond, to the Medical College of Virginia Hospital. His parents have to get him down there and stay there while he is being worked up and treated. Yet right across the river we have several very fine institutions that are doing this every day, but we cannot utilize this because of this political boundary sort of situation.

Mr. ROGERS of Florida. You feel the regional approach is better?

Dr. MAYERS. I feel there has got to be some place for a regional approach. I don't know exactly how this could be done, I will admit. I think that either the States would have to get together and agree to something on this, or they would have to cede certain funds out of their funds for these areas.

Mr. ROGERS of Florida. Do you deal directly with the Federal Government in some of your programs or do you go to the State?

Dr. MAYERS. We are different in Arlington. Commissioner Shanholtz testified earlier there are divisions in the State that are not part of the State system. This includes the big populous areas such as Arlington, Newport News, et cetera.

Mr. ROGERS of Florida. You are not part of the State?

Dr. MAYERS. We are called independent areas.

Mr. ROGERS of Florida. You do deal directly——

Dr. MAYERS. Yes, sir.

Mr. ROGERS of Florida. Do you have any difficulty finding out where to go to find out what programs are going on, what has happened in research?

Dr. MAYERS. We recently have been interested in taking a broad look at our community facilities and health services, and we have approached a number of different branches and divisions of the Public Health Service to see what help we could get in funding for a broad look. Each one is interested and they would be able to fund, say, a look at the heart disease, cancer or stroke, or heart disease, cancer and stroke problems in the community or some other categorical type, but to get a broad look would involve several of them. They are all very sympathetic with our problem. They appreciate that maybe this is really the best way to take a look.

Mr. ROGERS of Florida. But they still keep it in a categorical basis?

Dr. MAYERS. This is the way they are set up at the present time. This is why I think there is a need for a generalist. I don't see this generalist necessarily functioning with the local health departments, I think he could function very well with the State health departments.

Mr. ROGERS of Florida. What about your problem of health personnel? Is this a problem for you in your area?

Dr. MAYERS. It is not as much of a problem for us in our area as it is for people in some of the other areas. We have, for example, nurses whose husbands are students in one of the medical schools in the area or nurses whose husbands are on assignment here for one reason or another, so that generally speaking we have been able to keep ourselves staffed. We have a big turnover because of the peculiar situation of the people moving in and out so rapidly.

Mr. ROGERS of Florida. I saw a report some months ago that a survery had been made and the State of Virginia was short some 2,600.

Dr. MAYERS. I believe this is probably true, when you get out beyond this metropolitan area I think that the shortage exists. This, I guess, would include hospitals and health agencies. Our hospitals do have problems getting nurses and there have been shortages all the time in the hospitals in our area.

Mr. ROGERS of Florida. Do you have any training program going on in Arlington? In your hospitals?

Dr. MAYERS. No——

Mr. ROGERS of Florida. Have you encouraged any program or is there any way for you to encourage a training program?

Dr. MAYERS. There is a nurses aid program going on.

The hospital has just recently had a study made of the need for the hospital in the next 10 years. I have not yet seen the report that has been made on this. They had this done by a professional hospital survey group.

I met with the people from the survey on a number of occasions and I have a feeling that the report is going to recommend considerably increased activity in community health functions of the hospital.

Mr. ROGERS of Florida. Let me ask you this: Secretary Folsom mentioned that there had been a study done which showed that they could have a 50-percent reduction in the turnover of health personnel, which would bring about quite a savings. Were you aware of such a study and the results of it?

Dr. MAYERS. No; I was not. It was very interesting to hear about this.

Mr. ROGERS of Florida. One final question as far as I am concerned. Perhaps Mr. Gilligan will have some questions. If we try to develop a State plan and yet we have localities developing their own without regard to the State plan, will this not help bring about duplication, wastes, wastes of manpower in the health field?

Dr. MAYERS. Yes; I think it would.

I think it will be necessary in working with the States if we agree that the State department of health is going to be the one to deal with metropolitan area problems, that the State health department will have to do the job with all the local areas in the State. This is the problem as it stands right now: In many places the State health department——

Mr. ROGERS of Florida. Is not doing the job?

Dr. MAYERS. Is not in any manner ready to deal with the big cities in their State. It is only right now, as a matter of fact, as Commissioner Shanholtz mentioned in the State of Virginia that these independent areas are going to be brought in. But it is only as a result of the last legislature that this was done and this last legislature was a reapportionment legislature.

Mr. ROGERS of Florida. How much of your funds, would you say, are Federal funds that come to you in the running of your department in Arlington County?

Dr. MAYERS. Well, I cannot really say, because we get money that includes State and Federal moneys. It comes to about 10 percent of our budget.

Mr. ROGERS of Florida. I beg your pardon?

Dr. MAYERS. It comes to about 10 percent of our budget.

Mr. ROGERS of Florida. Any questions, Mr. Gilligan?

Mr. GILLIGAN. No thanks.

Mr. ROGERS of Florida. Any other questions? Thank you very much, Dr. Mayers. We appreciate very much your being here and you have been more helpful to us today.

The committee will adjourn until 9:30 in the morning, when we will hear additional public witnesses.

Thank you.

(Whereupon, at 3:10 p.m. the hearing was adjourned, to reconvene at 9:30 a.m., the following day, Wednesday, April 20, 1966.)

INVESTIGATION OF HEW

WEDNESDAY, APRIL 20, 1966

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON HEW INVESTIGATION
OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 9:30 a.m., pursuant to recess, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. ROGERS of Florida. The committee will come to order, please.

I would like to start with our first witness today, the dean of the School of Public Health, University of Michigan, Dr. Myron Wegman.

Dean, it is a pleasure to have you here, and we appreciate very much your coming to give testimony to the committee.

STATEMENT OF MYRON WEGMAN, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

Dr. WEGMAN. Thank you very much, Mr. Chairman. I am really grateful for the chance to come before this subcommittee. With your permission, I have a printed statement, which I have left with the clerk for the record.

Mr. ROGERS of Florida. All right, we will have your statement printed in the record at this point, without objection, and then you may give whatever testimony you desire.

(The statement referred to follows:)

STATEMENT OF MYRON E. WEGMAN, M.D., M.P.H., DEAN OF THE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

I welcome the opportunity to appear before this Committee and comment on the organizational structure and health programs of the Department of Health, Education, and Welfare. The experience upon which I base these comments has included rural health department work, large city health department work, international health activities, medical education and, currently, educational administration in public health. I am Chairman of the Executive Board of the American Public Health Association and have just finished three terms as President of the Association of Schools of Public Health.

The fundamental problem involved in the multiplicity of federal agencies concerned with health activities is the administrative problem of coordinating the many different roles and many different objectives involved. But an even greater problem relates to coordination at the state level. It is, unfortunately, true that not only are other agencies, besides the Department of Health, Education, and Welfare, involved with health work at the federal level, but, at the state level, there are other agencies besides the state health department. In many ways the immediate question of greatest concern is how to correlate it at *both* levels.

I can illustrate this with a specific problem in our own state. For a good many years, since the passage of the Social Security Act originally, the State

of Michigan has carried on what I believe to be an outstanding program for the care of crippled children. These children represent unique problems because of their need for long term care, the need for special expertise in their medical management and because of the great expense associated with these conditions. Until our last constitutional change, the crippled children's service was an independent one which also had responsibility for a state program for the care of "Afflicted Children", defined as indigent persons under 21 needing hospitalization for any medical condition. This program has always been closely related to health department activities and reorganization under our new constitution has now put the Crippled Children's service into the health department as an integral unit. The advent, however, of new administrative norms in relation to the administration of Title XIX of the Social Security Act promises to disturb a long standing arrangement which has brought great benefit to the children.

The explanation is not complicated. Title XIX provides that the Governor shall designate a single state agency for administration of the program and in our state the Governor has designated the State Department of Social Services which has a record of many years of excellent work in the welfare field and has a highly competent staff of welfare workers. The crux of the issue is that under the new legislation for Title XIX, the state stands to derive considerable financial advantage from administration of the Afflicted Children's program by the agency handling the general medical care for the indigent under Title XIX. To do this will require either separating the previous integration of the Afflicted Children's and Crippled Children's services or to divorce both of them from the ongoing programs of the department of health and the special knowledge of disease detection, case finding, management and prevention which that department has.

It may well be that standards of care can be raised to equal levels under administration by the Department of Social Services, for the Department has competent people, they have high ideals, and they certainly would not wish to compromise these ideals through rendering less than adequate medical care.

On the other hand, in order to do this, there would be need to be established in the Department of Social Services a considerable amount of medical know-how, embracing scope of services to be rendered, standards of care, and facilities to be used in related technical matters. Competence in this field exists in the health department and to set up such duplication would, in my mind, be following the letter of the law at the expense of violating the spirit of the legislation.

There is, of course, a general policy that coordination in operation must exist at the level of operation and can hardly be forced from above. At the same time, it is incumbent upon federal legislation and federal regulations to encourage rather than to make more difficult such coordination. There is no question that the state health agency must maintain medical competence to discharge its many other responsibilities for protecting the people's health. A simple and practical solution would be to encourage, in states where the welfare agency has been given the total responsibility for Title XIX, the contracting of responsibility for the medical care with the state health agency. This, in fact, is the way it has been done for many years in the State of Kentucky, and a recent order from the Governor of Massachusetts has essentially followed these principles. The major obstacle, however, is that most state welfare agencies are interpreting directives received from the federal Welfare Administration as preventing or, at the very least, discouraging such contracting.

I have spent time in elaborating on this problem because I think it illustrates a general principle which I hope will be of interest to this Committee and the Congress. There were very sound reasons for insisting in the legislation that the welfare agency be mandatorily responsible for determining eligibility of persons to be covered under title XIX. This is clearly the agency with the expertise and with the responsibility for doing the same thing under other federal programs. Furthermore, the welfare agency, by its very nature, has responsibility for the total program of care for the poor, involving many other things besides health. They are responsible for such matters as food, housing, clothing and other necessities of life, all of which have a bearing on the costs of medical care. The health agency, on the other hand, has what I would call a perpendicular overlap, since in contrast with the welfare agency's responsibility for all aspects of the care of one group of the population, the indigent, the health agency has responsibility for one aspect of the care, health, of all of the population. Since such an overlap is likely to occur under many other condi-

tions, I believe the Congress needs to consider more actively mechanisms for promoting coordination of effort at the state and local level, both through planning mechanisms likely to achieve this at the local level and by fostering cooperation and coordination of the units responsible at the federal level.

In the absence of such congressional direction I very much fear that one of the effects of this legislation will be the production of still further fragmentation of health services. This would aggravate an already serious condition and be directly contrary to the will of Congress, as expressed very clearly in the fact that the passage of Title XIX aimed to correct the inequities, lack of uniformity, and imbalance existing among the five medical care programs now pulled together under Title XIX.

One specific action can be taken readily by the Congress and would be highly conducive to fostering coordination and counteracting inevitable multiplicity of Federal interest in health. This would be to provide in the Department of Health, Education, and Welfare for a single person to be the Secretary's line officer with regard to health activities of the Department. This person should, I think, be the Surgeon General of the Public Health Service who already has direct responsibility for the major portion of federal health activities in the civilian sphere. Designation of the Surgeon General for this responsibiilty would also facilitate interdepartmental coordination within the federal government.

I understand that the Committee is also concerned with the alleged tendency of federal authorities to bypass the state health authority when sponsoring health projects and activities within their states. My impression is that the present tendency is in quite the other direction, although it is quite clear that in the past there have been instances in which bypassing occurred. Most of the time, however, such actions have been at the direct behest of Congress which, in passing specific types of legislation was clearly anxious to get a job done at a rate or scope beyond the immediate capacities, resources or interests of the state health agency. Theoretically, of course, even in these instances, it might have been possible to insist and that all projects and programs go through the health agency but, realistically, this would have engendered delays and difficulties.

A recent example of this has been the health program of the Office of Economic Opportunity. I am particularly involved in this in relation to Project Head Start, which, as you know, got underway with great speed. Congress clearly manifested its intent in this legislation that the Office of Economic Opportunity work directly with school districts and local projects in order to minimize administrative complications. I was particularly pleased to see, however, that this year the new regulations for the development of community action projects under the Office of Economic Opportunity call very specifically for careful coordination with state and local health services. Again I would point out that in as complex a subject as health, education, and welfare, the relations are such that no single unit can ever do the whole job alone. The achievement of coordination should be fostered by legislation and regulations. It may well be that as metropolitan complexes grow larger and larger, there will be health problems in which the mechanism of working through the state health agency may simply not be adequate.

What seems to be most important in this connection is that federal authorities keep constantly in mind the continuing basic responsibility of state health agencies and use every device, in those relatively few instances when it may be necessary to bypass the state health authorities, to keep them fully informed and aware of what is going on.

This, to my mind, is another reason for urging the centralization of technical responsibility for health activities of the Department in the Surgeon General of the Public Health Service.

The problem of flexibility in spending grant funds is one which I have seen at close hand in connection with teaching grants to schools of public health. These schools are unique in that 11 schools on the mainland of the United States, plus one in Hawaii and one in Puerto Rico, must serve the entire country. Federal responsibility for assisting both state and private universities involved in professional public health education was early recognized originally through specific grants for categorical health training programs. It soon became obvious, however, that such training programs could easily distort the fundamental curriculum of a school which was being asked to enlarge both student body and curriculum coverage. In 1958, therefore, the Congress passed the Hill-Rhodes Act to provide a sum of money on a formula basis related largely to the number of federally

sponsored students at the School, to be administered by the School in any way which would help the teaching program. I can testify fervently that this grant has been an absolute God send to the schools. In our own case, and, I believe, at the other universities, availability of federal funds has not in any sense diminished the steady increase in state support for our efforts. It has, however, permitted far more rapid expansion and has allowed us with clear conscience to maintain a very high out-of-state student ratio in our student body. At the same time, we have had certain grants aimed at stimulating the teaching of a subject of high priority, both through funds for faculty and for student scholarships. Judicious blending of the project grants and the underlying formula grant has made possible a sound ongoing program.

It is on the basis of this experience that I strongly endorse the concept of increased flexibility for grants to the states. In an important sense we are dealing here with a problem of staging and of development. When the federal grant program began few states were in a position, in terms of staff and experience, to accept total responsibility for managing federal funds. As time has gone on and state health departments have grown and matured, there is much greater need for the flexible grant to allow the health officer opportunity to develop the program which he and his advisers consider best for their state.

A very important aspect of a flexible discretionary grant fund would be an opportunity and a stimulus to do further health planning. Over the years the health departments, with sharply limited resources and immediate tasks constantly all of their abilities, have rarely had the opportunity or the means to undertake long range planning of health activities. A system of flexible grants would facilitate this very important development.

In summary, I believe that the history of federal-state relationships in the field of health has on the whole been a very salutary and productive partnership. In general, the federal government has pursued policies which have been conducive to raising standards and improving services. There is unquestionably room for improvement and moving ahead, on the basis of previous experience. The problems I have pointed out are by no means insoluble and the specific suggestions will, I hope, lead to even greater benefit.

ABBREVIATED CURRICULUM VITAE—MYRON E. WEGMAN

Born: July 23, 1908 at Brooklyn, New York.

Education: City College, New York, B.A. 1928. Yale University, School of Medicine, M.D. 1932. Johns Hopkins University, School of Hygiene, M.P.H. 1938.

Experience:

1932–36, Intern to Resident in Pediatrics, New Haven Hospital.

1936–41, Pediatric Consultant, Maryland State Health Department.

1941–42, Asst. Professor of Child Hygiene, School of Tropical Medicine, San Juan, Puerto Rico.

1942–46, Director, Training and Research, Child Hygiene and Director, School Health, New York City Health Department.

Part-time faculty appointments, Yale (1933–36), Johns Hopkins (1939–46), Columbia (1940–44) and Cornell (1942–46).

1946–52, Professor and Chairman of Pediatrics, L.S.U. Medical School and L.S.U. Pediatrician-in-Chief, Charity Hospital.

1952–60, Chief, Education and Training, later Secretary General, Pan American Health Organization (also Regional Office WHO).

Since 1960, Dean and Professor of Public Health, School of Public Health and Professor of Pediatrics, Medical School, University of Michigan.

Professional and Honorary Societies (Present Memberships; incomplete):

American Public Health Association (Governing Council; Chairman, Maternal and Child Health Section; Chairman, Reference Committee on Affiliated Societies 1950–53; Chairman, Committee on Constitution and Bylaws 1953–58; Executive Board 1964–. Chm. 1965–; 1958–63, Editorial Board, American Journal of Public Health (Chairman 1959–63).

American Pediatric Society; Committee on Medical Education.

Society for Pediatric Research.

American Academy of Pediatrics; Since 1950, Editorial Board, Pediatrics (Chairman 1961–63).

Society for Experimental Biology and Medicine.

Cosmos Club (Washington).

Alpha Omega Alpha.
Sigma Xi.
Delta Omega.
[1] See below.
Special Distinctions:
1955, Man of Year, City College of New York, Class of 1928.
1958, Clifford G. Grulee Medal, American Academy of Pediatrics.
1961, Townsend Harris Medal, City College of New York.
Address: Office—School of Public Health, University of Michigan, Ann Arbor, Michigan. Home—2760 Overridge Drive, Ann Arbor, Michigan.

Dr. WEGMAN. Mr. Chairman, there are a series of points that I would like to make in regard to the subjects that you are investigating. The first and most important to me is the question that you have raised about coordination, which hits me fairly closely, because in my public health career, I have had opportunity to work extensively at the local level, in rural southern Maryland, in State health departments, Maryland and Puerto Rico; in a big city, New York; in international health, in a number of other countries; and right now, I am chairman of the executive board of the American Public Health Association. I believe I have significant experiences besides the educational one in terms of various levels of work, to comment on this major problem of coordination.

As I see it, the difficulty is sort of a parallel one, as we are talking about the Federal and State relationship. There is a problem of coordination at the Federal level, but this is often reflected at the State and local level, because there is inevitably a tendency for the States to parallel Federal organization.

I have seen this most intimately recently in connection with the work that I have been doing as chairman of the Governor's Action Committee on Health Care in Michigan, concerned with the problem of organization of health services, and the impact of Federal health legislation.

More specifically, I have seen this in regard to our crippled children's program. Michigan has for many years had an excellent program for crippled children. In addition to this, we have had a program, not duplicated in many other States, for "afflicted children." The afflicted children's program involves the hospital care of any person under 21 who is indigent, so we have had a limited sort of title 19 in the State for a good many years.

Now along comes title 19. The legislation provides that there shall be a single State agency to administer the program, and the legislation further provides that the State welfare agency, by whatever term it is called, shall administer the eligibility provisions. This seems to me completely logical, because the State welfare agency has the competence, the experience, and the know-how to do this.

But then we go into the business of a single State agency, and in our State, the Governor, for a variety of reasons, decided that the State welfare agency should be designated as the single State agency.

Well, here we are right up against it. The State immediately finds that it will have a financial advantage if it puts the afflicted children's services within title 19, and the State is suddenly faced with a dilemma: Either lose a good deal of money or take one of two

[1] Phi Kappa Phi. 1955, Association of Teachers of Preventive Medicine. 1960, Michigan Public Health Association. 1963–66, President, Association of Schools of Public Health.

choices, neither of which, frankly, is pleasant. One would be to move the afflicted children's services away from the crippled children's service—split something which has been united and has worked together very well with a staff of physicians, nurses, workers throughout the State—and put one in welfare and leave the other in health. On the other hand, one can move the whole service over into welfare, divorcing services for some kinds of children from services for other kinds of children.

I am sure that this problem has been brought before this committee by others. I would like to emphasize my own feeling that while I believe that under most circumstances, it would be wiser to have the health department administer the medical care services that are involved, I recognize that we have here a sort of "perpendicular overlap."

The health department, by reason of historical development and logic, is responsible for one aspect, health, of the welfare of all the population. The welfare department is responsible for all aspects of the welfare of one segment of the population, the indigent. Thus there is a complete crossing of interests, which overlap in an important area.

What is done on this sort of problem at the Federal level has so much direct effect at the State level that I would hope very much that the Federal legislation would attempt to foster coordination at the local level. I don't think it is ever possible to get any single unit responsible for everything in this Government. There are too many shades and differences here.

Therefore, I would prefer to see some sort of system, such as is followed now, very effectively, I believe, in the State of Kentucky. More recently, the Governor of Massachusetts has issued an executive order along these lines, saying that the State welfare department shall contract with the State health department for the medical care services. In our State, however, we are told that the welfare department interprets the directives from the Federal Government as forbidding this.

This is a matter for direct local negotiation, of course, and perhaps not a direct concern of this committee, but the implications to me are that the legislation ought to be so written that coordination and interchange at the State level are fostered, rather than interfered with in any way.

In my opinion, it would have been easier and far better to assign responsibility for administration of medical programs to the State health department with direction to contract for eligibility determination with the State welfare department. On the other hand, I fear that if when the welfare department has been designated, it is not urged to contract with the health department for the medical care administration, there will be inevitable, unfortunate, and costly duplication.

In the absence of such congressional direction I very much fear that one of the effects of this legislation will be the production of still further fragmentation of health services. This would aggravate an already serious condition and be directly contrary to the will of Congress, as expressed very clearly in the fact that the passage of title XIX aimed to correct the inequities, lack of uniformity, and imbalance existing among the five medical care programs now pulled together under title XIX.

There is another aspect of coordination which I think is very important, and which hits home to me. My years of work internationally, particularly in Latin America, have convinced me that it is exceedingly important that the Federal Government have coordination of its international health work. I have met some very fine people in the Agency for International Development and its predecessors in the field of health, but it seems to me that it would be much better if this work were coordinated more closely with the work of the Public Health Service.

Again, I, for one—maybe I am naive about this—see nothing wrong about the idea of a contracting arrangement, under which the health agency might carry out the health work. This perhaps betrays a personal bias, Mr. Chairman, because I think health ought to be independent of politics. In the long run, political benefit to the United States will come from health work well done and be more evident if it is done for the sake of health and health alone than if there are political considerations in how the health program is administered.

One step toward better coordination at the Federal level that I think would be useful, given the inevitable mulitplicity of agencies and units of the Federal Government involved, is to give the Secretary of Health, Education, and Welfare a line officer responsible for everything in health in the Department, at least, and able to act as the Department's representative in work with other units.

To me, of course, the logical person for this ought to be the Surgeon General of the Public Health Service, as the man best qualified.

Let me turn for a moment to the question that was raised about the problem of bypassing the State health authority in connection with Federal health work.

My impression—and here I am on a little more tenuous ground, because I have had relatively little contact with this particular aspect—my impression has been that the present tendency is in the other direction. The State health officers to whom I have spoken have said that things are "better," the word, used to me by one health officer of a large State just last week. There is considerable more effort to go through the State health officer.

My impression has been that the Public Health Service, when it has bypased a State health officer, is most often following the direct mandate of the Congress that they want a job to be done, and they want a job to be done fast.

No State health officer that I know would deny the fact that he frequently has inadequate resources, that he has inadequate personnel, and that by the time you introduce another step, it might delay things.

I do believe that if we are trying to strengthen ongoing, continuing, fundamental health work in the States, the utility of going through the State health officer should be constantly recognized. In those instances in which it is necessary to bypass the State health officer for the purpose of immediate goals, he certainly ought to know everything that is going on, and not be in the position, as occasionally in the past, of finding out casually.

The OEO, of course, is one instance in which State health officers have been bypassed but for example there was a tremendous pressure to move the Headstart program, with which I am fairly familiar, more rapidly.

I suspect, Mr. Chairman, that as this country grows, and as the metropolitan complexes become more and more involved, the whole State relations arrangement is going to have to have some kind of modification. I am not smart enough to see just what, but I do think that we have to keep an open mind about how to meet this problem.

Finally, I would like to touch very briefly on the question of flexibility of grant funds. To me, Mr. Chairman, this is a question of staging and of maturity of programs.

For many years, the idea of giving earmarked money to get a particular job done was entirely logical, but our own experience at the schools of public health demonstrates the value of formula grants. I hope, Mr. Chairman, if I may put in a personal word that you are quite familiar with what is now section 314(c)(2), the Hill-Rhodes Act for formula grants to schools of public health. I can tell you as frankly as I can that this has been an absolute godsend to the schools, and completely essential.

Look what we were faced with. We had programs asking us to train people for medical care administration, to train people for various aspects of environmental health and air pollution, to train people in the field of mental health. All of these pressures meant lots of money, and all of a sudden, the basic teaching program was distorted, because there was no one available, and not enough money to support the underlying, permanent, ongoing programs of the school.

Now in our case, as a State school, I am in constant difficulty, because 75 percent of our students are from out of State, and the State legislature is not about to give us a very great increase of money to take care of them. The Legislation have increased our budget every year, but not enough to handle the load. Thus the flexible formula grant from the Federal Government has been of such importance, that I would hope very strongly that this device would be expanded substantially in work with the States.

The one other advantage of this, of profound importance, is that it will give the States some chance to work on planning. If there is one thing that we have learned, it is the necessity for helping to concentrate on both long- and short-range planning.

The States are constantly demanding more training in this respect, and with these flexible formula grants, I think they could do something further, in the way of planning their work and getting more effective use, both of their own funds and the Federal grant funds.

There are more aspects, Mr. Chairman, that I would like to touch on, but I know that you are pressed for time, so I will stop here, and be happy to answer any questions.

Mr. ROGERS of Florida. Thank you very much, Dean. Any questions?

Mr. CURTIN. Thank you, Mr. Chairman.

Just one or two questions, Dean.

In reference to this flexibility of funds, do I understand that you feel that the Federal Government should just make a general grant to the State and then leave it up to the States to determine how they are going to apply the moneys in that grant?

Dr. WEGMAN. I would endorse what you said, if you will delete the word "just." I think that there is continuing room for specific grants, for categorical grants in certain areas. I think it is perfectly proper

for there to be outside pressure from the Federal Government, from other groups, to say, "Let's put a little bit more push in this area, instead of another area." But I see room always for an underlying grant with which the States may have flexibility.

In other words, I see these two as complementary, the idea of categorical grants in certain areas, plus a substantial formula grant in which exactly what you said would be true, that we would say to the States that we recognize that there is a Federal responsibility for supporting basic health work for the citizens of the State. The Congress carries out that responsibility in part by giving money to the Public Health Service but here is money to be spent by the States right at the grassroots. You, the States, decide how it is to be spent. Of course, we want fairly detailed reports of what you are doing with it, and why it is helpful. My opinion is that such flexibile grants would be an exceedingly important device.

Mr. CURTIN. One other thing in reference to this multiplicity of projects. You seem to indicate that the State should have some say, with the moral suasion of the Federal Government, of having some particular group to pass on various activities, so that there would be little, or at least, less conflict.

Do you think that that should be an interstate committee for all of the States, or should each State have its own setup for the needs of that particular State?

Dr. WEGMAN. Oh, I would think the latter, Mr. Curtin. I think that it would be an important for each State to coordinate. I don't think coordination can ever be imposed from outside.

Again, I draw on my international experience, which has been most recent and freshest in my mind. You know, most of the developing countries of the world are receiving aid in a variety of ways. They get help from the World Health Organization in health, they get help from the Food and Agricultural Organization, they get help from the U.S. Government.

To try to coordinate these, if you have an outside group coordinating it, the outside group doesn't know the long-range permanent interests of the people that are on the spot who work very hard to get the individual countries to set up coordinating committees for that sort of thing.

Now in the States, I think coordinating committees can be quite useful. My specific suggestion, in relation to the health field, had to do with facilitating contracting one with another for the kinds of competence that each agency may have, but I would certainly like to see whatever coordinating committees are authorized set up within the State, at the State level.

Mr. CURTIN. Thank you, Dean.

Mr. ROGERS of Florida. Dean, your suggestion that there be a line officer directly responsible to the Secretary for all of the health activities in the Department of Health, Education, and Welfare is one that has been gathering, I think, a great deal of support. Former Seretary Folsom, yesterday, suggested that there be an Under Secretary for Health in the Department, as well as an Under Secretary for Education and one for Social Services—in other words, the three functions of the Department.

So your testimony is pretty much in line with that, although I think you make the suggestion that he perhaps should be the Surgeon General, rather than another person, but in any event, you do agree with the theory that the organization demands a line officer, in charge of all health activities and responsible to the Secretary?

Dr. WEGMAN. Yes, sir. I believe it should be a line officer. I use the term "line officer" because I think it should be a person competent on the technical side, rather than the political side.

Now it could be that there could be overlapping. I think it is proper, when a Government changes, for the Secretaries and the Under Secretaries to change, but I believe that the technical management of the line of health ought to be in the hands of a continuing technical person.

Mr. ROGERS of Florida. Now, we have had a good bit of testimony that a lot of our Federal programs which could be sponsored and are being carried out, emphasize activity rather than results.

In other words, so many visits, so many statistics, and so forth, rather than the results of the program. What would be your comments on it?

Dr. WEGMAN. Mr. Chairman, you are coming close to home. We in Ann Arbor are spending a great deal of Federal money right now that has been granted to us in an attempt to answer precisely that problem. One of the difficulties is how do you separate those two things?

It is so much easier to measure activities than to measure accomplishment. We have a large staff working in four different areas in the country, attempting to develop instruments for evaluation of progress. One thing, for example, we have thought important, is to recognize that very often, up to now, the measure used to evaluate progress has been too far from the activity itself.

For example, to try to correlate attendance at well-baby clinics with reduction in infant mortality is next to impossible—the two things are just too far apart to see the influence of one or the other. Our group is trying to break the analysis into stages of objectives, where achieving one objective becomes the means for achieving the next objective, and to work out tools so that this can be evaluated.

I guess, Mr. Chairman, as you perhaps know, I was out in Vietnam recently with Secretary Gardner and Surgeon General Stewart, and there I say two striking, contrasting examples of achieving specific results versus carrying on activities.

On the one hand, I saw in a cholera ward some of the most encouraging and heartening results I have ever seen. They were working with almost nothing, but with U.S.-supplied fluids, salt solution, and bicarbonate solution, with U.S.-supplied tubing, in one big open room with 60–70 patients—I will spare you the gory medical details, because they won't look good in the record, but I can tell you that from the 1st of January to the 19th of March, they have had almost 2,000 cases of cholera, and clearly they are cholera, because a substantial portion were proved bacteriologically, and they have lost only 5 patients.

Mr. ROGERS of Florida. Out of 2,000 cases?

Dr. WEGMAN. Out of 2,000. Now this is the kind of record that, frankly, I think the University Hospital in Ann Arbor would be proud

of. They have cut out all nonessentials. They just go right down the main line for what needs to be done to save these people's lives.

Mr. ROGERS of Florida. How much time are they spending on paperwork, would you say?

Dr. WEGMAN. On paperwork? Well, that would be hard to say. They have records on the cases. The records were minimal. They would weigh the patient when he came in, put him in bed, get a needle in a vein, take a little blood for a test, and zingo! they were underway with a formula.

They did keep records. If you ask me for a percentage, I would say it was very small, on paperwork.

Mr. ROGERS of Florida. Compared with what we are doing in this country.

Dr. WEGMAN. Well, don't push me into that, because there are some things that paperwork is pretty important for.

Mr. ROGERS of Florida. Well, I can understand that, but the testimony we are getting is that the requirements are of so much redtape, so much time to be clocked in, and records kept, et cetera, that many of our health personnel are having to devote a great deal of their time to paperwork, rather than actually getting out and carrying on their profession.

Dr. WEGMAN. I think that is right, sir. I believe that if we relate this to what we are talking about, evaluating results, I would emphasize that you can often evaluate results better by a sampling technique, and know what you are doing, as by a ponderous business of trying to keep a record of every single little thing that you do.

I would agree with that, but let me just mention, because it is so hot in my mind, if you will, the other side of the evaluation question, that I saw in Vietnam, the school health program.

Mr. ROGERS of Florida. School health?

Dr. WEGMAN. School health. Now I consider school health programs of great importance. I was the rapporteur of the WHO expert committee which outlined priorities on this, but I found that in Vietnam, with a tremendous shortage of physicians, a tremendous shortage of personnel, they were still following the fixed rule of routine examinations on all entering and leaving children in the schools.

Well, this is a good activity, but in proportion to the results in terms of cases found, and the utility of the work, it is just foolish to spend medical time this way. Here, I think, was an instance in which they were engaged in an activity in which they could report to me the number of examinations, and not the results while on the cholera ward, I could see the results in lives saved.

Now the two illustrations lend themselves, of course, to oversimplification, but here they were in the same city. Yet I believe strongly in seeking results. You remember Willie Sutton's story, Mr. Chairman. This is an example. You ought to go where the money is.

Mr. ROGERS of Florida. Yes. It was suggested by one of our witnesses that we have an outside group employed who would automatically review health programs as to results, and have them report to the Executive and to the Congress their findings periodically on all the various health programs we are engaged in.

What would be your feeling on that?

Dr. WEGMAN. This is an interesting possibility. I would suspect that to a certain extent, the National Advisory Health Council has that overall responsibility now, of watching the policies of the Public Health Service.

I think if you perhaps were to try to set up a group only for evaluation on a continuing basis, this would have possibilities. It would also have difficulties. I would worry about correlating it. I guess I am rather strong for the notion of limited and specific objectives when you come into this.

I would rather try to get competent people, outline the job and the results that you want them to do, and then come around from time to time and spotcheck how well this is being done, because I think if you try to set up a large continuing machinery for this, you might——

Mr. ROGERS of Florida. Well, I don't think it was necessarily just one committee. For instance, you might have an outside committee, as I understood the testimony, to check, say, the progress being made in the implementation of heart, cancer, stroke.

Dr. WEGMAN. Yes.

Mr. ROGERS of Florida. To see what the results had been and then to report back to us.

Dr. WEGMAN. Well, but to take this example, heart, cancer, stroke now has an advisory committee. That advisory committee is advisory to the program. The advice they are giving must be influenced by their evaluation of results.

Couldn't they do this sort of thing by setting up subcommittees and getting information as they wanted, rather than setting up a separate committee? I think—let me put it this way.

Mr. ROGERS of Florida. This could be, but if they are intimately involved in actually setting up the program, often I think there is a tendency to defend the present way of doing things, don't you think?

Dr. WEGMAN. Yes.

Mr. ROGERS of Florida. So that I think to get around that what was suggested was to have an entirely outside group come in and critically evaluate what progress really was being made.

Dr. WEGMAN. I don't know. I think that this might be—this might be possible if it were well set up. I can see some advantages to it. I would want to think through more some of the disadvantages.

Mr. ROGERS of Florida. Yes.

Now let me ask you about training personnel. How do you decide what is needed to be done in the public health field? Does the Department give you any goals to go on, or is this decided locally? How is this carried on?

Dr. WEGMAN. The matter of training manpower, Mr. Chairman, I think boils down to some kind of estimate of what the manpower are being trained for. We think the role of a university school of public health is to train the professional manpower that are in the leadership positions. We hope that the various individual departments, and we are eager to help them out as we can, will undertake the more specific inservice or preservice training programs for other than professional personnel.

Speaking from my own vantage point on this, we handle selection of students largely as a combination of pressure from agencies for people that they need, and pressure from students for what seems to attract them.

For example, right now there are many more applicants for programs in hospital administration than there are for programs in public health administration. I don't know why this is, entirely, but I suspect part of it is that the hospital is a very visible thing, and the problems of acute hospital care are more obvious, making it easier to attract to this career.

To some extent, this is affected by the funds which we have received from the Federal Government, and from others, in providing fellowships for students and support for faculty.

The Federal Government has been most generous, and we have been very appreciative of the help, both through the formula grants that I mentioned before and the project grants for faculty, and also for the scholarship funds.

On the scholarship funds, most of our money has come through what are called general purpose grants, to allow students to study in a variety of fields. The school is then on the spot in trying to say how to divide the money between environmental health, or microbiology, or medical care administration, or public health dentistry.

We have 15 different programs of study in our school.

This question relates somewhat to your original problem of coordination at the Federal level. Each unit, of course, is anxious to build itself up, and comes to us and says, Why can't you train more people in, for example, dental public health? And another one says, Why can't you train more people for chronic diseases? And we try our best within this, within the limits of funds available, and Mr. Chairman, if you will forgive me for a small plug, if we could only get some more buildings, we would be better off to do the teaching end.

All of this, I think, relates to the need for having a better balance, going back to your earlier remarks about results—what are the priorities in any particular moment.

Mr. ROGERS of Florida. Yes, this is what I wondered, if actual studies have been made, by our health people, and HEW, to project what they feel is needed, and these needs relayed to the schools, for instance, who are training, to try to build these particular programs.

Maybe it may not appeal, but it is something that is needed most critically.

Dr. WEGMAN. Yes.

Mr. ROGERS of Florida. Now is this being coordinated? Is enough attention being given to manpower in your viewpoint?

Dr. WEGMAN. I think no. If you ask me very directly, not enough attention has been given up to now to it. I think a good deal has been done. I don't mean to decry the effort which has gone on, but I think that the Public Health Service's attention to this could stand a good deal of "beefing up" and strengthening.

Mr. ROGERS of Florida. I share that feeling very definitely with you. I don't think we have done enough planning, nor have the future needs been translated to the organizations that can do something about it. I don't think we have done that.

Dr. WEGMAN. The second National Conference on Public Health Training in 1963 made as one of its primary recommendations that the Public Health Service give much more attention to the whole problem of manpower. We would like very much to have that, because we are right in the midst of it.

Mr. ROGERS of Florida. How many people are you training now in your schools?

Dr. WEGMAN. Well, in the fall term of this year, we had registered in our school the highest number we have ever had, about 350 students, at the graduate level in a variety of programs, most of them degree programs, a few postdegree work, master's and doctor's, covering 15 different areas.

Mr. ROGERS of Florida. Now are you projecting an increase of the student body, say in the next 5 years?

Dr. WEGMAN. We are projecting an increase—I hate to run this in again—dependent on space. We have no space to work in. We are scattered now in eight different buildings. We talk about trying to unify work in Public Health, and until we can get them together, we are going to be in trouble. But we are projecting an increase.

Mr. ROGERS of Florida. Are there Federal funds available now to help you?

Dr. WEGMAN. Yes, sir; there are.

Mr. ROGERS of Florida. Are they acting on your request?

Dr. WEGMAN. Yes, sir; I hope so. We haven't got our firm request in, but I hope so.

Mr. ROGERS of Florida. We would be interested in seeing some of this, too. If you could advise the committee, I think it would be helpful.

Any questions?

Dean, we appreciate very much your being here this morning.

Dr. WEGMAN. Thank you very much.

Mr. ROGERS of Florida. And we may come back to get some information from you.

Dr. WEGMAN. I would be very happy to help at any time, sir. Thank you.

Mr. ROGERS of Florida. You have been most helpful. Thank you.

I see our colleague, Congressman Kornegay of North Carolina, here. He might like to introduce our next witness to the committee.

Mr. KORNEGAY. I would be delighted to, Mr. Chairman.

Mrs. Dolan.

Mr. Chairman and members of the subcommittee; it is a real privilege for me to have the opportunity to introduce one of our most distinguished North Carolinians to the subcommittee, Mrs. Margaret Dolan, of Chapel Hill, N.C. Mrs. Dolan is the head of the department of public health nursing, Nursing Public Health and Public Health School at the University of North Carolina, Chapel Hill.

She has distinguished herself for many years in her chosen profession, and certainly is recognized, not only in our State, but throughout the country, as a real authority on the matter of nursing as it is related to public health, so it is a pleasure for me to have this privilege to introduce her to this distinguished subcommittee.

Mr. ROGERS of Florida. Thank you very much. We are delighted to have you present, and with such a distinguished North Carolinian, and I might say that our colleague contributes greatly, as I am sure you know, to the deliberations of this committee, and has been most helpful in helping solve many of the important problems of this Nation, so it is a real pleasure to welcome you to the committee, Mrs. Dolan, and we will be delighted to receive your testimony.

STATEMENT OF MARGARET B. DOLAN, R.N., M.A., PROFESSOR AND HEAD, DEPARTMENT OF PUBLIC HEALTH NURSING, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, N.C.

Mrs. DOLAN. Thank you very much, Mr. Rogers. Thank you, too, Congressman Kornegay. I wanted to thank you particularly for your invitation to appear before this committee to express some of my ideas and thinking about the problems and the issues under consideration.

First, I wish to express my deep appreciation and satisfaction to the Members of Congress for the magnificent way they have responded to the requests for legislation to meet some of the health needs of the elderly and other groups within our society with special needs, and also for expanding and raising the quality of educational and health programs, and for the support you have given for the training of personnel for health occupations.

No health worker can look at the health legislation that has been enacted in the last few years without realizing the tremendous opportunity that is presented to him for taking giant steps toward the goal of positive health, for all citizens, regardless of race, color, economic position, or geographic location. Yet despite these increased opportunities, and more adequate financial resources than we have ever had, there are problems and areas of deep concern.

The ideas and concerns I express have been formulated as a result of my observations and my conversations with numerous public health nurses ranging from staff nurses in local health departments to State directors of public health nursing and to consultants and directors at the national level, and through my teaching of graduate students.

I have learned of the frustrations, pressures, and overwhelming demands they constantly face in trying to implement the health programs that have been created when they try to provide needed nursing services to individuals, families, and communities.

Let me hasten to add that I do not mean to imply that we have too many programs or too abundant resources but rather that the utilization of these benefits is hampered by too little coordination and too little effective planning. Full use of these resources demands improved coordination and planning at every level—Federal, State, and local.

The ultimate objective of every service program is to reach and help the individual with health needs. More often than not it is the public health nurse who provides the link between the individual and the service. Yet new programs frequently are planned and established services altered without her knowledge or participation in planning.

The unique contribution of the public health nurse is in her ability to assess total health needs of the families she visits and to provide needed nursing services—bedside care of the ill at home, health counseling and teaching, and assisting the patient and his family to secure needed care and services from other community resources. But the extent to which she can make this unique contribution is determined by the administrative setting in which she functions.

If I could reduce all the problems, concerns, and frustrations I have heard and observed into two concepts I think I would identify them as—

1. Fragmentation of services.
2. Competition for scarce personnel.

I believe two mechanisms that have been increasingly used in financing health programs and activities have been responsible to a large degree for creating these two problems—fragmentation and competition for scarce personnel. They are the use of categorical funding and project grant funding.

It is recognized that categorical funds are designed to reach specific health goals and therefore that moneys so appropriated are to be used as expeditiously as possible to meet specific objectives and expenditures must be related to activities required for this purpose. Public health nursing administrators are responsible for effective utilization of nursing personnel for the improvement of general health services to families.

The goals of both categorical and general programs can be attained if program administrators clearly state their joint objectives, define activities, and determine methods of evaluation. Such an approach allows for utilization of combined abilities and skills of staff within an agency and for administrative determination of the best approach for providing services for a given community. It also provides a basis for planning the amount and kind of nursing time needed for a program within a system of priorities.

The requirement of certain Federal programs for the assignment of staff on a specialized basis in order to account to appropriating bodies for categorical funds has too often resulted in a type of program operation at the local level that has produced fragmentation and disruption of nursing services. Implementation and direction of a program are the prerogative and the responsibility of the agency rendering the services.

It is the responsibility of the agency providing services to determine the administrative structure and the personnel assignments and procedures to be adopted for efficient operation.

Some years ago several agencies—U.S. Public Health Service, Rockefeller Foundation, American Red Cross, Town and Country Nursing Service, and similar agencies—involved in providing nursing care, aware of the unnecessary multiplicity of nursing services in many homes, the excessive costs for administration, and more importantly, the consequent piecemeal services to individuals and families, undertook studies to identify ways to resolve these problems.

Results of the studies were sufficiently revealing that the nursing profession and public health administrators adopted the position that the needs of people and families are the basis for all health services, and that—

1. Nursing services should be provided as needed to encompass all phases of the agency's activities requiring nursing skills. Staffing and allocation of nursing personnel must be related to total community needs rather than to a particular activity or program. Public health nursing can be administered most efficiently and most economically as a family health service which focuses on the patient and the family.

2. Responsibility for case-finding, follow-up, nursing care of the sick at home and family counseling to promote change in health attitudes and behavior is most effectively carried by the nurse in a comprehensive family-centered service.

3. Public health nursing participation in ongoing activities to study given problems, to control specific diseases or to promote the health of specific occupational or age groups may, and frequently does, require specialized nursing consultants.

4. They would recognize and accept responsibility for accountability of funds—categorical and general.

5. Source of funds should not be the determining factor in the assignment of direct service personnel.

6. Administrative convenience of accountability of funds is not justification for the assignment of direct service personnel on a specialized basis.

For more than a quarter of a century this approach has proved to be an economical, effective, and administratively sound way for local agencies to fulfill their commitments to agency programs and to the community's needs for nursing service.

In any program area whether it be heart, cancer, tuberculosis, vaccination, and so forth, goals must be established. But more importantly specific targets must be spelled out in order to give us a way of measuring our effectiveness on the way to the goal. The personnel to provide the service must be utilized as effectively as possible.

Then we must measure our effectiveness by performance and change in family behavior rather than by numbers of staff employed, moneys expended or new services created.

Whatever the source of funds—categorical or project grants—at the local level there must be planning and coordination to insure the most efficient and economical service to people. A unified administration of public health nursing services offering comprehensive service has been found advantageous to the community because—

1. Complete care to individuals and families is more nearly approached than it is through categorically centered services. This approach protects the dignity and privacy of the person needing health service, and recognizes him as an individual who may have a variety of interrelated personal and family health needs. This approach is best implemented at the service level by a public health nurse.

2. Family-centered public health nursing permits rendering of service according to patient needs rather than limiting activities to those for which the agency has specialized funding.

3. Family-centered service permits the development of a strong nurse-family relationship which enables the nurse to elicit from the family early signs and symptoms which threaten the health of individual family members or the family structure.

4. The nurse's understanding of the family's personal and financial resources make it possible for her to help them to achieve health goals through utilization of the resources available.

5. A family-centered nursing service quickly discovers gaps in community resources for meeting health needs.

The current practice of some funding sources to require that nurses in local health agencies be utilized only in special categorical activities

is contrary to modern concepts of public health practice and is a regrettable regression resulting in incomplete and expensive services to individuals and families.

It is costly in terms of dollars and personnel, both of which are too precious to waste, but qualified health personnel is now in much shorter supply than the dollars. It is, in my opinion, one of our most precious resources at this time and we must use it wisely, efficiently, and effectively.

Two positive aspects of categorical grants are that they focus attention on new or neglected health problems and that they demand adequate evaluation and review. This value can still be maintained and further, when incorporated into the ongoing program, both are strengthened.

Both categorical funds and projects grant funds too often require specialized staffing at the local level. This accounts for the many instances of poor administrative practice which have been related to you: for example, many miles traveled by the public health nurse in order to visit only tuberculosis patients and contacts, nurses assigned only to vaccination clinics, or only to provide followup services for schoolchildren.

In fact, all three nurses could be traveling over the same territory daily. A specific example of the latter situation was reported to me just last week by a director of public health nursing in a local health department. One of the local schools was given a grant under the provisions of the Elementary and Secondary Education Act. Part of the grant was used to employ a social worker to follow up all the children who had been identified by the teacher and the public health nurse as having one or more health problems that needed correction.

The social worker spent weeks securing information about the children and the family that was already known to the public health nurse. The local health department—who employed the public health nurse—had no prior knowledge of the project or the grant.

I believe it would have been more effective and economical to have extended the nursing service for that school by the addition of a nurse to the staff of the health department so that the nurse who already knew the children, their families, and the circumstances could have provided the followup care indicated. Similar examples have been reported to me over and over again.

Nurses have been employed to carry out health projects for schools where there is no planning or coordination with existing health activities or programs in the community and where the nurse in the project has no guidance, supervision, or direction from a health authority. As a result there is a scramble for the scarce personnel and whichever agency can pay the best salary out of its grant gets the personnel without adequate attention to health needs of the families and community and the wisest use of the resources available. Frequently it is the agency that is charged with the responsibility for protecting the health of all the community that is robbed of its staff for these special projects.

The unpredictability of funds adds further to the problem created by the project grant technique of funding. Sound planning for services is impossible under a system of Federal grants where the amount of funds, time of their availability and continuity is unpredictable.

Recruitment of competent personnel becomes a major block, and once funds are secured there is pressure exerted to spend them within a specified period of time under threat of a reduction of funds for the next year's appropriation.

I do not wish to leave with you the impression that I am speaking against categorical funds or the project grant technique per se. Indeed we are indebted to both mechanisms for significant progress with various health problems.

However, I do emphatically speak against the growing rigidity of their administration and at the same time a relative decrease in the less rigid and less restrictive general health grants which support basic health services. Flexibility must be provided in order to allow budgeting and grant operation to be consistent with a State's plan for program administration and to permit local determination of methods of implementation.

Records can be kept in such a way so that time spent in approved project activities can be specifically identified and modern auditing procedures can be established to account for staff in terms of full-time equivalent positions. Advice and consultation should be available from the Federal agency to assist local administrators to institute these types of procedures for better use of the funds.

In summary, sound public health nursing administration is based on the concept of unifying the geographic area and family approach rather than fragmenting fieldwork into narrow categories. The family approach avoids confusion for the family, conserves travel time and expense for the agency, and enhances comprehensive care.

Thank you very much for this opportunity to present to you these principles on which sound public health nursing services are built. The concerns that I have referred to in my statement are those of many public health nursing administrators responsible for delivery of quality nursing care to individuals and families in their homes.

If you have questions, I would attempt to answer them.

Thank you very much.

CURRICULUM VITAE—MRS. MARGARET B. DOLAN

Present Position: Professor and Head, Department of Public Health Nursing, School of Public Health, University of North Carolina, Chapel Hill, North Carolina.

Date and Place of Birth: March 17, 1914, Lillington, North Carolina.

Educational Background:

Anderson College, Anderson, South Carolina, Associate of Arts degree, 1932.
Georgetown University School of Nursing, Washington, D.C., Diploma, 1935.
University of North Carolina, Chapel Hill, N.C., B.S.P.H.N., 1944.
Postgraduate Training in Tuberculosis Nursing, Syracuse University, 1945.
Teachers College, Columbia University, New York City, M.A., 1953.

Professional Experience:

Staff Nurse, Instructive Visiting Nurse Society, Washington, D.C., 1935–36.
Epidemiological Nurse, Tuberculosis Studies, U.S.P.H.S., Montgomery, Alabama, 1936–40.
Staff Nurse, City Health Department, Greensboro, N.C., 1941–42.
V.D. Clinic Supervisor, City Health Department, Greensboro, N.C., 1943.
Tuberculosis Nursing Consultant, Tuberculosis Program, U.S.P.H.S., 1945–46.
Generalized Public Health Nursing Supervisor and Tuberculosis Nursing Consultant, Baltimore County Health Department, Maryland, 1947–50.
Assistant Professor and Associate Professor, School of Public Health, University of North Carolina, 1950–59.

Professor, Head, Department of Public Health Nursing, School of Public Health, University of North Carolina, July 1, 1959—

Current Organization Activities:

Member, Board of Directors, American Nurses' Association, 1964–68.

Member, Board of Directors, National Tuberculosis Association and North Carolina Tuberculosis Association, 1961–

Member, North Carolina Medical Care Commission.

Fellow, American Public Health Association. Member, Governing Council, 1963–66.

Member, American Association of University Professors.

Member, League of Women Voters.

Member, President's Advisory Committee on Health Resources, 1962–

Member, Committee on Legislation, North Carolina State Nurses' Association.

Member, Nominating Committee, National Health Council, 1966–68.

Member, Medical and Health Committee, National Safety Council, 1963.

Member, Board of Directors, American National Council for Health Education of the Public, 1964–66.

Member, Program Committee, National Conference of Tuberculosis Workers, from May, 1964–66.

Member, Budget Committee, North Carolina Tuberculosis Association, 1964–.

Member, Governor's Council on Occupational Health.

Member, Committee on Resolutions, American Public Health Association.

Member, Board of Directors, American Journal of Nursing Company, 1962–66.

Member, Board of Directors, American Nurses' Foundation, 1962–66.

Member Executive Committe and Program and Budget Committee National Tuberculosis Assn., 1965–68.

Past Offices Held:

President, American Nurses' Association, 1962–64.

Chairman, Committee on Legislation, North Carolina State Nurses' Association.

Vice-President and President of North Carolina State Nurses' Association.

Vice-President, North Carolina League for Nursing.

Chairman, Public Health Nurses' Section, American Nurses' Association.

Second Vice-President, American Nurses' Association.

Chairman, American Nurses' Association, Committee on Legislation.

President, American Journal of Nursing Company, 1961–62.

Secretary, University of North Carolina Chapter, American Association of University Professors.

Chairman, Subcommittee on Educational Qualifications and Functions for Public Health Nurses, Committee on Professional Education, American Public Health Association.

Honor Societies:

Associate Member, Sigma Theta Tau, 1964.

Member, Delta Omega, Honorary Public Health Society.

Member, Kappa Delta Pi, Honorary Education Fraternity.

Received, John Carroll Award, 1962, Georgetown University Alumni Association.

Publications:

"Public Funds for Nursing Education," *Social Legislation and Nursing Practice*, published by American Nurses' Association, New York, 1960.

"Scholarships Needed for Teachers of Nursing," *The Health Bulletin*, North Carolina State Board of Health, Raleigh, Vol. 76, No. 2, February 1961, pp. 5, 8–11.

"How the Public Can Share in Financing Nursing Education," *American Journal of Nursing*, 60: 1480–1481. (October 1960)

"Employment Opportunities for Nurses," *Nursing Outlook*, 9: 225–226. (April 1961).

"Putting Our Own House in Order," *American Journal of Nursing*, 62: 76–79. (December 1962)

"The Pursuit of Excellence in Nursing," *Excellence in Nursing*, Papers Presented at the School of Nursing Program for the 175th Anniversary Observance, Georgetown University, Washington, D.C., March 20, 1964.

"The Role of the Nursing Organizations in Meeting Health Needs of Society," Papers Presented at a Symposium for Graduate Students, Nursing and Society—Patterns for Progress, University of North Carolina School of Nursing, December 3, 1964.

Mr. ROGERS of Florida. Thank you, Mrs. Dolan, for a very excellent statement, and for pointing up very specifically some problems that the committee is concerned with.

Congressman Van Deerlin?

Mr. VAN DEERLIN. You have made it clear, Mrs. Dolan, that we are wasting not only money, but perhaps more important, the time of highly trained people, and this is a loss which I should think we can afford even less when the needs of medicare begin to be met this summer.

Would it be your impression that the kind of confusion and duplication that has existed thus far could best be eliminated by a closer supervision within the Department of HEW?

Mrs. DOLAN. Well, I think I don't know exactly what you mean by a closer supervision. I think there certainly needs to be more coordination of the various departments and agencies within HEW which have health programs.

I think there has to be planning and coordination at all three levels. I don't have any particular organizational structure in mind, but I think it is generally recognized that we need to do something about the current organizational structure, in order to enhance better coordination and planning.

Mr. VAN DEERLIN. Well, the example that you gave of the lack of knowledge within the Department of Public Health about a program that was being sponsored under the school bill, this is one that apparently could be met only at the level of the department of government which was responsible for both programs.

Mrs. DOLAN. Right.

Mr. VAN DEERLIN. Thank you, Mr. Chairman.

Mr. ROGERS of Florida. Mr. Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

I gather from your statement you follow along pretty much the same recommendations that these grants of money could better be used if they were given to the State, without categorical limitation. Is that true?

Mrs. DOLAN. Well, I think categorical grants and project grants funds can still be utilized, but I think there must be flexibility in their administration at the local level, and I think there should be opportunity for administrative decisions to be made at the State level.

I don't think we have to eliminate categorical grants or special project grants, but my concern is how they are administered, and the demand they put on for specialization at the point of delivery of service.

Mr. YOUNGER. Well, the grants in HEW that are categorical must be spent for that purpose, and that purpose only. you can't give flexibility on a categorical grant for heart disease, and spend it for tuberculosis.

Mrs. DOLAN. No; but my point is that we can spend the money for heart activities, or heart disease activities, without requiring that nurses be employed only to do heart activity functions.

In other words, using the approach of the generalized public health nurse, and through accounting procedures, keep an accurate account of the service that she renders, and then therefore, in full-time equivalent positions account for those funds toward heart activities.

I think that you can have categorical funds, but at the point of delivery of service, you have one person who is providing the service for a family, rather than having three nurses, one providing tuberculosis services, one providing service in relation to heart programs, and another one providing service in relation to a cancer program.

Mr. YOUNGER. Well, the difficulty with that arises out of the accountability, the bookkeeping and all, the administrators who have been before the committee are trying to be relieved of that, and they want some flexibility of use.

You may get a grant for tuberculosis, and you may not have a tuberculosis problem, but you do have a measles problem, and you ought to be able to spend that money in the State which has that particular problem, and the State should be allowed to have some discretion on how the money is spent.

Mrs. DOLAN. Well, I believe that categorical and project grant funds should be used to complement and supplement basic health services, so I think that you can't substitute the categorical funds for general health funds. I think they can complement each other.

I spoke to a nursing consultant in a State health department just last week about this problem of being able to account for funds, when you had a generalized public health nurse who was carrying out all health services for a particular family.

Now within that particular family, the nurse may have both a tuberculosis problem as well as a person in the family with a heart condition. But the nurse in her daily records is able to account for both services rendered. They have a record system in that department now, so that all she has to do is to check a record. They have mechanized equipment, so from that point on there is a way of accounting for the time that she spends in tuberculosis activities and the time she spends in heart disease activities with some of the modern techniques of recordkeeping. Categorical funds can be accounted for without time-consuming recordkeeping by the nurse.

Mr. YOUNGER. Now you mentioned the problem of personnel, which I think everyone recognizes, and one of the problems, as I view it, is that we are passing out more and more demands for personnel, without training the personnel.

It seems to me that our first job, and the first appropriations that should be made, is to create and train the personnel, and then give them something to do, but we have felt that this foreign medical bill, where they want to train a thousand personnel to send overseas. We are short of personnel here. If we are going to train anybody, we had better supply our needs here first, before we start supplying the needs all around the world.

Mrs. DOLAN. Well, I think this is a dilemma that we all face. What comes first, the brick and the mortar for facilities, or the personnel to staff the facilities? Actually, it takes longer to train personnel than it does to build a building.

Mr. YOUNGER. That is right.

Mrs. DOLAN. And we need to start there, probably, but many times you have to demonstrate a need before you are able to convince people that something needs to be done about it.

Now I think the Nurse Training Act is going to make a considerable contribution toward this, but this has only been in effect a short period

of time, and we haven't had time, really, to see the full impact of this, but already we know that the appropriations for construction for collegiate schools of nursing is inadequate.

I think at the last meeting of the advisory council of the Nurse Training Act, grants were approved and funded for construction of five new collegiate schools of nursing, but actually, as best I recall, there were 15 or 20 projects that were approved, but there were no funds.

Now this is the thing, I think, that is perfectly obvious. We are going to have to increase the funds for construction of schools of nursing to increase the supply. Actually, we have continued to increase the nurse supply, but even though we have made progress in that, we haven't kept up with the demand. I think one of the real problems that we are facing today, not just with nursing, but in many other of the health professions is adequate remuneration. This has been a group of workers that have not benefited to the same extent as have other types of workers, in terms of compensation, and I think we are feeling this now. We have not been able to recruit into the health professions the same number of people that can be recruited into other fields that have made tremendous strides economically in the last few years. I think something must be done to make it more attractive for young peope to choose a career in the health field, so that we can begin to make some headway.

Now although we actually have had an increase in the numbers of young women and young men going into nursing, percentagewise, we are not recruiting the same percent of young high school graduates into nursing now that we recruited 10 years ago, because now there are so many other opportunities, even in the health field, that compete with nursing. Nursing is sort of low man on the totem pole, as far as compensation is concerned.

But we hear all the time about the great shortage of nurses, and I think one resource that we haven't tapped, and I think we are not going to tap, unless we do something about compensation, is the large number of young married nurses with families, whose husbands feel that it is really not beneficial for them to go back to work at the current salary level, because by the time they pay for babysitters and housekeepers to take care of the children, the amount of income doesn't really justify the expense to the family.

Now I think this is a resource. We have figures to indicate there are over 140,000 young married women who are currently registered, licensed, to practice nursing, who are not working, and I believe one of the deterrents is the rate of compensation.

Mr. ROGERS of Florida. Congressman Gilligan?

Mr. GILLIGAN. No questions.

Mr. ROGERS of Florida. Congressman Curtin?

Mr. CURTIN. Thank you, Mr. Chairman.

Mrs. Dolan, I understand from your statement that you feel that if there was an allocation of funds in general grants, that this would eliminate some of these duplications in the categorical funding and project grant funding, and that they could be cut down. If this was done, could we end up by spending about the same total in a State by reducing the amount in categorical funding and project funding, and putting those savings in general funding?

Mrs. DOLAN. Well, I don't feel qualified to make a statement to the effect that categorical funds need to be reduced. I do feel that we need to increase the support for basic general health services.

I think one of the reasons we have had to resort to categorical funds is because health problems have been created, because of the lack of support for basic health services, and we haven't really been able to meet the demand, so we use the specialized approach. And if you don't have good basic health services, certain things are neglected, which paves the way for increasing problems, and so we have used the specialized approach to attack some of these problems.

I think these things have to go hand in hand. I think we have got to have a basic floor, and that must be adequate, for general health services, and then if we have specialized problems, and we want to make a real impact on those in a short period of time, I think the categorical approach or the project grant approach is a very useful mechanism, if they are adequately planned and coordinated.

Mr. CURTIN. Thank you. That is all, Mr. Chairman.

Mr. ROGERS of Florida. I was very much interested in your example of how the various agencies allocating money for health programs would require for instance, in the TB program, the nurse who would handle the TB program would have only that as her activity. Maybe you can advise us as to the agencies or the funds which are most restricted in this matter; perhaps later for the record, if that information isn't readily available now. I think this would be helpful, because I think this is shocking, and that we are regressing where, if there is a family that needs help and you have to send one nurse to treat the TB, one nurse to treat heart, and one to treat another problem, that this is a ridiculous use of manpower, a waste of manpower.

And where we have critical shortages today, particularly in the nursing field, to not only encourage an improper use of the manpower, but to demand an improper use in the way Federal funds actually are being used, why, this is absurd.

Mrs. DOLAN. Well, it has been reported to me that there have apparently been administrative decisions made, requiring that specialized nurses be employed. Now this has been reported to me as occurring in the area of special tuberculosis project grants, and it has also been reported to me to the area of vaccination funds.

Now both of these activities, I know, in some places, have been carried on by the use of the generalized approach, the family centered approach. In some places, they have had to change this. They have been told this can no longer exist. They must become specialized.

Now I think there is a real place for specialized nursing consultants, to work with your generalized staff, but at the point of delivery of service to families, I think it must be generalized.

Mr. ROGERS of Florida. I would agree.

Now let me ask you this: Well, I would think you would want your generalized nurse to go out, and then when she finds people who happen to have a special problem, have them brought into the clinic for the consultant or the specialized nurse, who can spend her time doing only that.

Now there is great competition, you say, for a limited supply. In other words, there may be one program that is going to pay the

nurse more, and now I believe we are finding that the schools are getting aid from the Federal Government to hire nurses there, rather than to keep it in the Public Health Service. So we are getting not only a duplication, but we are having a shifting of personnel, simply because of a different pay incentive.

Is this correct?

Mrs. DOLAN. That is right.

Mr. ROGERS of Florida. Is there any suggestion that you would have for eliminating that? I guess it may have to be done here through legislation.

Mrs. DOLAN. Well, I think that requirements of joint planning and coordination should be incorporated into either the legislation or the administrative regulations. There must be coordinated planning at the local level, and project grants must demonstrate that there has been adequate participation by those agencies already existing in the community that are involved in these activities. They should participate in the planning. The use of the contract procedure, where a school might be able to purchase, through a contractual arrangement with the local health agency the nursing service needed.

Mr. ROGERS of Florida. I see.

Now are most of these restrictions as to the use of personnel emanating from the Federal level, or from the State level, or from the local? As to the nurse being used in tuberculosis problems only, and so forth?

Mrs. DOLAN. Well, as it has been reported to me, this has been a restriction that has come from the Federal level, rather than from the State.

Mr. ROGERS of Florida. Yes. Now let me ask you this: We have had some difficulty in the training of the nurses program, in trying to get the junior colleges adequately used. What is your feeling on that? Don't you think this is a great potential source if it could be used adequately?

Mrs. DOLAN. I think there is a great need for increasing the educational opportunities for the training or the education of nurses in community colleges and in 4-year college programs.

I think there is a need for the whole system of nursing education to move into the general stream of education, rather than requiring or having service agencies to bear this kind of responsibility. I think that the education and training of nurses is a responsibility of the educational system of our country. I believe, and am hopeful, that Congress will increase appropriations for construction funds, for new community college programs, and 4-year baccalaureate programs.

I do feel that there must be concern about the availability of faculty, an adequate faculty, and I believe also there must be an adequate system of accreditation, in order that we can be sure that the products of these programs are then eligible to write the licensing examination, because we really haven't produced a nurse until she is able to write and pass the license examination, and is then eligible for practice. I think we have to be careful that this development and expansion is an orderly one, so that standards are adequately safeguarded.

Mr. ROGERS of Florida. Yes. Well, now, is there any reason why a regional accrediting agency can't accredit the schools?

Mrs. DOLAN. Well, I believe that regional accreditation does not accredit the individual programs. They only accredit the institution,

as a general educational institution. And it is my belief that when we are concerned with the training of personnel who are responsible for personal services, like nursing, and medicine, or social work, where people who are dealing so closely with these types of personal services, that accreditation of institution is not enough, so there should be some system of accreditation where people who are competent within the area are able to pass on the standards of the particular program.

So I do not feel that regional accreditation of just the institution, without taking a look at the curriculum of the particular program and the resources of that school to reach its objectives as identified by that school, is adequate.

Mr. VAN DEERLIN. Will the chairman yield?

Mr. ROGERS of Florida. Yes.

Mr. VAN DEERLIN. To what national organization, Mrs. Dolan, would you have Congress look for advice in preparing legislation that has to do with accreditation?

Mrs. DOLAN. Well, I believe that accreditation should be a voluntary, nongovernmental activity, and I think that in the professional areas, accreditation should be by the profession that is involved, and by recognized, voluntary agencies that carry this responsibility.

Mr. VAN DEERLIN. Well, if a difference of viewpoint should develop between some of these voluntary agencies, in a field of nursing, to whom should we turn for advice?

Mrs. DOLAN. Well, I think the National Commission on Accreditation may be a very useful group to turn to, because this is the group that is responsible for coordinating, as I understand it, all kinds of accrediting programs. And I think that the National Commission on Accreditation could be a very helpful group in resolving any differences in this.

Mr. VAN DEERLIN. Thank you.

Mr. ROGERS of Florida. Do you think that Federal funds that would normally go to an institution should be refused if a private, voluntary groups says, "No, we don't want those Federal funds to go there"?

In other words, should the determination of use of tax dollars be turned over to a voluntary, nongovernmental unit to decide where those funds in effect go?

Mrs. DOLAN. Well, I believe that public funds should only be used in those cases where the agency or the institution has met nationally recognized standards. I think we have a responsibility that public funds, whether they be Federal or State funds, that the public has a right to expect that the institutions receiving those funds meet certain national standards of excellence.

Mr. ROGERS of Florida. Yes, now should those standards be set by the Government, if they are Federal funds, or do you just leave it to any voluntary group?

Mrs. DOLAN. Well, if it is an educational institution, and I am thinking now of accreditation of educational institutions, I think this should be a voluntary function, and not a governmental function.

Mr. ROGERS of Florida. Well, do you think Federal funds should go in there?

Mrs. DOLAN. We use this in all other areas, and I think nursing should follow this. For medical education, we look to the accrediting agencies of the American Council on Medical Education, and I think

all professional groups have identified national accrediting agencies, and they have been accepted by the profession and by the public as the group who has the competence to make those judgments.

Mr. ROGERS of Florida. I was thinking of accrediting junior colleges. We have great difficulty in getting them accredited, because there has been a feeling in the National League of Nursing that everybody ought to be a 4-year nurse.

Mrs. DOLAN. Well, no. The National League for Nursing accredits diploma programs, they accredit community college programs, and they accredit 4-year baccalaureate programs.

Now the agency has to request accreditation.

Mr. ROGERS of Florida. Well, and suppose there is a State agency where the nurses are involved in setting the State program. Do you still think it is necessary for them to go to the National League of Nursing, if the State nursing organization sets standards for the State?

Mrs. DOLAN. Well, the State agency that accredits is the Board of Nursing, which is a legally constituted body. We find that standards from State to State vary to such an extent that nurses who may graduate from an accredited school in one State that has maybe low standards would not then be eligible for licensure in another State, with higher standards, and so therefore, we believe that we should strive for some kind of overall national accreditation, so that the nurse who graduates from a nursing school in North Carolina is eligible to take the license examination, and she could practice in Michigan or New York or California, because we believe that her competence to practice should be determined on the basis of her knowledge and skill, and not from where she happened to receive her education, or the State.

Mr. ROGERS of Florida. Yes.

Now let me just pursue this, and I am not going to pursue it long. The determining factor is whether she passes an examination or not; is it not? Basically, this is how we determine a nurse may practice nursing.

Mrs. DOLAN. That is right.

Mr. ROGERS of Florida. Now it doesn't matter really, as far as her knowledge goes, as to whether she came from an accredited school, a 2-year course, or a diploma school in a hospital, if she can pass that examination. This is what we say now.

Mrs. DOLAN. That is right.

Mr. ROGERS of Florida. As a matter of fact, in my State, in Florida, the 2-year nurses have made higher marks than the 4-year nurses. But——

Mrs. DOLAN. Well, Florida is one of those fortunate States that has an excellent community college program.

Mr. ROGERS of Florida. That is right. So they should not be barred from Federal funds.

Mrs. DOLAN. But this does not exist in all States, unfortunately.

Mr. ROGERS of Florida. I would agree with you.

Now, but they would still have to pass the examination, you see, before they could practice in any State.

Mrs. DOLAN. Yes.

Mr. ROGERS of Florida. And pass the same examination that the 4-year nurse or anyone else has to pass. Is that not right?

Mrs. DOLAN. You are right, but the problem is, the student who may spend 2, 3, or 4 years in an educational program that doesn't prepare her, she writes that examination, and she fails.

Now the public then does not have a nurse, and the nurse has invested 2, 3, or 4 year in an educational program where she assumed that the quality of that educational program would prepare her to write and pass that examination.

Mr. ROGERS of Florida. Well, of course this could happen with any institution, in fact; but this also is getting into another area—Should we put money in those schools that need to be upgraded, or not?

Mrs. DOLAN. Well, this is true, and the accreditation process permits this through a "reasonable assurance" category [allowed for a loss for reasonable expectation] that they will reach accreditation.

Mr. ROGERS of Florida. And accreditation actually only means they come down and look about once every 6 years.

Mrs. DOLAN. Well, the accreditation program now provides that every school is reevaluated every 5 years.

Mr. ROGERS of Florida. Every 5 years.

Mrs. DOLAN. That is right.

Mr. ROGERS of Florida. We kind of got off on that subject here a little bit, but it ties in very definitely with some of the problems. Your testimony has been most helpful. I think you have pointed out a real problem, and a trend that is being forced from Washington on all of our health agencies by getting away from general health matters, and getting into this categorical approach, which is wasting manpower, and doubling our cost, probably.

Thank you so much. We appreciate you fine testimony.

Mrs. DOLAN. Thank you very much.

Mr. ROGERS of Florida. Our last witness this morning is director of health of the State of Washington, and the distinguished president of the Association of State and Territorial Health Officers, Dr. Bernard Bucove.

Dr. Bucove, it is a pleasure to have you with us this morning, and we appreciate your being here, to give us the benefit of your testimony.

STATEMENT OF BERNARD BUCOVE, M.D., D.P.H., PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, AND DIRECTOR, WASHINGTON STATE DEPARTMENT OF HEALTH

Dr. BUCOVE. Thank you, Mr. Rogers, gentlemen, my Governor has indicated to me that I may speak for our State as well as for the State health department, and as president of the Association of State and Territorial Health Officers, I feel I can reflect the feelings and concerns of that body, though the statement I have prepared has not been reviewed by it, Mr. Chairman.

Mr. ROGERS of Florida. All right.

Dr. BUCOVE. I do have a prepared statement which takes a little more than the assigned 20 minutes, and so I have prepared a shortened version to present this morning in order to leave some time for questions, if you do desire.

Mr. ROGERS of Florida. All right, fine, and we will put in your prepared statement as a part of the record at this point, without objection, and then you may proceed as you desire.

Dr. BUCOVE. Thank you.
(The statement referred to follows:)

STATEMENT OF BERNARD BUCOVE, M.D., D.P.H., PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, AND DIRECTOR, WASHINGTON STATE DEPARTMENT OF HEALTH

The State Health Officers across the nation were most interested when the establishment of this special subcommittee was announced, and I am grateful for the opportunity to appear before you. Your area of inquiry is obviously of considerable concern to those of us who work at the state level in the field of health. We are the middle-men in the federal-state-local chain, and therefore feel the pressures from both directions. We are at times frustrated, troubled, and torn, when in the presence of our own inability to muster state and local resources to meet growing demands in the health field, our problems are further complicated by fragmentation of health responsibilities at the federal level, the tendency of federal agencies to by-pass state agencies, and the increasing rigidity in the use of federal grants.

From our point of view your deliberations are most timely. Recent actions by the Congress are indications of the nation's growing concern for the resolution of problems in health matters through timely, well planned application of our newest scientific knowledge. There are increasing indications that the health professions in the private sector are arriving at a clearer recognition of the need to move with all of the social forces toward the coordinated delivery of comprehensive health services for the nation. Secretary Gardner has only recently undertaken his own study of the organizational structure of the Deprtment of Health, Education, and Welfare, the relationships between the various agencies in that Department which have health responsibilities, and how these factors affect federal-state-local ability to function well together. I am strongly of the opinion that the nature of the leadership we currently have in the Department of Health, Education, and Welfare, and in its major health agency, the Public Health Service, is such that it will take full advantage of these activities. If given the proper tools, I feel certain that the Secretary and the Surgeon General will proceed to help us forge a true federal-state-local partnership in keeping with our system of democratic free enterprise, which will move the health of our nation, and of others, to new heights.

For all of these reasons, I feel that these hearings are both important and timely. They hold the potential of considerable significance to the health of all our people, and those of us who labor and practice in the health fields. I can assure you of the full cooperation of the Association of State and Territorial Health Offcers, not only in these deliberations, but in the furtherance of those recommendations and actions which may result from them which will help us do our job better.

The fact that your subcommittee has been established is ample evidence that the Congress recognizes action by that body is a powerful factor, if not the most powerful factor, in influencing the manner in which the Department of Health, Education and Welfare functions. Your investigations as well as those of the Secretary and the Surgeon General must, therefore, complement each other. I would like to focus for a few minutes on the congressional aspects of the issues under consideration before commenting on the Department itself.

It is, of course, no secret to you that the phraseology of federal legislation and congressional intent, as expressed in committee hearings and reports, sets the stage for federal-state-local relationships, and thus often determines whether these will be weakened or strengthened. The requirements that are to be met by state and local agencies can, and often do, put the federal administrative agencies in the position, not only of dictating program activities, but administrative and even organizational patterns as well.

Too often (and in my way of thinking, once is too often) federal legislation appears to be unmindful of the historical and constitutional fact that municipal government is a part of state government. Channels to local agencies are opened and the federal agencies are encouraged to relate directly to them.

The reasons most often given for direct relationship stem from alleged inaction on the part of state governments. Lack of action on the part of only two or three states is sufficient to spark pressure for this kind of action. I would like to suggest that there must be better ways to resolve this kind of problem than saddling the entire nation with an approach that is inimical

to federal-state-local relations. Particularly is this regrettable when the mechanisms developed serve to repress state and community initiative where this does exist.

Federal action appears to develop from an understandable desire on the part of the Congress and the federal agencies not only to get things done, but to feel that *they* are doing them. Please do not misunderstand me. I am for a strong and forceful Congress, and strong and forceful congressmen. But I am also for strong, forceful local and state government and, particularly in matters of health, I would like to see congressional action which reinforces state government, and enables it to stimulate and support local government to action.

I recognize that some basic problems of government are involved here which are much broader than public health. Perhaps it will be impossible to resolve our problems of relationship in the health field until solutions to the more basic ones are found. I would hope not. Indeed I would hope that as a result of deliberations by this subcommittee, the means will be found which will point the way to a resolution of the broader problems.

I would like now to turn to the matter of the multiplicity of federal agencies involved in the administration and distribution of federal health funds. At the outset I would want to point out that it is not just a matter of simply keeping a current list of where we turn for monetary support. Consultation, and other supports, in our endeavors to move forward in new ways, or to strengthen ongoing programs, is as much involved as funding. These other supports and the development of channels of communication go with the funding authority, and herein lies one aspect of the problem. The more funding agencies which exist, the more we have to relate to, and the more channels of communication have to be established, the more fragmented, complicated and costly these channels become. Coincidently, the more diluted the responsibility of the major federal agency becomes in these matters, the more difficult it becomes for that agency to function in a coordinated, comprehensive fashion with the state agencies involved.

Fragmentation at the federal level begets fragmentation at the state and local levels. If fragmentation is bad federally, it is equally bad, and for the same reasons, in the states and locally.

Apart from the complications in relationships and increased administrative costs generated by fragmented responsibilities, is the element of competition that is introduced in such a situation. Competition in our society is considered a positive force. But when there is work to be done and problems to be solved, competition between agencies for authority and responsibility can be, and usually is, a delaying, and often destructive element. Competition for program responsibility is often at the root of federal-state problems. Program plans are at times, because of this, developed in secrecy, lest some other agency "steal a march"; inter-agency channels of communication break down as a result, not only between federal agencies, but between federal and state agencies. The need to demonstrate ability to act, in order to win favor in this competition for responsibility, often is at the root of direct federal-local contacts.

This type of competition not only affects the relationships between state and federal agencies, but much time and effort is sometimes devoted to protecting and competing which could be devoted to other more positive activities. Of course, we state agencies take sides too, and so the patterns of behavior are repeated at the state level to the detriment of local implemention of programs.

I have already touched on the item of the tendency of federal authorities to by-pass the state health authority when sponsoring health projects and activities within states. I have attempted, up to this point, to arrive at some of the underlying reasons for this tendency. Primarily, I see it comes as the result of an abiding desire on the part of people in these agencies to get a job done, to get as close to the problems as possible, and to be able to demonstrate a direct relationship between their activities and the successes achieved. Perhaps this is the best way to go about getting results. Perhaps with modern communications, state government *is* becoming obsolete. I would hope not. Inevitably the federal agencies would have to find some substitute for the state and local level of operations, as they already have in some existing federal operations such as social security. But in matters of health, and in other social functions, motivation and assumption of responsibility on the part of individuals is of

paramount importance in determining whether health services and resources will be sought out and utilized. Simply making services and resources available is not enough. People have to be stimulated to use them, and use them at a time when they will be most productive in the maintenance and fostering of good health. This requires involvement. Not merely involvement through a contribution in tax moneys to the federal government. This is much too remote and passive to spark positive action. What is needed is the kind of commitment that comes from communities and individuals in recognizing a problem, becoming aware of whatever assistance they may need in developing their own plan for action, evaluating their own resources, establishing their own system of priorities, and in an orderly fashion, the resources they need to furnish themselves with the services and facilities required to meet their needs.

In order that this might be accomplished, it is essential, it seems to me, that the state agencies not be moved in the direction of becoming mere branches of the federal agencies. An evolutionary trend in this direction is already quite evident, and the tendency of federal authorities to by-pass state agencies is hastening this along. Many examples of this can be cited, and seem to be increasing in frequency rather than the reverse.

The project mechanism, with its promise of federal dollars, lends itself quite well to the trend toward direct federal-local channels of communication. While doing away with the "middle man" may theoretically seem to be a desirable thing, I feel certain that some of the problems we are experiencing in such newer programs as the "War Against Poverty" would not be occurring if responsibilities had been planned and channelled through existing federal and state agencies in a more orderly way.

To put it rather simply, let us not be so hasty in our desire to apply remedies to problems, that we do not recognize the far reaching and long lasting effects of the manner in which these remedies are applied, on individual initiative and local enterprise, and similarly on state government's initiative and ability to function.

This brings me to the third issue of major concern. The desirability of allowing the states greater flexibility in spending federal grant money. It need hardly be pointed out that there is a wide divergence in the nature and degree of problems which require resolution in our 54 states and territories. The resources and ability of these entities of government to take issue with such problems varies just as widely. This is just as true at the municipal level.

It follows, therefore, that there must be some degree of flexibility in the spending of federal grant money. This has long been recognized. However, with the passage of time, and the desire of the Congress to address itself to matters which have emerged as national priorities and similar pressures from federal agencies complicated by those stemming from the problems of fragmentation, we find in many instances that services and efforts at the local level are out of balance. Developments in some parts of the country have thus not been in the areas of greatest need for those particular communities. By taking advantage of a specific federal program, a state or community may find its own limited resources so engaged that it is unable to address itself to what, for that particular geographic area, are more pressing and more basic health problems. We at the state level *do* have responsibility for the health of the people in those states. The state agency must evaluate the main threats to the public health in its area of authority, develop mechanisms for the determination of priorities, and the implementation of program. Assistance in carrying out these responsibilities has been and always will be welcome. But flexibility in the use of federal support and assistance is essential in this "crazy quilt" background of needs and resources in which we work. In turn the state agency must allow for this same degree of flexibility at the local scene.

The categorical approach, while it has served a very useful purpose, and perhaps will continue to serve a useful purpose, has nevertheless become too restrictive in many respects. First, as I have indicated above, it binds local and state resources and activities to the special categories, to the detriment of what may indeed be more pressing problems in certain particular areas. Secondly, the federal administrative agency by interpreting the intent of Congress through further restrictive language in rules and regulations contributes further degree of inflexibility. Accounting then gets to be a problem and I would suggest that if there were fewer categories, and fewer restrictions, accounting could be a great deal simpler, less time consuming, and less costly.

These problems, associated with the categorical approach, are more sharply evident in the use of the contract mechanism as now utilized by the federal government to develop new health programs, while maintaining some kind of relationship with a state agency. Here the degree of inflexibility is even more marked.

The contract mechanism has been conceived as a means whereby state and local agencies can be used to implement federally conceived plans, addressed to federally viewed needs and federally developed priorities. It is therefore the antithesis of what I have been saying is needed in order to spark action on the part of individuals, communities and states.

I would like to make the following recommendations relative to the three general issues for your consideration:

From time to time it has been suggested that the solution to the problems which arise from the multiplicity of federal agencies with major health responsibilities, lies in the establishment of a separate Federal Department of Health with Cabinet status. Ultimately this may be necessary. However, I believe at this time that it would be more advantageous to retain the current operation within the Department of Health, Education and Welfare, and the Secretary be encouraged and assisted to reassign major responsibilities in health to the Public Health Service. It is manifestly impossible, and perhaps not even desirable to delineate and dissect out, all health responsibility from the number of agencies with health concerns of one degree or another. And so, having established the Public Health Service as a major health agency, in fact as well as in name, particularly with regard to the distribution and administration of federal health funds, there will still be a need for the Service to develop close liaison with all of the other federal agencies with health concerns and responsibilities.

The success of this would be enhanced, it seems to me, with strong leadership within the umbrella of a broad department such as Health, Education and Welfare. Only after there has been a clear definition of responsibility within individual units of the Department, and good interagency relationship with sound mechanisms for continuing these relationships, could a cleavage into separate departments be effected without adding to our problems.

A reconstructed regional office, in keeping with the changes suggested above, would be a positive force in the maintenance of good federal-state relationships. The Regional Office staff is close enough to, and has the time and interest to visit the area as necessary. It thereby gains a clearer understanding of our problems, our strengths, and our weaknesses, and is much more able to respond quickly and sympathetically to our needs than is possible for the staff of the Washington, D.C. office. Reinforcement of the role of the Regional Office along with a resolution of the problem of fragmentation, would set the stage for a greatly strengthened federal-state-local partnership.

Involving the state health agency in all aspects of federally sponsored health projects and activities which are program-oriented, is certainly desirable. Such an involvement could do nothing but enhance the coordination of these projects and the integration of their products into on-going or newly developed state and locally supported activities. State agencies should be looked to by prospective applicants as the first port of call for support in the development and submission of such applications. The state agency should be involved in the review process in the actual granting mechanism, and in the periodic evaluation of such projects. If this were done deliberately and conscientiously, I feel certain that better projects would result, that there would be a greater possibility of worthwhile activities demonstrated by such projetcs being continued and replicated in other parts of the state, to say nothing of what this would do to strengthen the ability of the state agency to function as it should.

A desirable degree of flexibility in the spending of federal grant money, combined with accountability, is contained in a well prepared bill presently before Congress. This is H.R. 13197 introduced by Congressman Staggers. Its counterpart in the Senate is S. 3008. Passage of this bill, the Association of State and Territorial Health Officers believes, will do much, not only in providing this degree of flexibility, but by supporting comprehensive planning, and basing continuing federal support on such a plan would do much to enhance coordination, at least at the state and local levels of government.

Thank you for the opportunity to make this presentation. I will be happy to answer any questions you may wish to direct to me.

CURRICULUM VITAE

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Personal: Born—Ontario, Canada. Married—Children, 4 Sons. Citizenship—U.S. Citizen.

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Academic:

University of Toronto—M.D. 1937—D.P.H. 1946.

Specialty—Public Health and Preventive Medicine.

Practice: Private Practice Saskatchewan—Rockglen (1939-41), Foam Lake (1948-49).

Military Service: Major, Medical Corps, Canadian Army 1941-1945.

Public Service:

Regional Health Officer, H.R. #3, Saskatchewan 1946-1948.

District Health Officer, Thurston-Mason County Health District, State of Washington 1949-1954.

Chief, Division of Local Health, State of Washington Department of Health 1954-55.

Director, State Department of Health, and Chairman State Board of Health, State of Washington 1955 to present.

Professional Licenses and Societies:

Licensed as M.D. in State of Washington.

Licentiate Medical Council of Canada.

Fellow, American Public Health Association.

Member, Western Branch, A.P.H.A. and Washington State Public Health Association.

Charter Member, American Association of Public Health Physicians.

Member, Washington State Medical Association.

Member, American Medical Association.

Member, Royal Society of Health, England.

Past Assignments and Affiliations:

Past President, Washington State Local Health Officers' Association.

Past President, Conf. of State & Provincial Health Authorities of North America—1963.

Member, Advisory Committee U.S. National Health Survey, 1957-1962.

Member, Governing Council American Public Health Association, 1957-1965.

Member, Advisory Committee to Cancer Control Program U.S.P.H.S., 1959-1965.

Chairman, Governor's Inter-Agency Com. on Health, Education & Welfare Programs, 1958-1966.

Chairman, Committee on Long Term Illness and Problems of the Aging, Association of State and Territorial Health Officers, 1960-1962.

Member, Advisory Committee to Research Utilization Branch of National Institute of Mental Health, 1963-1966.

Member, Surgeon General's Ad Hoc Com. on Planning for Mental Health Facilities.

Member, Surgeon General's Ad Hoc Com. on Planning for Mental Health Activities.

Current Assignments and Responsibilities:

President, Association of State and Territorial Health Officers, 1965-.

Member, Health Insurance Benefits Advisory Council, 1965-.

Member, Advisory Committee of State Officials to Atomic Energy Commission, 1960-.

Member, Washington State Advisory Committee to Selective Service System, 1961-.

Member, Surgeon General's Adv. Com. on Community Health Services & Facilities, 1961-.

Member, Governor's Inter-Agency Com. on Health, Education & Welfare Programs, 1966-.

Associate Clinical Professor, Dept. of Preventive Medicine, University of Washington, 1958-.

Member, The President's Committee on Employment of the Handicapped for the State of Washington, 1966-.

Dr. BUCOVE. The statement is confined primarily to the three general issues as confined in your letter of April 5. The timeliness of your deliberations can't be overemphasized, and we State health officers, who are the middlemen in the Federal-State-local chain, are grateful for this opportunity to be heard.

There is great forward movement in all sectors of health in the Nation today, and the manner in which the major Federal agency with health responsibility is organized and the manner in which it relates to State and local government will have a considerable bearing on the manner in which the developments take place, the degree of success attained, and the types of problems which occur.

Your investigations, I am sure, will compliment the studies now being completed by the Secretary of the Department of Health, Education, and Welfare, and the Surgeon General in these same areas of concern.

I can assure you of the full cooperation of the Association of State and Territorial Health Officers, not only in these deliberations, but in the furtherance of those recommendations and actions which may result from them, and which will help us do our job better.

I will point out briefly something which you already know quite well. Namely, that the phraseology of Federal legislation and expressed congressional intent is probably the most powerful factor affecting Federal-State-local relationships.

I would therefore like to have you recognize that the health officers of this Nation are anxious to do their jobs, and jealous of their responsibilities and authorities. We feel that if given the proper tools, we can help our local governments and our people as individuals carry forward their responsibilities in health matters better than any other organization of government.

We would plead to you, therefore to review every piece of Federal legislation, health legislation, that is, to determine whether it strengthens or weakens our ability to function.

The multiplicity of Federal agencies involved in the administration and direction of Federal health funds has several severely negative effects on the health programs of the States.

If it were simply a matter of keeping a current list of where we turn for monetary support, it wouldn't be terribly bad, but with the funding responsibility go necessary consultation, training responsibilities, and other supports to the States, and the need to develop channels of communication. It therefore follows that the more funding agencies there exist, the more complex and costly the channels of communication become.

Coincidentally, the more diluted the responsibility of our major health agency in these matters, the more difficult it becomes for that agency to function in a coordinated, comprehensive fashion with the State agencies involved.

Fragmentation at the Federal level begets fragmentation at the State and local levels, where it is equally as bad, and for most of the same reasons.

Competition between agencies arises as a result of fragmented responsibilities, and in this kind of situation, instead of being a positive force, it can be, and usually is, a delaying, destructive, and costly element. It affects States in several ways. It affects our relation-

ships not only with the several Federal agencies involved, particularly if we see them favor one as opposed to another, but affects our relationships with counterpart Federal, State, and local agencies.

It has been, I believe, one factor which has generated direct Federal-local contacts. This is done in order to demonstrate ability to function and function quickly, so that the agency will then have the appearance of vitality and capability in this competition for responsibilities.

In addition, competition of this type takes considerable time and effort, which could be devoted to other, more positive activities. Of course we State agencies do take sides, and so the patterns of behavior are repeated at the State level, to the detriment of local implementation of the program.

The bypassing of the State health authority does take place, and many annoying instances can be cited. Apart from the suggestion that competition between Federal agencies may be a factor here, I see this as primarily a result of an abiding desire on the part of people to get a job done, to get as close to the problems as possible, and to be able to demonstrate and feel a direct relationship between their activities and the successes achieved.

I sympathize with them. I feel the same way, but I feel it is a self-defeating approach in solving most public health problems. In matters of health, motivation and the assumption of responsibility on the part of individuals is of paramount importance in determining whether health services and resources will be sought out and utilized.

Simply making funds, services, and resources available is not enough. People have to be involved through a commitment that comes from individuals in a community, recognizing a problem, becoming aware of the assistance they need in developing their own plan for action, evaluating their own resources, establishing their own priorities, and in an orderly fashion, the additional resources required to furnish themselves with the necessary services and facilities.

We State health officers feel we can do this kind of job well. We often do need assistance in the form of consultation, training, and other aids, and when we get it, it is most appreciated, particularly because it is usually of high caliber. But when direct contacts are made by Federal agencies, it can be most disruptive to this whole procedure.

I might cite an example. We feel that in this approach, there ought to be flexibility as well as flexibility in the grant mechanism, Mr. Chairman. We approach our local health officers, our local health departments, in exactly the same way. We assess their capabilities, and we use their resources to the full, but where they are incapable of performing a certain function, they are always involved, and fully aware of what is going on.

We usually work through them, even though they are incapable of performing.

The project mechanism, with its promise of Federal dollars, lends itself quite well to the development of direct Federal-local channels of communication. While doing away with the middleman may theoretically seem to be a desirable thing, I am convinced that fewer problems would arise, and better projects be developed with greater possibilities of continuation of program arising from these projects

if the Federal agencies were to use the full resources of the State agencies in this mechanism.

With regard to the third issue of major concern, the desirability of allowing the State greater flexibilty in spending Federal grant money, it need hardly be pointed out that there is a wide divergence in the nature and degree of problems which require solution in our 54 States and territories. The resources and ability of these entities of government to take issue with such problems varies just as widely.

This is also true at the municipal level. It follows, therefore, that there must be some degree of flexibility in the spending of Federal grant money. This has always been recognized, and there has been flexibility, but more and more, with the passage of time, we see this flexibility tightening up.

In the categorical approach to Federal grant-in-aid is an expression of national priorities. And, as a result of their application, we find in many instances that services and efforts of the local level are out of balance.

Developments in some parts of the country have not been in the areas of greatest need for those particular communities. By taking advantage of the specified Federal program, a State or community may find its own limited resources so engaged that it is unable to address itself to what for that particular geographic area are more pressing and more basic health problems.

Flexibility in the use of Federal support and assistance is essential in this crazy-quilt background of needs and resources in which we work. The categorical approach, while it has served a very useful purpose, and perhaps will continue to serve a useful purpose, has nevertheless become too restrictive in many respects.

Now the problems associated with the categorical approach are even more sharply evident in the use of the contract mechanism as now utilized by the Federal Government to develop new health programs. Here the degree of inflexibility is even more marked. The contract mechanism has been conceived as a means whereby State and local agencies can be used to implement federally-conceived plans, addressed to federally viewed needs, and federally developed priorities.

It is, therefore, the antithesis of what I have been saying is needed in order to spark action on the part of individuals, communities, and States.

I would like to make the following recommendations relative to the three general issues for your consideration.

From time to time it has been suggested that the solution to the problems which arise from the multiplicity of Federal agencies with major health responsibilities, lies in the establishment of a separate Federal Department of Health with Cabinet status. Ultimately this may be necessary.

However, I believe at this time that it would be more advantageous to retain the current operation within the Department of Health, Education, and Welfare, and the Secretary be encouraged and assisted to reassign major responsibilities in health to the Public Health Service. It is manifestly impossible, and perhaps not even desirable to delineate and dissect out, all health responsibility from the number of agencies with health concerns of one degree or another.

And so, having established the Public Health Service as a major health agency, in fact as well as in name, particularly with regard to the distribution and administration of Federal health funds, there will still be a need for the Service to develop close liaison with all of the other Federal agencies with health concerns and responsibilities.

The success of this would be enhanced, it seems to me, with strong leadership within the umbrella of a broad department such as Health, Education, and Welfare.

Only after there has been a clear definition of responsibility within individual units of the Department, and good interagency relationship with sound mechanisms for continuing these relationships, could a cleavage into separate departments be effected without adding to our problems.

A reconstructed regional office, in keeping with the changes suggested above, would be a positive force in the maintenance of good Federal-State relationships. The regional office staff is close enough to, and has the time and interest to visit the area as necessary.

It thereby gains a clearer understanding of our problems, our strengths, and our weaknesses, and is much more able to respond quickly and sympathetically to our needs than is possible for the staff of the Washington, D.C., office. Re-enforcement of the role of the regional office along with a resolution of the problem of fragmentation. would set the stage for a greatly strengthened Federal-State-local partnership.

Involving the State health agency in all aspects of federally sponsored health projects and activities which are program oriented, is certainly desirable. Such an involvement could do nothing but enhance the coordination of these projects and the integration of their products into ongoing or newly developed State and locally supported activities.

State agencies should be looked to by prospective applicants as the first port of call for support in the development and submission of such applications. The State agency should be involved in the review process in the actual granting mechanism and in the periodic evaluation of such projects. If this were done deliberately and conscientiously, I feel certain that better projects would result, that there would be a greater possibility of worthwhile activities demonstrated by such projects being continued and replicated in other parts of the State, to say nothing of what this would do to strengthen the ability of the State agency to function as it should.

A desirable degree of flexibility, in the spending of Federal grant money, combined with accountability, is contained in a well-prepared bill presently before Congress. This is H.R. 13197 introduced by Congressman Staggers. Its counterpart in the Senate is S. 3008.

Passage of this bill, the Association of State and Territorial Health Officers believes, will do much, not only in providing this degree of flexibility, but by supporting comprehensive planning, and basing continuing Federal support on such a plan would do much to enhance coordination, at least at the State and local levels of government.

Thank you for this opportunity, and I would be happy to answer any questions.

Mr. ROGERS of Florida. Thank you, Dr. Bucove. Members of the committee? Congressman Younger?

Mr. Gilligan?

Mr. GILLIGAN. No questions; thank you.

Mr. ROGERS of Florida. I was interested in your comment when you said you did not think it was now time to have a separate Department of Health.

It has been suggested by other witnesses that the Secretary of HEW does need a line officer, not just a staff man, but perhaps an Under Secretary of Health. Does this conform to your feelings?

Dr. BUCOVE. Yes, it would, Mr. Rogers, and frankly, I have been thinking that at the State level, we ought to emulate much the same kind of structure as we find at the Federal level.

I feel many of our problems, particularly with the welfare agencies where we are finding a growing encroachment, if that is the word, into the health field, that if these two agencies were combined at the State level with a strong director, in a position to coordinate our activities, we would all be much better off.

Again with line people in charge of the specific areas.

Mr. ROGERS of Florida. I understand from your testimony, too, you feel that the regional offices should be beefed up, in effect.

Dr. BUCOVE. Yes, I do. My reason being that the regional offices, having fewer areas to concern themselves with, get to know us better, they do know our strengths, our weaknesses, we can relate to them much more easily, and they are much more sympathetic to our problems.

Mr. ROGERS of Florida. Yes. Well, now, what would you say is the main difficulty that State health people have with the Department as to its health functions?

Dr. BUCOVE. I think that problem is fragmentation, if I were to single out anyhing at all, this would be it.

Mr. ROGERS of Florida. It is just hard to center on who has the responsibility for what programs, too many programs coming out, and it makes it difficult to deal with.

Dr. BUCOVE. That is correct, sir, and again title 19 is posing some very acute problems in this regard. In title 19 of the medicare law, there are considerable health aspects, and in most States, the responsibility for administration has been assigned to the Department of Welfare.

Now a number of us have developed good working relationships with our departments of welfare, and I would hope that this will continue.

I have some concerns, I must say, that with the stimulus of title 19, and the kind of support our State agencies are getting from the Federal agencies in welfare, I am very much concerned that we will find some of our welfare departments really developing health departments within their agency.

Mr. ROGERS of Florida. Will that increase the cost of duplication, if this were to develop?

Dr. BUCOVE. This is one of the reasons given for this. As a matter of fact, it is my understanding that the Federal agency has been telling the States that this is the direction in which they must go.

Now I don't read this in the legislation, but this is what I am told that they are saying.

Mr. ROGERS of Florida. They must do it through the welfare department?

Dr. BUCOVE. That is correct.

Mr. ROGERS of Florida. Rather than through the health department.

Dr. BUCOVE. They are being discouraged from going to the health departments. As a matter of fact, Mr. Chairman, I was told this morning something we were told has already occurred in the State of Michigan. Dr. Heustis' deputy—Dr. Heustis being the State health officer for the State of Michigan—has just been hired by the welfare agency to set up health programs under title 19 in the department of welfare.

Recently, too, at a meeting in Chicago, I heard the director of the department of welfare of another State remark in public that if he wasn't going to get things done by his State health department in the way that he wanted them done, he was going to set up his own health agency. Just as bluntly as that. And I don't think this is good, and I don't believe that this was the intent of Congress.

Mr. ROGERS of Florida. Has your association taken this up with the Secretary of HEW?

Dr. BUCOVE. Yes, on several occasions. We have.

Mr. ROGERS of Florida. What reaction have you gotten?

Dr. BUCOVE. He listened very carefully. I don't know. I know that there have been some discussions with the commissioners involved, and we have been at times mollified, but we still see things happening, Mr. Chairman.

Mr. ROGERS of Florida. Well, I think it would be helpful to the committee if you could outline some of these problems and the difficulties that come about, and as the public health officers might envision a duplication of effort or increased cost in handling the program through two agencies, when one is already set up to do the work.

Dr. BUCOVE. I would be happy to do so.

Mr. ROGERS of Florida. Would you agree with the previous witness—and I am sure you were here just a few moments ago—who said that the family type nursing is more economical, is a better approach, rather than dividing her activities into a categorical approach as the Federal Government seems to be trying to insist upon?

Dr. BUCOVE. There is no question about this, Mr. Chairman. This has come up in discussions through the State and territorial health officers with the Surgeon General and his staff, and it is my understanding that this problem has now been worked through. As a matter of fact, I don't believe that now, that this is actually the way in which the instructions read. This is the way they were interpreted, but we are now being able to report on the basis of equivalents, equivalent time of a nurse, rather than having to field a specialized nurse or specialized sanitarian, or any other specialized type of people.

Mr. ROGERS of Florida. How much time is this taking up in accounting procedures?

Dr. BUCOVE. Accounting procedures are always a sore point with us, Mr. Rogers, and we had quite an experience in this recently in our own State, where the people from GAO came to visit us for 3 days, and stayed 6 months. It was very enlightening to both of us.

But this matter of accounting, in trying to set out, oh, punching a clock, as it were, and keeping the record of time spent, it gets real difficult—there must be, and can be, as Mrs. Dolan indicated, other ways of accounting.

I would like, on the same point, if I may, to enlarge somewhat on what Dean Wegman suggested: that the auditing procedure, in my way of thinking, is a much better way of determining whether or not the funds are being properly spent.

If I might cite, for example, one might look at how we have spent the newly developed chronic disease moneys, and there are restrictions written into the law here.

One might look at what had actually happened in our State as a result of the infusion of these moneys. The fact that we now had more nursing homes which met our licensing standards; the fact that we had far more nursing homes now which have registered nurses on their staff, and that the ratio of nurses to patients within the homes had gone up exceedingly.

This, to me, was far more important than how much money we were spending for how many people on whose staff. And I think much more realistic——

Mr. ROGERS of Florida. In other words, you were saying to evaluate results rather than just activity.

Dr. BUCOVE. That is correct, sir.

Mr. ROGERS of Florida. Well, this is what we are getting from the hearings, we have the feeling we have developed a system of this accounting that we are stressing activity, it seems, more than results.

Dr. BUCOVE. Right.

Mr. ROGERS of Florida. That seems to be a general criticism of the present operation.

Are there any other questions?

Mr. GILLIGAN. Mr. Chairman, just one to clarify a point I think I understood a moment ago.

Doctor, did you say that presently, under present regulations and procedures, it is not really required that individuals be assigned to individual programs, but that there is some option open to the local health departments and State departments to assign an individual to a number of programs, if some accounting procedure can be set up to account for their time?

Dr. BUCOVE. This is the way we would like to see things done, Mr. Gilligan.

Mr. GILLIGAN. But is it possible now?

Dr. BUCOVE. It is.

Mr. GILLIGAN. The impression I have gained from hearing some of the other witnesses is that it is impossible or illegal to do it now, and I was interested by what I understood you to say that this is at least a possibility today, although maybe difficult of accomplishment.

Dr. BUCOVE. Well, perhaps we are a little more firm in our approach with the Federal agencies than other States, Mr. Gilligan. I do know that when we want to do something a certain way because we feel it is going to bring about the desired result, we press for doing it our way. And in most instances, we are able to convince the Federal agency that this is the way it ought to be done.

Now I mentioned the contract mechanism because we are having exceedingly more difficulty in that approach because here we are told that the Federal agency is purchasing a service from us, and so they are going to tell us, and have indeed told us, what service they are purchasing, what kind of people will be employed, and how many

people will be employed, and even down to where they will be stationed how many desks, and how many telephones, and all.

And this gets most difficult.

Mr. GILLIGAN. Well, I can understand that, under the contract mechanism, but at the present time, have you actually had the experience of, under the categorical program approach, of assigning an individual to activities in one or more of these categorical fields, and simply splitting up their time by some sort of accounting procedure?

Dr. BUCOVE. Yes; we have done this.

Mr. GILLIGAN. Thank you, sir.

Mr. ROGERS of Florida. Does counsel have any questions?

Mr. SLOAT. Dr. Bucove, going back to this question of the title 19 problem, we have been told that possibly the most serious problem facing the State health departments at this time is the question of what is going to happen to them if the State welfare departments are designated as the title 19 administrative agencies. We have been told that the welfare departments, when so designated, will probably develop very sizable health and medical operations, and in effect, take over the health activities of the State.

Will this not lead, in your opinion, to competition between the welfare and the State health departments for scarce health manpower and wasteful duplications of health money?

Dr. BUCOVE. There is no question about this at all, Mr. Sloat, and I believe I indicated considerable concern for this kind of thing happening.

As I cited, this is already occurring in a number of States, and even in my own State, where we have had excellent working relationships with our welfare department in the plan which they submitted to the Federal welfare agency, they have indicated that they plan to get into such things as preschool health examinations, immunization programs, and this kind of thing, and we have been pressing our welfare departments to assist us in this for years, and now there seems to be a suggestion that they may attempt to do this themselves, and I think this would be obviously, to me at least, the wrong thing to do. They ought to reinforce what we are doing, through perhaps a contract agreement, rather than setting out on their own.

Mr. SLOAT. I believe you heard Dean Wegman earlier this morning suggest that a very simple solution to this serious problem would be to have the welfare department contract out the health services to the health department.

As things now stand is there any incentive for the welfare department to do that, or are they likely to want to build up their own health activities and enlarge their own domain, particularly, if, as I understand it, they are being encouraged by the Federal agency to do so?

Dr. BUCOVE. The incentive, it would seem to me, would be in developing for the State a coordinated program. Now this to me would be the incentive, but it is my understanding that the State welfare agencies are indeed being discouraged to do this by the Federal agency.

Mr. GILLIGAN. Could I interrupt just at that moment? You made reference before, Doctor, to the bill, H.R. 13197, which would not only permit but encourage the development of comprehensive health planning in public health services.

In your opinion, would the passage of such legislation move it in the direction of eliminating the possibilities of competition, for instance, between Welfare, State welfare departments and State health departments?

Dr. BUCOVE. Certainly this is my hope, Mr. Gilligan. It does provide the opportunity.

Mr. GILLIGAN. Did I understand you to say a moment ago that you felt that the Federal Government was at the present time, at least, in practice, if not in theory, discouraging the cooperation between the agencies?

Dr. BUCOVE. Yes, sir.

Mr. GILLIGAN. Thank you.

Mr. SLOAT. Is this the Welfare Administration that is encouraging, so to speak, the welfare agencies in the States to keep title 19 health activities within their own domain?

Dr. BUCOVE. Well, the answer has to be yes, as I understand it.

Mr. SLOAT. Could you describe what the problems are in regard to this question of the ability of State welfare agenices to contract out health services?

Dr. BUCOVE. I don't really see that there needs to be any problem. I think that the authority is there. The welfare agencies could contract with State agencies, State health agencies, to provide the health services for the welfare programs.

This has been done in other States, and I can see nothing in the Federal legislation which would say that this can't be done, and I know of nothing in the laws at the State level which says that this can't be done.

Mr. SLOAT. I understand that the State health departments have been advised that it is illegal for health services to be contracted out to them; is that correct?

Dr. BUCOVE. I have heard this said.

Mr. SLOAT. One short question.

On the top of page 9 of your statement, you suggested that the Secretary of HEW be encouraged and assisted to reassign major responsibilities in health to the Public Health Service.

I believe Congressman Rogers questioned you before as to the advisability of establishing line administrative responsibility for various health programs in the Department, but this is a somewhat different question, as I understand it, to actually reassigning specific health programs from other agencies to the PublicHealth Service.

Is that correct?

Dr. BUCOVE. Yes, sir.

Mr. SLOAT. Could you elaborate as to which programs you feel would be most appropriate to so reassign?

Dr. BUCOVE. Well, the one that occurs to me, at once, are health responsibilities which are spelled out in the Children's Bureau, and some of the health respsonbilities that are set out in title 19, which relate to this.

Mr. SLOAT. Do you feel there are others that you might think of if we gave you more time, and if possible, to supplement the record?

Dr. BUCOVE. Yes.

Mr. SLOAT. As to which health programs it might be beneficial to reassign?

Dr. BUCOVE. Yes.

Mr. SLOAT. Thank you, sir.

No more questions.

Mr. ROGERS of Florida. Thank you very much, Doctor. We appreciate very much your testimony. It has been most helpful to the committee.

Dr. BUCOVE. Thank you.

Mr. ROGERS of Florida. Tomorrow I think we will start with our panel. Is that correct, Mr. Sloat? Do we start with our panel tomorrow?

We will start at 10 o'clock tomorrow. Therefore, the committee will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 11:40 a.m. the special subcommittee recessed, to reconvene at 10 a.m., Thursday, April 21, 1966.)

INVESTIGATION OF HEW

THURSDAY, APRIL 21, 1966

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON HEW INVESTIGATION
OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. VAN DEERLIN (presiding). The subcommittee will come to order.

Today promises to be a real highlight in the inquiry that has been underway for nearly a year now into the health services provided through the Department of Health, Education, and Welfare.

We are privileged today to have a panel on which a number of very distinguished public servants are participating, including the Surgeon General, Dr. William Stewart; Dr. Stanley F. Yolles, Director of the National Institute of Mental Health; Dr. Ellen Winston, Commissioner of Welfare; Miss Mary Switzer, Commissioner of the Vocational Rehabilitation Administration, and a number of others.

This round-table will be on the general subject of the present status of the Federal-State-local health relationship, as affected by the organizational structure and programs of HEW.

The general issues selected for discussion are the multiplicity of Federal agencies involved in the administration and direction of Federal health funds, and the effect of this fragmentation on the health programs of the various States.

Second, the alleged tendency of Federal authorities to bypass State health authority when sponsoring health projects and activities within their States; and third, the desirability of allowing the State greater flexibility in the spending of Federal grant money.

To preside over this panel, to moderate the panel, keep it moving, we are delighted to have Prof. Herman E. Hilleboe. He is from the School of Public Health and Administrative Medicine at Columbia University, and former health director for the State of New York.

Dr. Hilleboe, will you introduce the remainder of the panel, and start the discussion?

PANEL MEMBERS PRESENT, ROUND-TABLE DISCUSSION ON FEDERAL-STATE-LOCAL HEALTH RELATIONSHIP

PROF. HERMAN E. HILLEBOE, MODERATOR, SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE, COLUMBIA UNIVERSITY; DR. G. D. CARLYLE THOMPSON, DIRECTOR OF PUBLIC HEALTH, STATE OF UTAH; DR. JAMES L. DENNIS, DIRECTOR AND DEAN, UNIVERSITY OF OKLAHOMA MEDICAL CENTER; DR. JOHN R. PHILP, DIRECTOR OF HEALTH, KANSAS CITY, MO.; DR. ROBERT KIMMICH, DIRECTOR, MICHIGAN DEPARTMENT OF MENTAL HEALTH; DR. WILLIAM J. PEEPLES, COMMISSIONER, MARYLAND STATE HEALTH DEPARTMENT; DR. LESTER BRESLOW, DIRECTOR, CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH; DR. ALFRED L. FRECHETTE, COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH; DR. WILSON T. SOWDER, STATE HEALTH OFFICER, FLORIDA STATE BOARD OF HEALTH; DR. WILLIAM STEWART, SURGEON GENERAL OF THE UNITED STATES; DR. STANLEY F. YOLLES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; DR. ELLEN WINSTON, U.S. COMMISSIONER OF WELFARE; MISS MARY E. SWITZER, COMMISSIONER, VOCATIONAL REHABILITATION ADMINISTRATION; DR. JULIUS RICHMOND, PROGRAM DIRECTOR, PROJECT HEADSTART, OFFICE OF ECONOMIC OPPORTUNITY; DR. BERWYN MATTISON, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. HILLEBOE. Thank you very much, Mr. Chairman. I would be very glad to introduce the members of the panel. I think you have met all of the people from the Federal Government. I didn't remember if you introduced Dr. Richmond. I don't know if you knew that he was in here. Have you mentioned Dr. Richmond?

Mr. VAN DEERLIN. No, I haven't. I have a question mark here. I wasn't sure he was present.

Dr. HILLEBOE. He wasn't here until just a minute ago, so I thought I would let you know that on my left is Dr. Julius Richmond, who is the Program Director of the Project Headstart, in the Office of Economic Opportunity. He is an old friend in the pediatrics field. He was a professor of pediatrics at Syracuse, at the Upstate Medical Center, and then more lately, I guess, dean of the school. He still is. He is dean on leave of absence.

The other members of the panel are Dr. Carlyle Thompson, the director of public health of Utah; Dr. James Dennis, the director and dean of the University of Oklahoma Medical School, next to him; Dr. Robert Kimmich on my right, who is director of the Michigan Department of Mental Health; and Dr. William Peeples is down at the end.

Dr. Lester Breslow, who is next to Dr. Kimmich; Dr. Alfred Frechette, the commissioner of health in Massachusetts, and of course we couldn't have a meeting like this without having somebody from the good State of Florida, so we have Dr. Wilson T. Sowder, State health officer of the Florida State Board of Health.

Mr. VAN DEERLIN. I warn you, Professor, that at this time, we are limited to two Californians as members of the subcommittee.

Incidentally, Chairman Paul Rogers of Florida is at a funeral that he found it essential to attend this morning, and will be with us by about 11 o'clock.

Will you proceed?

Dr. HILLEBOE. Another member of our group is Dr. John Philp, who is director of health of Kansas City, Mo., and Dr. Philp is just recently from New York City where he was acting commissioner of health, and has been deputy commissioner of health for some time, so you will notice that we have largely State health officers here, because our primary concern has been in Federal-State relationships. The staff thought that we needed to bring in someone who is expert in the field of mental health, and so we are fortunate in having Dr. Kimmich with us. The staff thought, too, that because of the great problem of our cities, the problem of health in Federal, State, and local relations, that we should have a representative from one of the cities.

It was not a question of getting equal numbers, or having large representation, but actually a question of having some of these people to present some of their particular views.

By way of introduction, let me just make a few comments about ground rules for the meeting. Oh, I am sorry. My good colleagues have told me that we left out an important member of the group. I had his name checked off down here, but I shouldn't have checked it off. The person I am talking about is Dr. Berwyn Mattison, who is director of the American Public Health Association down at the right.

Dr. Mattison was a distinguished commissioner of health from the State of Pennsylvania before he came to the American Public Health Association, and before then, he was a county health officer, in Erie County, in which Buffalo, N.Y., is located, as you know, a very large county health department, and so Berwyn brings to the group a broad viewpoint, not only from that of the health officer, but from a person in the broad field of public health.

Did I leave anybody else out?

Just a few ground rules about our roundtable. As you can see, we have divided the subject matter into three sessions. The first one this morning is going to be on fragmentation. The second one this afternoon is going to be on so-called bypassing of State health authorities, and the third one, tomorrow morning, will be on flexibility in use of Federal funds.

And the fourth session tomorrow afternoon will be a summation of the general suggestions by all the participants. We hope particularly that our colleagues from the Federal departments will be here to give us some of their views on what has transpired in the 2 days, and this is not to say that they are not to participate otherwise. We would like to have them participate in every one of the sessions.

I have asked in the first session this morning Dr. Dennis to serve as rapporteur, and pull together some of the critical issues that have come up. We find it useful in our meetings of professional groups, to have one of the members of the group serve as a rapporteur, or a recorder, to bring out the salient points, perhaps a half a dozen of them, and perhaps some of the recommendations that have to do with

new material. This is a nice way of bringing together what has been said. So on the fourth session, tomorrow afternoon, Dr. Dennis will have 15 minutes to sum up what went on this morning. In the afternoon session today, Dr. Kimmich will act as rapporteur, and he will bring up on Friday afternoon a summary of things that went on in the afternoon session. Tomorrow morning, Dr. Sowder will act as rapporteur and bring to us some of the discussions of the meetings.

We have found that this is a very simple way, Mr. Chairman, of summing up what goes on. We can then discuss this with the members of your group, and the members of the panel, if this is all right.

Usually, when we have meetings that run as long as 3 hours, we like to take a little break, so probably this afternoon, we will take just a stretch, and also tomorrow morning and tomorrow afternoon.

As far as the participants are concerned, although the subject matter is roughly grouped into three areas of fragmentation and of bypassing and of flexibility, there necessarily will be some overlap. This we can't be too concerned about, but we will try to keep within these areas, because the areas are distinct, although they have interrelationships.

Secondly, we want all members of the panel, our colleagues from the Federal Government and from the various States, to participate in any part of the discussion that they want. If they will participate and bring up some of the questions that have been brought out in the papers, this will be very much worthwhile.

The final point I would like to make Mr. Chairman, is that this is a most opportune time to have this discussion, because so many new programs have developed because of Federal legislation within the last 2 years.

Now we need to look at the relationships of these various things, or, some of the legislation that has been introduced—and I refer particularly to H.R. 13197—in Congress, having to do with planning, and bringing together various grants. We won't get into a discussion of this, because this is a separate problem, but everything that will be said will have some bearing on this. Any legislation involving planning obviously can be important only if the planning works out, and the planning will work out only if we get straightened out on some of the problems of fragmentation and of bypassing and of flexibility. It is quite opportune that this discussion is taking place now, before the Federal groups begin to write their rules and regulations. Conceivably, they might even find time to consult with some of the State health officers in the development of these programs, and some of the city health officers.

This is the thing that we will need to do that has not been done before. This discussion is really a matter of necessity, because unless this is done, the fragmentation is going to become so bad that we are going to get bogged down. So it is quite opportune that we have this discussion.

So we will get right down to the business of the meeting, and the first presentation is to be by Dr. James Dennis, from Oklahoma, on fragmentation of Federal health activity, and its effect on State and local programs.

Dr. Dennis.

Dr. DENNIS. Mr. Chairman, members of the committee, distinguished colleagues of the panel, I am Dr. James L. Dennis, director of the University of Oklahoma Medical Center and dean of the school of medicine. As a medical educator, I share your concern and a sense of responsibility for the deficiencies that are rapidly emerging in the fields of health services.

The underlying problems are complex and are related to the many dramatic socioeconomic transitions of our time and culture. These include: (1) Population increase, (2) shifts from a rural to urban-suburban dominated society, (3) the explosion of scientific knowledge and increased technology, (4) the development of an informed, health-conscious public, (5) political sensitivity to the health needs and demands of the public, and (6) a dramatic, historymaking response by the 89th Congress, to the medical needs of the public.

After this unprecedented escalation of the federally sponsored health programs we now find ourselves in the thick of "thin things." In my opinion, the difficulties stem from very basic reasons: a failure to recognize that health services are people, professional people who must be "produced" by appropriate institutions of learning. Perhaps most significant, there has been a failure to develop coordinated planning, followed by coordinated organization and coordinated administration.

We now face the massive task of resolving the problems that have been created by these deficiencies. The shortage in health manpower is further aggravated by an almost unbelievable fragmentation, duplication, and multiplicity of health services and programs located in an ever-increasing number of agencies, bureaus, and divisions, all of whom currently appear to be in a competitive race to develop crash programs for manpower production, a belated recognition of the statement that health services are trained people.

All the evidence suggests that these manpower programs are being hastily conceived and with the same pattern of fragmentation, duplication, and lack of overall planning that characterized the health programs. With your permission, I shall assume the role of a "devil's advocate" and support my contentions with a documentation of some pertinent facts.

I hasten to add that this information comes from material available to me in my office, and in no way can be considered to be a comprehensive inventory of the existing Government-sponsored health programs.

Because my specialty field is pediatrics, I have a deep personal interest in child health programs. I have in my possession documents that list federally sponsored child health programs under the aegis of 16 different Federal bureaus, divisions, agencies, institutes, commissions, administration, departments, offices, or sections.

Under each of these there are from several to many services and subprograms. Eleven of these represent various components of the Department of HEW, with the Children's Bureau being only one.

Many of my colleagues are particularly perturbed by the child health programs that have developed through the Office of Economic Opportunity (OEO) and through the Office of Education under the Elementary and Secondary Education Act of 1964.

Legislation for these programs includes authority to provide a broad scope of health services independent from, and unrelated to, similar existing programs for which the Congress and the States appropriate funds.

In the OEO and Office of Education programs, large appropriations have provided "the means"; but the "ways" are frequently found in the hands of persons who have neither training nor experience in the public health fields.

A bypass of the professional skills and resources of experienced and established public health workers will jeopardize the accepted standards for professional child care and make it difficult, if not impossible, to maintain that which we have.

Established agencies concerned with health services face serious difficulties in the competitive recruiting for professional personnel at all levels. Federal regulations governing the major health programs administered through the Public Health Service, or the Children's Bureau in HEW, require that personnel be employed under approved merit system plans that define personnel policies, qualifications, and compensation for those employed. (It is my understanding that other agencies administering Federal funds for health services do not require that programs be carried out under approved merit system plans.)

Higher salaries can and are being offered by agencies outside the Public Health Service, sometimes without due consideration of qualifications. Subprofesional personnel have been employed under professional titles. I have been told that food service workers in the Headstart program havee been hired as nutritionists.

School districts can employ, at higher pay, registered nurses without public health training or experience, or vocational nurses at higher salaries, shorter hours, and longer vacations than can be provided by local health departments. Many school nurses work without either medical or nursing supervision. They almost never provide services on a family unit basis. They make relatively little use of the nursing skills in which they are trained and for which there is dire need in community hospitals and local health departments.

I have long been an advocate of school health programs, but a drain of graduate nurses into a less responsible school position, where they do not utilize their professional training potentials is to be deplored at this time.

Headstart programs have been successful in focusing attention on the needs of low-income preschool age children, but the health services appear to be fragmented into segments of services provided on a "vendor" payment basis.

Physicians have been asked to provide good physical examinations, including laboratory work, for as little as $2 to $3 as remuneration per person.

In same instances the children have had laboratory tests for diabetes, but no thought was given to tuberculin testing, although from an area with a high incidence of tuberculosis. What happens to the child found to be in need of medical care? This is open to question.

OEO, through the community action programs (CAP), can support neighborhood health centers for both preventive and treatment services, independently from local health departments. The Children's

Bureau and Public Health Service have authority to provide grant-in-aid funds for similar purposes, and a recent memorandum indicates that there are Federal funds, for the same purposes, in the neighborhood facilities programs under section 703 of Housing and Urban Developments.

These duplications are wasteful of money and manpower. Perhaps, more serious in the long run, is the lowering of standards. The "filling station" concept of child health services is in distinct contrast to Children's Bureau standards and philosophy of treating the child as a whole, with sensitivity to the child's family, social, and interrelated needs, and adherence to accepted minimum standards of pediatric medicine under sound, established administrative and professional direction.

For many years most Federal funds for the major health programs for children have been administered by the Children's Bureau. Their contributions to the elevation of standards of pediatric care and insistence on the maintenance of such standards represents a highlight in the history of American public health.

The admitted gaps in child health programs in many parts of our country represent, to some extent, the fact that State and local health departments have not been adequately supported through State and local appropriations.

Admittedly, they have not always demonstrated the creative leadership we would like, but it has been necessary to do with what they have had to do with. It does not seem logical to leave them in a state of poverty, while nonhealth oriented agencies conduct a poverty program with an abundance of funds that bypass and usurp the established programs by offering higher pay with lower professional qualifications.

If Federal funds are to be appropriated to other Federal agencies for health services for children, their policies, procedures, and minimum standards should be correlated with the established, more comprehensive overall child health and welfare service standards that have evolved over many years.

It is my considered opinion that the experience, standards of excellence, and organization of the Children's Bureau should in some way be utilized, by legislative direction or administrative mandates, to administer, coordinate, and/or approve federally sponsored community child health programs.

Now, let me leave my pediatric bias and look at some other examples of fragmentation, duplication, and multiplicity in the health services.

Programs for mental health and mental retardation: I was able to identify 22 Federal programs for mental health and mental retardation. These were listed under the sponsorship of the National Institute for Mental Health, the Public Health Service, Bureau of State Services, Children's Bureau, Vocational Rehabilitation Administration, community action program, Office of Manpower, Automation, and Labor (Department of Labor), U.S. Employment Service (Department of Labor), Division of Elementary and Secondary Education (Office of Education) and Division of Community Health Services.

I do not feel qualified to evaluate each of these programs, but duplication and fragmentation is abundantly evident. This one field provides an area where a comprehensive study of programs and their relationships to each, as well as to the national needs, might be fruitful.

Programs for the aged: I found it of interest, that under the heading of "Programs for the Aged" (including medicare), I was able to identify only six major titled programs in only four Health, Education, and Welfare administrative agencies.

The fact that these are probably the largest and at the same time the best planned and organized programs, suggested that a minimum of duplications and fragmentation might bear a significant correlation to a well-planned program involving a minimum of agencies.

Programs for disabled and rehabilitation: Every person who is chronically ill or handicapped from any disorder is disabled, hence all are candidates for some kind and degree of rehabilitation. It is not surprising that vocational and rehabilitation programs cut a wide swath and touch on a majority, if not all, health programs.

In our material we identified 18 Federal programs that could be classified as programs for disabled and rehabilitation, administered by nine separate agencies and divisions.

Community health programs: A large number and a wide variety of community health programs may be identified under the sponsorship of the Office of Education, Bureau of State Services, Children's Bureau, community action program, Division of Community Health Services, U.S. Public Health Service, National Institutes of Mental Health, Division of Medical Facilities (Public Health Service) and Urban Renewal Administration. The overlap is obvious.

Miscellaneous: In addition to the multiplicity of categorical and health agency programs, there are special "group" programs that include the Appalachian regional programs, Division of Indian Health, Cuban Refugee Staff, Migrant Agricultural Workers Health section of the U.S. Public Health Service (also a migrant branch is listed in the community action program), the Veterans' Administration, and each of the Armed Forces—all of these offer very broad health programs to large, selectively restrictive groups.

The community action program of OEO lists grants for health, family planning, vocational rehabilitation, welfare, multiservice neighborhood centers, as well as project Headstart day care and its special health programs. The spectrums of these selective "group" programs duplicate major programs in various branches of the Department of Health, Education, and Welfare in almost all respects.

I can think of arguments for such a scatter and duplication. Certainly, with such multiplicity we cannot describe our health programs as "centralized." However, slogans such as "Competition is healthy," "16 heads are better than 1," and so forth, do not suffice for those who have devoted their lives in the pursuit and support of standards of excellence, administrative responsibility, and the rationale of feasibility. Perhaps we want or need all of those programs under all of these agencies? If we do, it should be planned with reasonably coordinated cooperation.

All of the duplications I have mentioned are compounded at the State level since they too have developed unplanned, uncoordinated channels and programs, and I hope we can address ourselves to these in our discussion.

Conclusion: The legitimate aim of criticism is to direct attention to the excellent. The objectives of our Federal health programs are ex-

cellent; unfortunately, the "means" provided to reach the "ends" fall far short of excellence.

In a final analysis, the "means" must represent a combination of overall planning based on needs and resources, a coordination of programing, diligent administration, and above all, enough properly equipped people, in the right places.

And I might add, at the right time.

The health agencies of this Nation are currently blessed at top levels, with superbly qualified persons in key positions. The deficiencies are in terms of the quality and quantity of health manpower available and essential for the implementation of already authorized health programs, and complicated by the absence of a planned coordination of programs.

Congress has demonstrated an amazing sensitivity to the many very real and critical needs in the fields of health services. You have given us a challenging mandate to move, and move now, toward new and exciting horizons.

I am expressing a considered opinion when I say that "confusion, duplication, fragmentation, and the absence of coordination in planning and administering health programs places the objectives of Congress, and the welfare of this Nation, in jeopardy."

I suggest that we mobilize the best brains of the Nation to plan a "charted course," and that we man our "ships" with an organized and disciplined crew before we set sail. At the moment it would appear to be "full steam ahead"—without pulling up the anchors. We can do better, and that we must.

I will close with a quote from Thoreau:

> If you have built castles in the air your work need not be lost, for there is where they should be. Now, put foundations under them.

Thank you very much, sir.

Dr. HILLEBOE. Thank you very much, Dr. Dennis.

I think that unless there is some point that you want clarified, I would like to have you hold your comments and discussions until the end of the three papers. Then we can look at the broad picture in toto. So if you will simply make notes of questions that you want to ask, or comments that you want to make, it will be more lucid if we wait until we have heard from some of the other persons and groups.

The next person to present material is Dr. Thompson, who is director of public health for the State of Utah, and he speaks as a health officer. Dr. Thompson.

Dr. THOMPSON. Mr. Chairman, members of the committee, Dr. Hilleboe, distinguished members of this panel, first in discussing fragmentation of health services, one must recognize two types of fragmentation. First, there is the fragmentation that stems from the special categorical appropriations, and these are usually administered through the same Federal administrative unit.

Second, there is the more difficult problem of fragmentation stemming from appropriations administered by separate governmental agencies or major administrative units.

Before discussing the problems which these two types of fragmentation develop, it is only fair to recognize that there are advocates for fragmentation on the basis that the advantages or virtues outweigh the disadvantages.

The main advantages which have been stated include the ready response of legislators and Congressmen for appropriation of funds to meet special needs such as the appeal which results from a single disease or crippling condition.

It is also said that it requires special effort on the part of an individual, a group or an agency who not only seeks the special grant but also by reason of the special assignment is able to devote their whole effort to the special program in contrast to the diluted effort which is alleged to arise when one of the special programs is included in a general appropriation or in a general agency having many responsibilities.

These are recognized as tangible advantages but they are also evidence of the lack of an overall coordinated planning by appropriate governmental agencies that would result not only in the special appriations and the particular attention to their administration but would also take into consideration the proper placement of these appropriations and their administration in governmental agencies so as to avoid the disadvantages.

Slowly over the years the disadvantages have been coming to light. It is a commendable event that this committee is seriously studying these matters.

It is also commendable that Secretary Gardner and the Surgeon General, Dr. William Stewart, have given new stimulus to studying these matters. I say new stimulus because this topic has been a matter of discussion by the Association of State and Territorial Health Officers at their annual conference with the Surgeon General of the Public Health Service and the Chief of the Children's Bureau for many years.

Both the association and the Public Health Service had had task forces working cooperatively in an effort to avoid the disadvantages. It must be recognized though that this effort, at least until recently, was by its nature limited for neither the association nor the Public Health Service were in a position to adequately or perhaps even properly express any views concerning those fragmented health services not a portion of the Public Health Service or the Children's Bureau.

Unquestionably, the Congress itself must share responsibility for fragmentation because undoubtedly some of it stems directly from legislation. It is recognized that such legislation in most instances did not require fragmentation but permitted it.

To a substantial degree over a period of many years some of this permissible fragmentation as it has affected the States has been substantially resolved by the States. For example, over a period of years the States crippled children's services, which at one time were only partially in State health departments are now almost wholly in State health departments.

This is likewise true of the administration of the Hill-Burton construction funds. Nevertheless, because this fragmentation is still permissible in Federal legislation, it still exists in some of the States.

In contrast, however, there are Federal health laws which by their nature or by the administration of them, have almost precluded State health department participation in some health programs. These programs by their nature have a significant relationship to

already existing or developing programs in the health department either by reason of stimulation by other Federal grants or by reason of interest in the State.

For example, we can refer to the program of the vocational rehabilitation services which contain a significant element of medical and related health services overlapping similar services for specific age groups in the crippled children's program.

Albeit, over the years these two programs have largely evolved a working relationship which in some States I know is on a very fine cooperative basis.

At the same time it does raise a question of the staffing and administrative relationships and professional direction which each program must develop separately and in some instances resulting in a questionably adequate professional performance.

The problem is fresh before us in 1966 as the new provisions of the Social Security Amendments of 1965 are brought to fruition. It is very clear that the kind of professional health competence required to perform certain services under title 18 are really no different, if quality health services are to be rendered, than those required under title 19. The health services in the antipoverty programs should also be mentioned.

A fair question then would be, "Should not the Congress or the Federal agency adhere to some basic principles that would not only prevent fragmentation but assure the absence of it?"

This should apply equally to the States and local areas if for no other reason than that the Federal Government is underwriting in some cases all of the expenditure and in other cases a very substantial portion of the expenditure.

While these are only a few examples of the problems of fragmentation of Federal health services that have developed over the last 30 years and are still developing, they have resulted and will continue to result in, unless corrected: (1) Uncoordinated health services; (2) duplicated administrative and professional costs; (3) the use of public funds in some parts of the Nation on the simple premise that funds are available rather than on the premise of meeting the greatest need at the State or local level.

In summary then, this results too often in the expending of public funds in such a manner that the maximum possible value is not rendered to the taxpayer. While these general conclusions relate to both types of fragmentation of health services, they are compounded when the appropriation or its administration is by independent governmental units.

While it may be that at this time the very large Department of HEW is making an effort to solve this problem within itself, it must be recognized that within the Department are a substantial number of organizational units which appear to continue to have substantial independence.

Having recognized that there are advantages and disadvantages to the two types of fragmented health services, are we then faced with a dilemma? Must we continue to have such fragmentation in order to secure the appropriations for the needed services?

And, must we have continued independent administration in order to secure the development of these services? With the interest shown

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by this committee and the Secretary and the Surgeon General, I don't believe we have a dilemma nor do I believe we must pay the price of fragmentation that has heretofore been the case.

The growth of the Federal health grants system to States has been phenomenal since the passage of the Social Security Act in 1935. The growth represents not only substantial increase in the amount of special appropriations but also a multiplicity of special appropriations.

This has resulted in the initiation of new agencies or the growth of new agencies or administrative units to carry out these programs. It should be recognized, too, that none of these specialized health programs have failed to bring substantial benefits to vast numbers of people and thus this discussion does not in any sense imply any criticism of the legislative decision to bring these programs into being.

Whether the basis for these special programs was at one time valid is not necessary to evaluate because of the evident need which they met. The special interest groups which supported the initiation of these special programs have played an important role and made a significant contribution.

The question now is should this type of fragmented health services and its administration be continued and the question further is should new programs recently enacted or those still to be enacted be subject at this time to further study in terms of some basic Government principle which would lead to an effective administration and performance of professional services supported by the appropriations without the disadvantage of fragmentation.

It is also recognized that there is a basic need for not only justifying the appropriation initially but in reporting to Congress the services and results which have stemmed from the appropriation.

The problem is one of developing a means of accountability so that the Congress is assured that the funds were used for the purposes intended. A new approach to this problem is necessary in the administration of these programs.

It was argued recently that every specialty program in Government is entitled to the necessary staff to carry out the program intended by the Congress. This argument was made in support of fragmented health services. In reply, I would only say that the programs are entitled to the staff services, and let me repeat staff services, not staff, necessary, to carry out the program.

It should be the responsibility of the Congress or of an administrative plan developed by the Department of HEW to assure that these staff services are obtained from the same appropriate professional staff in the Department so as to avoid the unnecessary duplication of staff by each of the programs feeling the necessity of a separate staff.

In my opinion this responsibility should rest with the Surgeon General as the most logical person having overall professional responsibility for the provision and supervision of the necessary professional health services for all domestic health programs authorized by the Congress.

The problems of fragmented health services are more apparent and much more serious at the State and local levels than at the Federal, especially in the States and localities of small populations. The Federal pattern of operation to a considerable extent influences the State organization.

In every case, however, certain Federal requirements for organization and budgeting must be met to retain eligibility for Federal grants. In many instances these requirements force States, especially when grants are small, into a series of poor choices. They can choose to follow a type of fragmented health service which generally requires an unduly heavy workload of determining categorical costs; or, the State may elect abandonment of the health service because of the excessive staff cost and program complications to justify the effort by its limited staff.

This is portrayed in the environmental health field with the multiplicity of Federal agencies and grant programs in this area. Radiological health, water pollution, air pollution, and general health categories have earmarked Federal funds which currently involve us. When occupational health grants become available, only the public water supply feature of our environmental health program will be without the support of a Federal grant.

In addition, there are State funds used in each of these areas of interest. Overlapping of these activities in these programs is inevitable. Radiological health has air pollution aspects. Water pollution control and water supply have radiological aspects. Industrial health closely relates to air pollution as well as radiological health. All have general health implications.

These circumstances make it desirable to have flexibility of action if the staff are to meet most effectively the problems in all of these areas as they occur. This permits direction of daily functions into channels of productivity in the State. This flexibility is difficult, if not impossible, to maintain with too rigid earmarking of funds.

We tend to be forced to plan our work on the basis of predetermined expenditures rather than on the bassis of the best effectiveness. Such predetermination cannot under any circumstances be done with enough foresight to insure the most effective programs.

This is not to negate the necessity for prior planning on the best estimate of how to use a small staff in this interrelated field but the problems in the area are of such a nature that at best some modification in the predetermination is almost inescapable.

Our problem is compounded, too, when a vacancy or two occurs and by chance it may occur in a position budgeted out of one or more of either of the categorical funds.

At the same time that the vacancy occurs, the demand for program activity could be greatest in the position budgeted with the Federal grant. Efforts to make budgetary changes to coincide with the required work program have resulted in objections because of the accusation of substitution of Federal categorical grants for other funds, either State or Federal.

As a matter of fact, in this type of situation the program service performed in the categorical field was substantially in excess of even the categorical allocation, part of which was lost because of the technical difficulty involved in this fragmentation.

In connection with some categorical grants such as cancer and heart and with special projects such as tuberculosis and immunization, we have been prevented from using these funds to give general assistance to local areas as the local areas have improved these special programs.

With small grants under $50,000 in the State of Utah it is impossible to allocate these special funds to local areas on an effective basis.

For example, in the employment of an additional nurse, when the total nursing service locally may consist only of two to seven or eight nurses, a disproportionate emphasis is placed on the special program and is obviously improper.

At the same time we have been prevented from using these funds as general assistance to the local areas which, in a pool with other categorical funds, could result in increasing the local nursing staff by a substantal margin but in balance with the level of program warranted in that area.

In the case of the heart and cancer funds we have been unable to use them in aiding local areas in improving these special activities. This creates resentment against the program because while the State encourages their development, it offers no assistance.

With respect to immunization and tuberculosis project grants, for example, the problem is resolved more readily because the grants are larger and we have been able to assign nurses to various areas of the State for different periods of time throughout the year.

In the more populous areas this permits a nurse to be assigned full time. In the rural areas this permits the assignment of a nurse for only a few days at a time. In both instances the nurse never becomes an integral part of the local nursing service and duplicates travel in the county.

While this is the best we can do at the present time it would seem that assistance should be devised whereby at least in the smaller population areas these funds can be made available to local areas on the basis of evidence of increased local program activity by the total local staff rather than by an identified single individual.

It is recognized that the topic of fragmentation has a close interrelationship with the other two topics to be discussed in these 2 days. Solving the problems related to any of these topics will undoubtedly have a beneficial effect on others.

I would like to close by saying that there are many other things that could be said on fragmentation, but not in the limited time. I hope the discussion will permit them to be brought out.

Dr. HILLEBOE. I think you will get a chance later on, Dr. Thompson, to add some additional comments, and thank you very much for your presentation.

Are there any questions about clarity or information you want to ask?

If not, let's go ahead to our third paper, and then we can have some discussion on the points in all of them.

The next panelist is Dr. John Philp, director of health in Kansas City.

Dr. PHILP. Thank you.

Mr. Chairman, Members of the Congress, members of the distinguished panel, ladies and gentlemen, I am Dr. John Philp and I am presently director of health in Kansas City, Mo.

My entire professional life, aside from military experience, has been in public health positions at various levels of government. I have served as director of public health in two different rural counties in California, as assistant chief of the division of local health service

and later as chief of the division of alcoholic rehabilitation in the California State Health Department, and as first deputy commissioner of health and later as acting commissioner of health for New York City.

As you see, my experience has included small county, large State, and large municipality public health administration. I have had the opportunity to observe the end results and accomplishments of a large variety of Federal grant-in-aid programs for health purposes.

In this introductory and preliminary statement I have been asked to discuss the multiplicity of Federal agencies involved in the administration and distribution of Federal health funds and the effect that this has on the health programs of the various States.

Since I have not undertaken a comprehensive survey on this subject I can comment only from my own experience in the States and in the communities where I have worked. Although there are a number of observations that might be made I intend to limit my comment in these introductory remarks to two major points:

1. The multiple sources of Federal grant-in-aid financing for health purposes.
2. The necessity to look at the effect of Federal financing on community—particularly metropolitan areas—as well as the effect on State health programing.

Probably the most helpful document published and distributed recently by the Department of Health, Education, and Welfare is a document printed in December 1965 titled "To Improve Medical Care, a Directory to Federal Grants and Other Financial Programs To Aid the Development of Medical Care Service, Personnel and Facilities." Actually this document is supplemental to another publication entitled "Grants-in-Aids and Other Financial Assistance Programs Administered by the United States Department of Health, Education, and Welfare," the latest edition I believe being 1964–65.

These two publications have been a road map to public health administrators in States and in local communities. With the aid of these publications it is possible to determine what forms of Federal grants-in-aid exist, who may be eligible to receive funds and how application for these funds may be initiated and pursued.

A glance at the summary of these publications indicates that there are over 90 Federal allocations for various aspects of health services, training and research. This figure does not include allocations or grants which may be available from Federal agencies other than the Department of Health, Education, and Welfare.

In my opinion, the net effect of this multiplicity of grants has been to cause fragmentation of health services and programs at both the State and local level.

With the present system of Federal grant-in-aid financing for health programs it has not been possible for States and metropolitan areas to do comprehensive public health planning or to utilize Federal funds for the support of those services and programs deemed most important and given top priority by the State and community.

Rather it has been necessary, because of categorical Federal funds, to set up categorical programs frequently through new bureaus, divisions, or units which are required as a part of the categorical Federal health legislation.

I do not say that all of this is bad because we all know that valuable and necessary services have been initiated and carried out which would not have been possible without special Federal assistance.

However, it is my impression that when the Congress of the United States allocates funds for health programs it is the intent that these funds be used for the health and benefit of people.

The present categorical kaleidoscope of Federal health funding has necessitated a multiplicity of Federal offices to carry out each designated program, a similar multiplicity of Federal offices at the regional level of the Department of Health, Education, and Welfare and a third multiplicity of offices at the State level of health administration.

This fragmented organization at the Federal, regional and State level has caused an inefficient use of scarce public health personnel and a competition among the various federally funded programs for such personnel. If one looks at the staffing of public health services at the community level and compares this with the staffing of the various bureaus, divisions and units at State, regional and national levels it becomes quite apparent where the public health manpower is concentrated.

Yet most of these Federal, regional and State offices provide no direct services to people themselves but are set up primarily to administer the various funds and appropriations and to "stimulate" desired program activity at the community level.

It is my opinion that the multiplicity of offices that have been necessitated by the categorical funding arrangements has resulted in an absurd administrative structure at the Federal, regional and State level and a misuse of scarce public health manpower.

As an example, the typical regional office of the Department of Health, Education, and Welfare will have separate regional staffs in the following categories:

1. Grants-in-aid administration;
2. Health education and information;
3. Mental health services;
4. Health mobilization;
5. Public health training;
6. Community health;
7. Accident prevention;
8. Chronic diseases;
9. Communicable diseases;
10. Community health services;
11. Community health services—Migrant health;
12. Dental public health;
13. Hospital and medical facilities;
14. Nursing;
15. Environmental health;
16. Air pollution;
17. Environmental engineering and food protection;
18. Occupational health;
19. Radiological health; and
20. Water supply and pollution control.

While there may be administrative and organizational rationale for some of the divisions, it seems eivdent that these particular divisions were established to conform with a particular Federal appropriation

rather than on the basis of any predetermined administrative or organizational logic.

A similar situation exists in the organization of State health agencies. For example, the Children's Bureau requires that a State health agency must have a director of maternal and child health—I believe the precise language is "an identifiable unit"—to administer the funds available through the Children's Bureau.

Therefore, the typical State health agency will have a major unit to handle the funds in relation to the health of mothers and children but rarely do you see other major units to administer health funds for other age groups. This is because Federal categorical funds have not been available with similar administrative requirements for other age groups. If this had been done one would see divisions or administrative units established to administer the health funds for each specified age group.

What one does see though are administrative units to administer health funds for categorical disease programs. These include organizational units to deal with the problems of venereal disease, tuberculosis, cancer, heart disease, radiological health, and so on.

Probably the most striking administrative separation of health programing has occurred in the mental health field. This has developed largely by the type of Federal funding for mental health programs and the concurrent administrative requirements for the receipt and use of funds.

The net result has been to create "a separate but equal" health agency for mental health to parallel the health agency for physical or public health.

There is no administrative or medical logic for this separation, yet this pattern is now an established fact and one which probably cannot or will not be changed. All of this multiplicity of categorical financing has created serious administrative overlappings and inefficiencies, but even more important this has caused fragmentation and segmentation of services to the individual who in the long run is supposed to benefit from these programs.

One final word needs to be said about the nature of State health agencies. In general, I think it can be stated that the purpose of the State health agency is threefold: (1) To give assistance to the local communities within the State for the development of public health services and programs. This assistance may take the form of consultation, stimulation, technical assistance, and to varying degrees financial aid. (2) To engage in research, investigation, and fact-finding to provide information necessary for planning programs, for evaluating programs, and for solving problems. (3) To provide direct services to the people of the State.

Although there are some exceptions and there are variations from State to State, I believe that few State health agencies engage in direct service operations. Few operate clinics or conduct directly service programs for the people. The bulk of State health department manpower is concentrated in the activities of administration, technical assistance, research, and investigation.

What then is happening in the communities, in the towns, and in the metropolitan areas? To put it more bluntly, how are the people themselves benefiting from these federally designed programs?

First of all, one must know where these people live. Without repeating in detail the obvious, I will simply state that the vast majority of people in the United States live in or around metropolitan areas; areas which are a part of a metropolitan complex. Frequently these complexes involve several municipalities, several counties, and in some situations more than one State.

In each of the metropolitan complexes there is a central or core city which is the industrial center, the economic center, and unfortunately usually the center of social and health problems including disease, poverty, poor housing, crime, and all of the other problems with which we are familiar.

In looking at disease alone one can see that such problems as tuberculosis, venereal disease, infant and maternal mortality, and most others are predominantly problems of the metropolitan area.

Since these are where the problems of health are concentrated, to what extent do the categorical Federal grant-in-aid programs assist in alleviating these problems? The unfortunate answer, in my opinion, is that they have had only limited and at times undetectable impact. Most of the Federal categorical health grants are grants to States and only in the last few years have special grants been made directly available to cities and other political subdivisions of the State. These exceptions are in such fields as tuberculosis, venereal disease, and immunization assistance.

However, the traditional Federal grant-in-aid program is a formula grant to States, so therefore one must look at how the State utilizes these funds and to what extent these funds are put to work in the areas where the problems are concentrated.

I cannot respond to this question for every State although it would not be difficult to make such a study or survey. I can give you some general information about three States with which I am familiar.

In California, the bulk of Federal grants-in-aid for health purposes is retained by the State. Federal funds contribute less than 5 percent to the local health department budget. A State public health assistance program provides additional money for the support of local programs, but this is weighted to favor the rural areas and the local community still carries about 84 percent of its total public health bill.

A similar situation exists in the State of New York where all Federal grants are retained and utilized by the State health agency. New York State does, however, have a State grant-in-aid program to city and county health agencies which in general provides for 50 percent reimbursement of all public health expenditures at the local level. The word "all" needs qualification since the State has defined what is considered public health and what is not considered public health. Because of this some local activities receive reimbursement while others may not.

Again, however, this system applies on a statewide basis but with some special advantages and considerations to the rural areas. Also, there is no recognition of the principle that health funds should be directed to the areas where people and health problems are concentrated.

In New York City, for example, which has 5 percent of the Nation's population, it also has 9 percent of the Nation's tuberculosis. This fact and many other similar facts are not recognized in the State program for financial assistance for health services in New York City.

In the State of Missouri the problem is even more apparent. The two major metropolitan areas of Kansas City and St. Louis have the major concentrations of health problems, yet categorical Federal health funds are retained and utilized by the State. Kansas City receives a magnificent total of $40,000 per year through reimbursement by the State which is only a small percentage of the city's health budget and constitutes only a fraction—that is, about 4 percent—of the amount of categorical Federal grant-in-aid received by the State.

And to depart here for a minute, although Kansas City has approximately 12 percent of the State's population, it receives from the Federal Government only 4 percent of the Federal grant-in-aid funds received by the State of Missouri.

Now I bring this problem to your attention because of the rather prevalent feeling among State health officials that the Federal Government has been guilty of bypassing State government in supporting community programs and in dealing directly with some of the major metropolitan areas.

My answer to this is that unless the State, in every respect, recognizes the urgency of the need and the concentration of the health problems in metropolitan areas and correspondingly redesigns its own program to assist in planning and meeting these problems, then it will be necessary more than ever for the Federal Government to develop a direct and simple method of dealing with the major metropolitan areas in this country. These areas are literally the melting pots of disease and social problems.

I, for one, would like to see the elimination of the present multiplicity of categorically Federal grant-in-aid programs. I would like to see this replaced by a general overall Federal health assistance program.

I would not object to this health assistance program involving a system of block grants to States, provided that there is an ironclad guarantee that these funds will be directed to those areas of the State where the health problems and population are concentrated. This should also guarantee a minimum of administrative machinery and a maximum concentration of personnel and direct service activity at the local level.

Dr. HILLEBOE. Mr. Chairman, I would like to initiate you Members of Congress to a little practice we have in our public health services.

We find after we have been sitting down for a whole hour of 60 minutes, we have to get up and stretch. So if the members of the panel and the congressional group will stand up for a minute, I will explain how we will handle the panel. I think it is very important to stand up and stretch for a minute. I do this particularly out of respect for the ladies.

Let me say that because we have a minimum number of microphones, in our discussion if you will simply indicate that you want to talk, or perhaps raise your hand and let me know, I will try to get you all in order and we will follow through.

We have had an excellent presentation by representatives from three different groups. I know that many of my colleagues around the table have been making notes and are getting ready to ask some questions. I shall be very glad to keep this on an informal basis. If you have any questions or comments that you want to have directed to a par-

ticular individual, simply mention which one you want them directed to.

I notice my colleague on my left has been making notes, so I will give him the pleasure of being the first one to start.

Dr. RICHMOND. Thank you very much, Dr. Hilleboe.

This has been a very interesting sequence of presentations. I think we all recognize from these presentations that we are dealing with a complex problem of organization of one of our very basic social institutions. As a consequence, there are no easy answers.

It is apparent from the presentations this morning that we are dealing with a pluralistic society in which we are groping in pluralistic ways for solutions.

I think by way of introductory remarks, I might start with the last presentation which, concluded with a focus on the basic issue, the health problems of people. It seems to me that the main thrust of Dr. Philp's presentation was that we have people living in our communities, some of them in rural communities, but a predominance of them living in urban communities who do not receive adequate health services.

The organization of the health services has not as yet succeeded in delivering very significant, technologically well-developed services, to the people who need them most.

I think the other presentations focus on a very important issue, and that is whether the institutional forms we have set up are adequate if we just support them more fully. If we go to Dr. Dennis' presentation, it seems to me what he was saying is that we have the institutions—certainly the Public Health Service and the health services that flow from it, the Children's Bureau, and many other services—and since their standards are excellent, it is largely a matter of our providing them with sufficient support.

But as the Secretary of Health, Education, and Welfare, Mr. Gardner, has so ably indicated in some of his writings, what we need to be concerned about is the possibility of organizational dry rot. That is, we have developed institutional forms for delivering services but perhaps we don't pay enough attention to reordering the forms and recasting our institutions or at least building in some potentialities for self-renewal.

I would be concerned, in connection with the first two presentations particularly, that the view is that we need to support our existing agencies somewhat more adequately, somewhat more effectively, and the job will largely be done.

I think this morning's meeting is a very wholesome one because it raises the question whether this is so, or whether we need to look at new forms.

In connection with some of the new programs, and I have had the opportunity this past year to direct one of the new Federal programs which has been mentioned this morning, Project Headstart, I would only say that if the job were being done, certainly there would be no need for any new agency to step in, or for Congress, indeed, to enact legislation to set up a new agency and, presumably, the services that it would stimulate, initiate, or support.

In connection with meeting the problems, meeting the needs of poor people, I would like to emphasize that the Office of Economic Oppor-

tunity is concerned about health problems largely because, as is apparent from the presentations this morning, the health needs of certainly the poor population have not been adequately met. One could cite the infant mortality statistics, the tuberculosis statistics, the venereal disease statistics and others which Dr. Philp has commented on so well.

What I am suggesting is that we, in a new agency like the Office of Economic Opportunity, have not generated a new need. What we are doing, I believe, is responding to a demand. If we might take the Headstart program as one model since it has been mentioned, I would point out that a short 14 months ago there was no comprehensive program for the care of young children below school age, and since that time some 561,000 children have been in a summer program of 8 weeks' duration, and approximately 150,000 children are currently enrolled in a yearround program.

Again I would emphasize that this program was projected by the Office of Economic Opportunity not because it was looking for work, but, rather, because there was recognition that there was a need which people in communities across the Nation were asking to have met.

In connection with the development of the health program within a project like Headstart, it is important to note that only about 8 percent of the preschool children in the poverty population are the recipients of continuing health services. If existing agencies had been delivering the services, utilizing the high standards that have been mentioned, certainly there would have been no need for the incorporation of a new health program in a program of this nature.

What I would like to comment on now in terms of new institutional forms, moving away from Headstart, is the fact that a new institution or a new agency need not necessarily be looked upon as one which would mean further fragmentation.

Again I come back to the Economic Opportunity Act which, under its section 205, which provides for the development of community action programs, has a very broad charge, a noncategorical charge, if you will. As the Office of Economic Opportunity has moved into the area of developing health programs, we have put the pressure on local communities for integrating services rather than fragmenting them further. Let me provide one or two brief examples.

In the Headstart program, we insist that local communities not displace existing health services, but that, rather, through the Headstart program, the staffs of these programs work out arrangements for families and children to use services that exist in communities.

Unfortunately, we are finding that this is a difficult task to accomplish. It is more easily said than done, because professionals are not accustomed to reaching out into the community and pulling services together—for reasons that have been very well described here this morning.

We have been going through an educational process. Anyone reading the literature prepared for Project Headstart, can see that we put great emphasis on providing for the children and their families ways through which they may come in contact with the immunization programs, the maternal-child health programs, crippled children's services all of which exist with many others in the community already.

So the effort is not to displace these services, rival them or compete with them, but, rather, to integrate them through the Headstart

program and through the introduction of professionals who have, as their charge, the integration rather than the further fragmentation of these services.

Another example through which this might be accomplished is the neighborhood health center which Dr. Dennis mentioned in his presentation. Again, because of the very considerable fragmentation of services, particularly for the poor, we think it may be possible to establish a one-door, comprehensive health facility in the communities and to bring together through this one-door facility the funds and the resources that now go into the variety of fragmented services.

What I am suggesting, therefore, is that new institutional forms which the Congress may establish need not necessarily be looked upon as augmenting the process of fragmentation and discontinuity of services which now seems to be so prevalent.

It has been our very deep commitment in the Office of Economic Opportunity, to take this charge, to integrate health services, in a very serious way. But since we have gone down the road to fragmentation for so long a period of time, I think that a considerable period of reeducation is going to be necessary, reeducation particularly of people in the health professions, before they can see the wisdom and move into new patterns of integrating their services and their functions in more effective ways.

Thank you.

Dr. HILLEBOE. Dr. Mattison, do you want to comment?

Dr. MATTISON. I guess this is the penalty for having jotted down some notes.

Yes, there are two or three things which occur to me. One concerns what Dr. Richmond was saying about if the job had been done, then there would be no need for Congress to set up new programs and new agencies.

I would like to point out that, as a local health service officer back around 1954, I was pointing out the concentration of certain health problems in the low socioeconomic areas in my particular jurisdiction and asking for more funds, more nurses, more doctors and more clinics to meet those needs, even though at that time most of our services were concentrated in the poor areas. They were not granted. They were not forthcoming either from local, State, or Federal levels.

Times have changed in the last 10 or 15 years. There is greater affluence, there is a whole new spirit of intolerance of poverty and those social characteristics which lead to illness. It is now fashionable to spend tax dollars to fight poverty and ignorance, and some of these other things which affect health.

But I don't think that is any reason to say that we have to forget the agencies and the instrumentalities that communities have had for many years in order to do a better job in these especially afflicted areas. Obviously, some agency, some group of agencies, must be "beefed up" to do the better job. There is no reason why we shouldn't start with what we have.

I would like to mention one other thing which has concerned me for some time, and that is the effect of a reflection downward—and as a local and State health officer I would have objected to that word "downward," I guess—a reflection downward of patterns which are established at the Federal level, organizational patterns which are established at the Federal level.

Just during the past few weeks I have heard of at least two States where they are already thinking about taking various sanitary engineering activities out of the State health department, setting up some kind of a new organization within the State in line with the kind of suggestion that has been made that water pollution control be taken out of the Department of Health, Education, and Welfare, and put into the Department of the Interior, and the talk about housing and perhaps atmospheric pollution being taken out of the Public Health Service and put into the new Department of Housing and Urban Development.

I would like to point out that even if this is logical, and I am not sure that it is, at the Federal level, that the reflection downward of some of these patterns makes even less sense at the State and local level, and that the concentration of professional know-how which has been built up in the field of environmental health, for instance, within the Departments of Health at the State and local level probably are doing a better job there than they would if the same talent were shifted over to the Department of Public Works or even to some independent, non-health-related agency.

Dr. HILLEBOE. Dr. Breslow?

Dr. BRESLOW. A comment on this point of fragmentation. When we build highways, we are accustomed to turning the job over to engineers. In establishing educational programs, we call upon professional educators. In developing welfare programs we are more and more bringing into leadership persons who are professionally qualified in welfare work. But when it comes to placing responsibility for health programs, the attitude historically has been that almost anybody can run a health program if he has some general experience in administration.

We need to face very candidly the reason why this has happened in actions of the Congress and the State legislatures. I believe Dr. Richmond has put his finger on the main point. The fact is that those in governmental health programs over the past few decades have failed to assume the leadership which is needed to meet the health problems of people. Before we can be hopeful of assuming any more responsibility, we have to face this historical fact. We should avoid becoming the type of organization to which Mr. Gardner has referred as undergoing organizational dry rot.

However, some things ought to be said on the other side of the picture. When these programs for health are placed in various governmental agencies—welfare, education, and others—with a few outstanding exceptions, and some of them are in the room here today, the medical personnel in these agencies have tended to be part time and untrained in medical administration.

This reflects, I believe, the lack of willingness of good medical administrators to work under circumstances in which decisions about the medical components of the programs are formulated and really made by nonmedical people. I think it is worthwhile to spend a couple of minutes on the nature of the medical components of these programs because obviously they are complex programs and not all medical.

The public assistance medical program is by no means all medical, nor is the school medical program. But there are medical components. I would like to list a few of them.

First, is the formulation of the benefit structure. The specific medical and health services that are going to be provided is a matter requiring medical judgment. Are we going to provide drugs? What kind of drugs? Or is it preferable to provide diagnostic examinations if there has to be a choice? There often does have to be a choice.

Second, what are the standards for the service going to be? For example, if we are going to provide cardiac surgery, what kind of facilities and personnel ought to be required for the provision of cardiac surgery? That is a medical problem.

Third, there are relationships with the medical, dental, and other health professional groups, and with the hospitals. These require from the standpoint of the governmental program and the public interest, competent, full-time medical administrators in the governmental programs.

Also, there should be evaluation of the programs, not just the number of dollars going in and coming out in various forms, but the medical benefits of the program. Evaluation in this sense is a medical matter.

Thus we do have in these programs important medical components.

Now that the Congress is responding on a more and more appropriate scale to the health needs of the entire Nation, I think the time has come to put health programs together in a different way. Most important, there should be established at the Federal level competent national health planning and leadership.

I believe, and I think that those in State and local health work generally believe, we should express to you as strongly as we can that the capability for this already exists in the Federal Government, in the Office and in the person of the Surgeon General of the Public Health Service.

We would like to see the leadership potential of this office maximized. Further, we would like to see, through such a mechanism as has already been mentioned, H.R. 13197, and possibly in other ways, support to the development of a similar capability in the States through comprehensive planning for health purposes.

Dr. THOMPSON. I would like to ask Dr. Richmond one question: How far would he get with the Headstart program if he hadn't had the big appropriation from the Congress, and how far does he think I would get in Utah if I had that money in Utah; that is, instead of not having it?

Does he recognize that some of us try to get these moneys many times, as Dr. Mattison has just said, and have failed to get it because the people who we had to get it from, the State legislatures, the county commissioners, or the Federal agencies, didn't have it or were unwilling to give it?

I would say rather than having failed to assume leadership we were unsuccessful in our effort. Albeit, some health officers, and I could name a few, haven't done this, but I think a majority of them have and some have tried in a significant degree, and some have succeeded in part.

Dr. HILLEBOE. Have you a comment on that?

Dr. RICHMOND. Obviously, to accomplish any program one needs to have appropriate support. I don't think we have suggested we have failed. The point is, as I indicated earlier, that there is great need which has not been met. What has been developing is the demand.

We have more articulate populations, and particularly the poor are recognizing what they consider, and what society is coming to accept, as their entitlement to health services.

Obviously we cannot accomplish these shared objectives if we don't have support. But occasionally, because of a combination of circumstances, support becomes available in one form or another. In relationship to Headstart, certainly I didn't determine that the support would become available. But when it became available, it seems to me that those of us who are professionals had a charge to try to make it work as effectively as we could.

While we have not accomplished all that we would have liked in this program, the fact is that 550,000 preschool children who didn't have adequate health services 14 months ago have had many significant health services provided for them. Although one can raise the question as to whether in some instance a food service worker may have been called a nutritionist, the fact is that some 550,000 children were better nourished last summer than they had been before.

I also feel it is appropriate to enter into the record that when new agencies and new forms come along, this need not necessarily dilute the standards for care that have been established. What we were trying to do is to capitalize on the long experience of the Children's Bureau and other agencies in Health, Education, and Welfare to make this kind of a program a more effective program.

We don't come into this unaware of the long history and the long struggles that people in the official health, education, and welfare agencies have had over the years.

Dr. THOMPSON. I would like to put into the record another example of where substantial grants were forthcoming from the Federal service to meet a need that was long recognized, that was handled in exactly the opposite way in the OEO office.

This was in connection with the tuberculosis grant where actually the money was available to the State and the State made it available to the areas of the State where tuberculosis existed.

In the State of Utah, our tuberculosis comes principally from two counties, a few square blocks in Salt Lake and from a county that is an extremely rural area. We have been able to integrate the Federal tuberculosis money into the existing structure, I think, to the better use of the taxpayer's dollar, to the benefit of the people who need the service, and with the integration of the staff, with the one exception that I mentioned, we are now able to use the nurses to get the full integration.

I would think we would have assurance of integration rather than the confusion that we have had.

Dr. HILLEBOE. Dr. Peeples?

Dr. PEEPLES. I would like to make a couple of comments about some of the things Dr. Richmond has said. One is that I think the program under OEO for Headstart was primarily an educational program and it was put in the hands of the educators to carry out. In many instances these educators did not contact public health people, the professionals that Dr. Breslow mentioned.

On the other hand, in many cases they did contact them and they found that the health people were not willing to help them because there was not enough money provided for that section of their budget

to provide the health service itself. In many cases there were funds left over in this program and the educators came back after the program was over and suggested that these children be looked at, that there be rehabilitation programs of a medical nature done on the children who were found.

In Baltimore City, this program operated quite successfully. The only question that I had about the program was that they got very few new children into the program who had not been supervised medically before, because there was quite a good basic program in Baltimore City. This is in contradiction to Dr. Richmond's statement that there had been no comprehensive health programs available to these children.

I think this is true in certain areas, but it is also not true in other areas.

The State of Maryland, in deference to what Dr. Mattison said, had, a number of years ago, appropriated a small sum of money, $250,000 to provide for the preschool experience of handicapped children, those who had difficulties of various and sundry types, to give them an experience prior to entering school.

We realize that more funds were needed, but they were not available at that time. I think the real question here is in the spirit of does—let's say—an educational agency wish to cooperate with the health agency, and on the other hand, does the health agency really wish to cooperate with whatever agency has responsibility for the program.

If this spirit of cooperation is not there, then it doesn't matter whether the funds are available in one or the other. There must be that spirit.

Dr. HILLEBOE. Dr. Stewart?

Dr. STEWART. Mr. Chairman, the description of the problem which the papers gave this morning, I think, is quite accurate and very clear. This problem has been with us for a long time. It is described in the literature for 25 years. It is also described as an increasing problem in the literature.

You are seeing really the end point of something that has been going on for a quarter of a century. I don't think it would do us any good to spend time on why this has happened, except as it relates to what we might possibly do about it. The reasons why, I think, are very complex, and we could spend the rest of the time talking about why.

I think more important is what do we do about it, how do we get from here to where we want to go? First is where do we want to go? What are we really trying to do which, as an end point, will end up with better health services for people?

I believe that health programs will be in many agencies for some time to come. But I believe also that there should be one agency which has the health of the people as its sole responsibility and objective.

The problem, it seems to me, is to make sure that one always sees clearly what is the objective of a certain program, and how do the health functions of that program fit into that objective. For example, the U.S. Military Establishment is in business for national security, but it is going to have a medical component—a health component—

because this is part of providing the Military Establishment with its capability for protecting national security.

Likewise, I think that one can look at traffic control in a city, where the job is the flow of traffic. But it has a health component because it is trying to prevent accidents from occurring.

These, then, are programs which have, as objectives, some things which are not health objectives, but have a health component as means of meeting those obejectives. I think this is quite legitimate. But the health department at any level has as its concern the health of the population that it is responsible for, and its means are means toward that objective. I think we have to be clear as to what the objectives of the various agencies are that we are talking about.

Given this, what, then, really is the relationship between the two types? It seems to me the principal reason why there is need for an agency which has as its sole function the health of the people is to provide an official home for the professional and technical competencies that are necessary to carry out these programs. They need to be the best that one can get together into an organization. In order to do this, I believe they need programs—major programs—to administer which are directed toward the health of the people. This gives them a place, a job, a goal.

But I believe they also should serve as the source of professional and technical competence for the health components of other agencies which have health programs as part of programs directed toward other objectives. I think they should carry out the functions in that relationship that Dr. Breslow mentioned, although I think I could add a few more. But it is not simply a matter of consultation; it is also a matter of participation.

I agree with Dr. Thompson on the inflexibility of the grant programs which we have had, and I think the illustrations he gave become more apparent when you are in a State which has a smaller population, because the inflexibility becomes even more acute in that situation. In a sense, we have been saying to State health officers and departments over the years, "Here is some Federal money which, if you match, you can use to carry out a program for a specific purpose. But we do not give you any responsibility in carrying out that purpose." The job of implementing something without responsibility is a very difficult thing to do.

I think there are other things that one could discuss, but I believe that we really ought to set as a goal a strong health agency in all levels of government—an agency which has as its responsibility the health of the people of that jurisdiction, which is charged with getting the professional and technical competence that it needs to carry out its programs, and which participates in the health components of other agencies' programs.

I think we should try to move in that direction. We have tried in the last 6 months, in proposals now before the Congress, and in other proposals, to move in this direction. There is a long way to go and I think this is only the beginning. I think this needs to be done at all levels of government. A lot of it depends on what kinds of support we get from the public.

It is very difficult to run public programs without public support, and particularly support from those segments of the public which rep-

resent special interests. These include the doctors, the hospitals, the groups who are interested in health movements.

One can set goals related to the health needs of the people, but unless attention is paid to the machinery to carry out the programs, they remain just dreams. Nothing really happens. Our end point of concern must be what effect it has had on the health of the people, and we must measure it this way.

I think that is all I have to say.

Dr. HILLEBOE. Thank you.

Dr. Kimmich?

Dr. KIMMICH. Dr. Stewart just mentioned something about machinery which was along the line I wanted to comment.

We tend, I believe, to speak about fragmentation as some sort of a dangerous situation, which indeed it may be. But I believe, also, we are talking about "fragmentation" rather loosely at times.

During the course of these 2 days maybe we in this panel, and in subsequent discussions by Dr. Stewart, his staff, and others, will have the question of what we are talking about clarified. Fragmentation to me is a very negative word. It is the breaking apart of a necessary unity.

At times I feel that some of the things we have talked about today, that we have alluded to in discussions that have led up to our appearance today, are not necessarily references to "fragmentation," but, instead, may be references to the administrative delegation of parts of tasks. The planful analysis of the task to be done and the best ways in which an organization can be put together in its component parts, which winds up doing a job well, may indeed be interpreted by some as fragmentation.

What I am trying to say is that it is commonly absolutely necessary to see a function or a program, or a goal, in terms of its component parts and assigning people and resources to these component parts in such a way the job will be done with responsibility and with dispatch.

I get a little bit concerned about this thing. I, too, join in the complaints about overfragmentation, overspecialization of things. But I simply hope that we will not get caught in something which can be carried to an absurd point on the other hand. If we do not have fragmentation then what do we have? Do we have some kind of homogeneous situation in which somebody does everything for everyone and there is only one department of government, or maybe two, the department of people and the department of everything else, which, of course, would be the absurd carrying out of this complaint that we have about hyperfragmentation.

I believe there are complaints, and I would say that in the area that we have labeled fragmentation, my concerns have more to do with the discoordination, the disunity, perhaps, of parts of Federal legislation or grant regulations, Federal grant boundaries, shall we say, in such a way that these develop large gaps, and categorizations come about which make it almost impossible to put them back together at the State or local level in a smooth way.

I am less concerned about the organizational—less concerned, not unconcerned—frameworks within which the grants and legislative acts are carried out. This is important, and I don't want to get off this point and say I don't care what the organization is. I think it is very

important, but I believe that as Dr. Peeples said, the spirit of cooperation must be there.

I know from my own experience in various jurisdictions that if the spirit of cooperation and coordination is present, this will be done, no matter what the organizational framework. If it is not present, it will not be done, no matter what the organizational framework.

Let's not confuse fragmention (which is some kind of a destructive situation making movement and proper local application impossible) with a delegation of parts of a job to be done. Let's not equate separation of a job into its component parts with impossibility of a coordinated task.

Dr. HILLEBOE. Dr. Mattison?

Dr. MATTISON. Could I suggest what the doctor has been saying is that we should immunize ourselves not only against fragmentosis, but also against monolithiasis?

Dr. HILLEBOE. Very good. We ought to immunize ourselves against fragmentosis, a new disease entity that your subcommittee today created—so you are creative people—and the second one was monolithiasis. "Lithiasis" means a stone caught in some ducts so things can't move. This is the kind of thing you get sometimes in big organizations.

Dr. MATTISON. We are no more for a monolith than we are for fragmentation. There has to be some middle ground.

I would like to go back to something Dr. Stewart said. I think that one agency, whether at the State, local, or Federal level, cannot do all the things for all the people. On the other hand, there are not enough trained professionals to have separate health departments in health, in welfare, in education, in agriculture, in conservation, and you go on and on.

So there has to be some middle ground here between a monolith and between all these fragmented bits. I would like to say that I would agree with what Dr. Stewart said, providing he definies participation with these other agencies a little bit more definitely. I think that health departments, health agencies, ought to run some health programs. I think there are others which can be perfectly properly operated by other official agencies so long as two things happen:

First, that the competent health agency provides standards—standards not only of program but of personnel; and second, that there is authority given to them to monitor those programs so that they see that the standards in both the program and personnel are being enforced.

Dr. STEWART. I think I would agree with you. I think the key to participation is what Dr. Peeples said. He called it a cooperative spirit. I would say a "We trust one another" kind of relationship.

Dr. MATTISON. Even more so when it is in writing.

Dr. STEWART. If you are talking about a health program in another agency which is using this as a means toward some other goal, and there is a participation of the health professionals, the agency that is responsible for the total program has to have enough confidence and trust in the professional input they are getting from the health organization to feel that this is really what is needed and will not act as a deterrent to this other goal. Likewise, the reverse is also true.

This, I think, is the key to participation. It is different than advice, which you could take or leave. It is different than consultation. It is a working together on a portion of a program. It includes the plan, the implementation, the evaluation. It is not just the plan.

Dr. HILLEBOE. Dr. Peeples?

Dr. PEEPLES. I was going to change the subject slightly here and get on to another part of this. We have been in considerable difficulty with Dr. Stewart and his auditors because we have not used categorical funds strictly in a categorical way. We have put these funds in to really support matching State funds to local health departments where health services are given.

We have had a difficult time, according to the Federal accounting systems for these funds, of showing that the funds have been used specifically for, let's say, heart disease or services to cancer patients. But we have given those services to patients with heart disease and we have given those services to patients with cancer, so we feel that supporting the service, be it for cancer, for stroke, for patients with tuberculosis or for patients who are afflicted by maternity or what have you is the most important point.

We so far have escaped any penitentiary sentences or even returning very much of this money to Dr. Stewart's coffers.

On the other hand, when $10,000 was appropriated to the State last year to set up a specific dental program, we turned this money back to the Public Health Service because we did not have a specific, planned program which would make good use of this money, although we could show that dental services which had not received any previous Federal matching was spending some $250,000 in State and local funds.

We also turned back some $42,000 just recently for laboratory services for the heart disease program. We could not justify this program because we didn't have enough heart disease programs going in the State at that time to justify this much laboratory service.

When we get to the point of planning heart disease control services for certain populations within the State, then I think we can justify these laboratory services to support such heart disease control services, but I think there must be planning prior to appropriation, and if the appropriation is a result of planning, then I think we are all on a better footing.

Dr. STEWART. I think Dr. Peeples gives a good description of some of the problems that can arise from this inflexible categorization of grants. Even worse than that, occasionally a person with heart disease gets cancer and this really messes it up even further.

Dr. HILLEBOE. Dr. Dennis?

Dr. DENNIS. I would like to ask if we are going to have an opportunity this afternoon to perhaps discuss the impact of the requirement for matching funds and the way this affects fragmentation in the lower levels.

Dr. HILLEBOE. You can have an opportunity this afternoon or right now, whenever you want.

Dr. DENNIS. Some of the problems of fragmentation are magnified at the local level due to the requirements for matching funds. I know that in our State over the past years, if you study the history of how various health services and programs have been set up in the various

agencies, they have gone to whatever agency that happened to have the matching money rather than according to a plan or according to any logical reason.

As a result, most of the health programs and plans in the last few years have wound up in the department of welfare rather than being related to a bonafide health agency. I am not stating this is good or bad, one way or the other. I am pointing out that it was related almost entirely to having funds for the matching purposes at the State level. As a result, we see medicare administered by the State department of health, title 19, in the welfare department; crippled children which, as you pointed out in most States is under the health department, is in the welfare department, and title 19 covers much of the same program.

We are running into problems of duplication and fragmentation, with questionable standards. The development of health programs on the basis of availability of matching funds would be one of the things that I would hope that a planning and coordinating group could look at. If we are going to meet our goals and objectives of taking care of our people, I think that we must look at this. How can we best meet those goals?

I would also like to raise one other point: I enter into this discussion as a medical educator reflecting the problem of the medical schools in terms of support, and the fact that we are sometimes caught like a ping-pong ball between all the various agencies that have the money and to whom we turn for help to get things done in our own programs, in order to produce the health manpower the agencies require for their services.

This morning I became the Devil's advocate and emphasized other aspects, but I would like to point out that to plan services, "retail stores," if you will, without first knowing how you are going to man them is not very good planning.

We have a real shortage of health personnel, not only physicians, but, in all other health fields, yet, I find as a medical educator, that I can find money for the support of research programs and categorical programs of all kinds. I can build laboratories, I can even now perhaps, if I have money to match, build medical school classrooms, but I cannot support primary educational functions for the production of the people that you are going to have to have if you are going to run these health service programs. Manpower production has to come first or we are in trouble.

Dr. HILLEBOE. This is also true when we set up so many different groups that want the same people and compete for the same people, using funds from the same source.

One question that has come up from Dr. Richmond's comments I would like to direct to Dr. Winston. This is a very broad one. I have been interested in public welfare in its broad sense ever since I worked in a welfare department in 1933.

This is some years ago, Dr. Winston, but things have not changed very much since then. The point is this: I quite understand, and many of us do, how the Office of Economic Opportunity developed. There are social reasons and other reasons, and I have no objection to this sort of thing because in its wisdom the Congress and also the President had this kind of legislation introduced. But I wonder, Dr. Winston,

if the time has not come to put this Office of Economic Opportunity where it rightly belongs—in the welfare administration?

I am quite conscious of the fact that your legal responsibilities are such that it is well defined what you must do, particularly in the field of public assistance. But you are dealing with people in this area who need help. Certainly if we are going to think of welfare in its broadest terms, we should think of public welfare and not just social or economic welfare.

I wonder in terms of cutting down the number of groups working in this field if we shouldn't look toward bringing the Office of Economic Opportunity and all its activities into the Welfare Administration on a long-range basis. What is your feeling about this?

Dr. WINSTON. I will be glad to comment on this in some rather general ways.

I think in the first place, you have to recognize that the Office of Economic Opportunity is a many splendored thing, and there are programs which are carried out through that office which are health-oriented, education-oriented, or are very directly related to the interests of the Department of Labor and even of Agriculture.

In the second place, there has been real effort, continuing effort, to have consultation, to cooperate appropriately in many areas. It so happens that in the Welfare Administration we do administer directly by delegation one of the titles in the Economic Opportunity Act, title 5, which is the work and training program, a program under which we have today about 57,000 men and women who are getting vocational experience, training in special skills, often literacy training, and a family-centered program to help raise them and their entire families out of poverty.

We have a close parallel to this in the adult literacy program which, by delegation, is administred by our Office of Education.

Over a period of time, and depending partly on the people who are involved, we have a high degree of cooperation. I have on my staff a person directly responsible to me who does nothing except serve in a liaison capacity just with the special interests of the Welfare Administration as they relate to the Office of Economic Opportunity.

Dr. Richmond and I are old friends and we have worked long in the child care field. We share common objectives here with regard to day care for children, however defined, and concern that all of the elements of a good program for children be involved, whoever happens to be operating the program.

I think in looking at the programs of the Office of Economic Opportunity, and other programs which are in the same general area and serve primarily the same general public, there are two or three major factors that we always need to keep in mind.

In the first place, our money comes differently. In the long established programs under the Welfare Administration, the funds, after all, are very specific in terms of the purposes for which they can be used. They call for very specific matching on the part of States. There is very little in the way of discretionary money.

You would be surprised, I am sure, in terms of the size of the programs how how little discretionary money there is that can be used for experimentation and innovation.

The Office of Economic Opportunity, on the other hand, has the very great advantage of having very substantial discretionary funds. Of course, where you are plowing in new funds, this is tremendously important.

Dr. HILLEBOE. You wouldn't mind having that, would you?

Dr. WINSTON. Well, I certainly would like some more.

In the second place, I think we should recognize that in the basic programs which we are operating, we have a multiplicity of detail in the law. In other words, we are carrying out very specific programs that are very clearly and carefully defined in terms of requirements and what have you in the law.

The legislation creating this new governmental structure is much more general and leaves the door open for the directions in which a program shall be built. So that is another difference.

Then we have the whole question of the relationships with other levels of government. Under the established welfare and indeed the child health programs, too, and this was referred to this morning, we work with States. We work with States which, in turn, operate programs directly or supervise those programs with local administration. So we are always going through levels of government as we get to the people whom we serve.

In the Office of Economic Opportunity, the relationship generally is Federal to local. This is another important factor. What I realize I am doing here is pointing out the major areas of differentiation that have to be fully recognized in terms of any effort to evaluate program areas or goals.

Another area that becomes extremely significant is that under the basic public welfare programs the program must be statewide, it must be in operation in every jurisdiction, it must be available in the way of whatever services it has to offer to all people in like circumstances on an equitable basis.

This is a very different approach from a program that is basically a project-oriented program which may develop in some communities but not in other communities, which may serve one group in a community but not a like group in the same community. So really here we are talking about programs in which the basic characteristics, the basic factors, upon which those programs are established broadly are quite distinguishable and have a very strong impact upon the kind of program you operate.

I do think that I would like to update you a little with regard to your welfare experience because increasingly we have moved into changes in administration, into new ways of doing things. I can submit statewide policies as well as special projects. So it is not a basic overall difference, but there are differences in degree in terms, frankly, of the availability of funds.

Dr. HILLEBOE. I opened this discussion and I don't want to continue this dialog, but I would like to make just a couple of points.

I think our representatives from the States are very much concerned about this relationship between health and welfare activities in the States, and why they can't do things for each other.

There are two general homilies I would like to make. One is that it is one thing to go steady and be good friends; and it is quite a different one when you are married, working as a team, and have the

same authority and responsibility. I think we cannot compare the two.

Really, if you have a marriage between the welfare aspects of the Office of Economic Opportunity and the Welfare Administration, I think this would be more permanent, more beneficial, and there would be more developed.

The second homily, and I think it is a prominent one, is one that my father made—who happened to be a banker—that when you get to the point where you have a little money to invest, he said:

> Put about 90 percent of it in good securities, the blue chips, but keep about 10 percent and speculate with it. It won't hurt you and you will have a lot of fun. If you lose it all, it won't damage you. But you might hit sometime.

I would like to see the Welfare Department pulled out of the rigidity of its public assistance program and have some opportunities for flexibility, not necessarily in old-age assistance, aid to dependent children, aid to disabled, or so forth. I would like to think of the Welfare Administration as expanding into the whole field of human welfare.

Just to let you know that I am updated, I have been meeting with the commissioner of welfare of New York State for 16 years every month for a half day, and if he hasn't updated me, it is his fault.

I think some of the members of the group would like to bring up this question of fragmentation with health and welfare, because this is a very critical issue. It reaches down into every single community. I wonder if some of the health officers, or perhaps Dr. Kimmich, would like to discuss this, and also have some dialog with Dr. Winston. We have the expert here and this is the opportunity to engage her. If you don't, I will.

Dr. SOWDER. I will, if you let me bring in a couple of other things.

I enjoyed the three papers this morning. Each of them said things I wish I could have said as well. I want to emphasize one of the things that Dr. Dennis said. I don't know whether it was understood or not. That is about manpower for health.

We have been talking about the desirability of cooperation with other programs and that sort of thing. But nobody said anything about whether or not they are going to have enough people to man all of these multiple programs. I feel, along with Dr. Philp, that we have perhaps too few people and too little public health money at the local levels as compared to State and Federal levels.

One of the reasons for that is that we have too many categorical programs, requiring too many leadership positions at State and Federal levels. It is just the nature of things that for every such program you have to have staffing and that takes up scarce personnel. I think, and I am sure I am not alone in thinking, that we are going to have a shortage, perhaps not of money, maybe there is an adequate amount of money, but a shortage for many years of people in public health.

I don't think we need as many leadership positions as are required for the way we are doing things now. I think administration could be simplified and we could do with fewer people at the Federal levels, in the regional offices, and in the State offices.

Incidentally, Dr. Philp, we haven't had a complaint about the distribution between urban and rural areas in Florida for about 20

years, but we have lots of complaints about the State keeping too much money instead of passing it on to local communities.

We also have some complaints of our own to make because we can't get the money down to the local levels because of the overcategorization. The difficulty in getting down there is showing satisfactorily, that it is being used for the purpose for which it was appropriated. We are trying hard but in many programs we have to operate them at a State level just because we can't put it into the local machinery where they have one- or two- or six-nurse health departments. We can't have a special nurse on TB, venereal disease, immunization, and all that, so we have that problem.

I might say, also, that this applies to the health components in other agencies, such as welfare. How in the world can the country afford to provide for experts; and, you might say, leadership programs in technical and professional fields in so many departments when people capable of filling them are so scarce?

I think personnel, rather than money, is the biggest problem we have. I think we have to conserve our leadership and use it in the best way possible.

I have one other point. Dr. Philp spoke of the need to put the money where the people are, and I agree with that, but I would like to comment on this point. I think we have to remember that people do not stay in the same places, that they are mobile. It is very shortsighted to attack tuberculosis problems in New York City, Miami, or Jacksonville, and forget about where these people got tuberculosis and where they came from. In other words, we have to look at the country as a whole, our States as a whole, our communities as a whole, and remember that the fellow who is now in a big city, in Chicago, or in Pittsburgh, perhaps came from a rural area in the South.

In our State, for example, we have carefully analyzed the occurrence of tuberculosis, because we were up against this philosophy that too little money was going to the metropolitan areas, and that this was where tuberculosis occurred. We divided the State into population thirds, by counties, all equal in population and we found no difference in the prevalence of tuberculosis in the third made up of the rural counties, and the third made up of the two or three biggest counties.

What I am saying is that it is a shortsighted policy to pour all our money, just because of these platitudes, where the most people are. The people are everywhere. Particularly in the case of diseases that are contagious, we have to fight them everywhere in order to keep them out of the places that we may be particularly interested in.

Dr. HILLEBOE. I think there is another point, too, Dr. Sowder, on this business of what you do with the people in urban centers. In addition to looking at the relative amount of diseases, such as tuberculosis, in an urban center compared to the nonurban center, as Dr. Stewart pointed out, we have to have the professional skills to go in and look and see whether or not the people in the city are using the money the way they should use it to get the most out of it.

It is conceivable that a given amount of money spent properly, with good administration and good leadership, going into details of it, for example, in tuberculosis, examining the contacts, see that you don't lose the cases, following them up, this has to be looked at as well. So I don't think it is just a matter of distribution of funds, but I think it

should be distribution of funds after it has been shown that the funds are properly spent for which they should be spent.

Mr. YOUNGER. I would like to have some comment on the fact of whether the Federal Government would be better off and the State governments would be better off if we made a blanket appropriation for health and gave it to the States, and you in the States would administer it the way you want to, put it wherever you want to put it, wherever you need it.

In other words, we would show a little more confidence in the ability of the State to do a job. It seems to me that if we get all the people on the State, the local and the Federal payroll, there are just not enough personnel to go around, and we know it. I would like to have some comment after the recess on the possibility of that approach.

Dr. HILLEBOE. We will note this question, Mr. Younger, as to whether or not a block grant of money to the States, with proper safeguards, of course, would not be the way to handle this. I think this would be very appropriate. We shall bring it up immediately after recess.

Mr. ROGERS of Florida. A great deal of the testimony we have had in the first 3 days pointed up so much emphasis on activity, to show something was being done, rather than emphasis on results. I think we should go into that a little bit.

Should we have outside groups come in to evaluate or should it be done inhouse? What approach should be made to shift us from this preoccupation with activity over to results?

Dr. HILLEBOE. The business of how many pamphlets are passed out; yes. There is a nice expression for that that we use in public health, Mr. Congressman, and that is that we should measure effect and not effort. I think this is what you are driving at. It seems to me this is very pertinent. We shall be glad to bring it up after the recess.

I think Dr. Richmond wanted to make a comment on one thing.

Dr. RICHMOND. I thought it might be well to just pick up on this manpower issue which has been raised and which has been amplified. I am a little diffident about talking about manpower in the presence of Dr. Stewart because he has written and spoken on this so extensively and so well, but since I, too, am a medical school dean charged with responsibility for the education of physicians and other people in the health professions, I would like to comment on a few of the difficulties that we are in at the present time by way of producing the manpower to deliver the services that we keep talking about.

I think that we, as professionals, always are beset with the emphasis on the maintenance of quality and are concerned about training all of the people that we need before any authorization for services or any plan for implementation occurs or is developed. I think that in a society like ours we, as professionals, must gradually learn that things don't come out quite that evenly.

For example, some 15 years ago the Association of American Medical Colleges was publicly stating that we needed to double the output of physicians by 1975. Well, we moved from about 6,000 physicians per year being graduated to approximately 8,000, and it doesn't appear that we will hit that mark by 1975.

It seems to me that we must admit the fact that we haven't trained enough, but I think we might also be pushed toward looking at a

reorganization of our services and particularly the development of new institutional forms, perhaps, by which we can stretch the professionals' time.

This is no time to get into the details or complexities of this, although we are all struggling with it in many different ways. What I would suggest is that the new demands which are upon us, which are becoming of almost crisis proportions, emphasize not alone that we ought to train larger numbers of people in the various health professions, but also that we ought to take a very hard look at how their services are being utilized.

I think in time, because of external pressures upon us through demands for new programs, we will learn increasingly more effective ways for doing this.

Dr. HILLEBOE. Dr. Kimmich?

Dr. KIMMICH. I have a couple of brief comments. Fortunately, Dr. Richmond just made one of them. That leaves the other, which was simply a remark for the record.

Dr. Philp said on page 4 of his statement there was the lack of administrative and medical logic for separation between administration of mental health and health programs. I felt it necessary not to let this go by without a comment that there are a number of people who strongly take issue with this point. It is not a completely unanimously held opinion either way.

Rather than arguing the merits of either at the moment, I did want to make the comment for now and it can possibly come up in another context.

Mr. ROGERS of Florida. May I just ask this: Dr. Richmond, you said that only about 8 percent of the children who are now given health care under the OEO program had received health care previously.

Dr. RICHMOND. Continuing health care, the kind of supervision we would consider to be optimum.

Mr. ROGERS of Florida. Did any of these children fall into the welfare program?

Dr. RICHMOND. All of these children presumably have available to them existing maternal and child health services through health and welfare departments.

Mr. ROGERS of Florida. But they have not made use of them. Is there any reason why they have not?

Dr. RICHMOND. I think the reasons are complex in this population group of low educational levels, lack of motivation, lack of familiarity with existing institutions and patterns.

Dr. WINSTON. Perhaps I better put just a partial answer into the record at this point and we can speak to it later. Dr. Lesser can certainly bring the figures on the increasing number of children who are cared for under the various child health programs administered through the Children's Bureau.

We have been very deeply concerned about the whole question of health services for low-income children. I am delighted that Dr. Richmond indicates that when the problems have been found in the Headstart programs they could be corrected and the children could continue to be followed for their health services because this is just a big job in itself, just for that group of children.

But we have been extremely concerned over the fact that where States have had funds to match available Federal moneys for health programs, the State money has normally gone to health programs for older people. We are delighted to have health programs for older people, but not when we have a good health program for older people and we have had practically nothing for children.

We also can give you for the record the fact that all the State matching funds which have been made available, and there have been sizable funds, the great bulk of them have been not for children. At the present time we have some 12 States in which there have been practically no programs financed under our fairly generous vendor matching programs for the health care of children in ADC families.

I would like you to know about a series of meetings which we held last year reflecting our concern over this problem before we even dreamed that we would have the new legislation. In January 1965 we brought together an advisory group to talk about the overall problems in adequate health care for children in low-income families with particular reference to the children who were known to public welfare departments, not only in the programs of aid to families with dependent children, but also children in foster care and children who were receiving other types of social services.

The result of this was that we organized what we called teams out of our regional offices consisting of the person in the regional office who carried major responsibility for working with States on the program of aid to families with dependent children, the person with major responsibility for child welfare services under the Children's Bureau program, and the person with major responsibility for child health services.

This group, sometimes augmented, went into every State last year and sat down with the top leadership from the State health department, and I am sure some of the members of this panel participated in those meetings, and the leadership from the State welfare department to direct themselves, together, to looking at the resources within the State to meet the health needs of children from low-income families, to talk about the gaps, to talk about the most effective utilization of what was available already and how gaps might begin to be filled.

Moreover, we had summaries of these discussions which are in our office and which have been used extensively because we recognize very clearly, I think, in this one type of activity, the common concerns of State health and welfare personnel for the health needs of children and the necessity of their working closely together and coordinating both what is currently available in the way of resources and supporting each other in seeking to fill in the gaps.

Mr. ROGERS of Florida. That is something I would like to pursue a little bit afterward.

Dr. HILLEBOE. Yes. We will do that after lunch. There are still about six people who want to talk, but I will hold them until after lunch. I have the points that you gentlemen have made. We are bearing down on the subject now.

Mr. Younger wants us to talk this afternoon about the general grants to States. I think also we should talk a little bit about the fragmentation between health and welfare, between mental health and physical health, between crippled children and vocational rehabilitation for adults.

We must get into some of these things. Fortunately, we have another 1 hour and 15 minutes after lunch. We will try to crystallize this for after lunch.

Mr. VAN DEERLIN. We will recess now and reconvene at 2:30 this afternoon.

(Whereupon, at 12:45 p.m., the subcommittee recessed, to reconvene at 2:30 p.m. the same day.)

AFTERNOON SESSION

Mr. ROGERS of Florida. The committee will come to order, please. We will turn it over to you again, Dr. Hilleboe.

Dr. HILLEBOE. Thank you very much, Congressman Rogers.

I think that we had one comment that Dr. Breslow from California wanted to make in fragmentation and then we are going to get into the two questions of Mr. Younger, and that you brought up, Mr. Rogers. There are three or four other things we would like to cover. We would like to spend from 2:30 until 3:45 to continue the discussion of fragmentation. This is really the major concern we have. I would like to get right into it and ask Dr. Breslow if he will continue the discussion in this area.

Dr. BRESLOW. Thank you, Dr. Hilleboe.

This is in response to the remark that only 8 percent of the children getting services under the OEO program had been getting services previously, and the remark that this might have been due to a lack of motivation or other factors relating to the mothers of these children.

I would like to discuss fragmentation from the point of view of how these several programs which the Congress has initiated really impinge on a mother. Let us assume a mother who is receiving aid to families with dependent children. The most likely medical event in her life is to have another pregnancy and another child. Let us follow the process through, assuming that the mother is intelligent and highly motivated.

She would start off by seeking care for her pregnancy, prenatal care from a health department clinic supported perhaps by maternal and child health funds. However, when the time came for delivery she would be sent to a public hospital supported by local funds; there she would encounter a new group of doctors, receptionist's forms, and papers.

In the hospital she would be examined by a physician and her infant would be examined by a physician. Neither of them would see her again. She would take the child home. Being an intelligent, highly motivated mother, she would take her child to a health clinic. There she would get well-baby care and perhaps immunization. However the baby might get sick. So she would take the sick baby to the clinic. They would tell her that they only care for well babies. Because the child is now sick she must take the baby to a welfare medical care program, perhaps the doctor over the drugstore on her corner. She would take the child there and he would provide care for a few days. The baby might then become quite ill and have to go to the hospital. She would take the baby to the welfare program doctor thinking he would admit the baby to the hospital. But that program does not provide for hospital care. She would take the baby back to the public hospital.

Even this might not be the end of the story because the child might

be eligible for crippled children's services and have to go to a different hospital.

I submit that if a man from Mars looked at this situation he would think that the whole scheme had been designed to obstruct care, not to provide it; he might be right, as a matter of fact. We should not talk about the motivation or intelligence of these pople so glibly. If any of us or our families had to go through such stress and turmoil to get ordinary care, I think we would have a great deal of difficulty and might become discouraged.

Recently we have seen the inauguration of the title 19 programs in some of the States. One might think that this general health program would solve all of the problems, but it does not. We still have the special health programs: crippled children's services, tuberculosis programs, prenatal, postnatal, venereal disease, and all the other special programs. These are usually good programs, with high standards built over the years and with physicians well qualified for the work.

It is unfortunate that in the communities of the country and in the States there is generally not adequate provision for the integration of the title 19 programs with these specialty programs. To accomplish such integration is still a struggle, primarily because the older health programs have grown up in the health departments. They can be criticized and I would be one of the first to criticize them for their inadequacies in the past and present, but when we fragment care further in these new major programs for people who are so much in need, we are merely perpetuating the difficulties, not solving them.

Mr. ROGERS of Florida. What do you think can be done to correct this?

Dr. BRESLOW. I would think that the principal step would be to incorporate into the Federal legislation—and, of course, then into the regulations—a requirement that the medical components in the administration of the public assistance medical program, title 19 program, be placed in the agency that has the competency to provide direction to the medical components of the program. That means the health agencies of the country.

The fact is that the title 19 legislation carried for the first time a provision that the Governor of each State could decide which department would have the administrative responsibility for this program. Previously the legislation had required that the programs go to the welfare departments. They have grown up there. Merely putting in the authority for the Governor to transfer the administrative responsibility has not solved the problem.

In some States, and California is one, we are making substantial progress because we have a health and welfare agency to which the Governor can assign the responsibility. Then it can be subdivided, with those things that are medical going to the health department, those things that are welfare going to the welfare department. But I think the major step would be for the Congress to write into the legislation a requirement that the medical components of the program be administered by the medical agencies of the States.

Mr. ROGERS of Florida. Now under the existing law, since there is some choice given, could the Department of HEW through an administrative order channel it to the health department?

Dr. BRESLOW. They could do a great deal to encourage it.

Mr. ROGERS of Florida. Is this being done?

Dr. BRESLOW. In my opinion, no, sir. I will give you a couple of examples.

When a spokesman for the Welfare Administration of the Department of HEW appeared before a committee of the California Legislature, his presentation was such as to push the entire administration in the direction of welfare. When asked by a legislator on the committee the direct question: Doesn't title 19 give the authority to the States to assign this responsibility; his answer was yes, but it would create a great amount of difficulty.

That was one experience. The other experience was in the past, with the previous public assistance medical care programs. When California explored the possibility of a contract between the department of social welfare and the department of public health, for the department of public health to provide the medical administrative services for the welfare medical care programs, the consultants from the Welfare Administration who came to visit us rejected that notion. I think that the policy of the Welfare Administration has been very clear. It has been antagonistic to the assignment of this responsibility to the health departments.

Mr. ROGERS of Florida. They do no want to deal on a contract basis at all with the health department?

Mr. HILLEBOE. That is essentially the case.

Dr. BRESLOW. They discourage it as far as they can.

Dr. HILLEBOE. Mr. Chairman, I think some of the other States have had the same problem. We were talking to Dr. Frechette. What has been your experience?

Dr. FRECHETTE. In our State of Massachusetts the Governor designated the welfare agency as the administrative agency. Then the Lieutenant Governor, who is a former Assistant Secretary of HEW, suggested that the welfare department contract with the health department for the medical aspects. I was at the conference with the welfare administrator and the welfare administrator said if we do carry out such a contract he still will have to have a duplicate medical care administrative unit in the welfare department.

In spite of the contract we still have to have a medical care administrative unit in the State welfare department.

Mr. ROGERS of Florida. Is that required because of Federal legislation or Federal rules?

Dr. FRECHETTE. Federal rules, as far as I can determine, I haven't seen any legislative authority for this but this was made as a categorical statement.

Mr. ROGERS of Florida. Where did that come from? From the Commission of Welfare?

Dr. FRECHETTE. The State commissioner of welfare who said that he had substantiating documents to this effect. I haven't seen them yet.

Mr. ROGERS of Florida. I would like to follow this. He is assumed to have received those instructions from the Department here.

Dr. FRECHETTE. That is right.

Mr. ROGERS of Florida. And the Commissioner of Welfare?

Dr. FRECHETTE. That is right.

Mr. ROGERS of Florida. Do we have a representative here?

STATEMENT OF DR. ARTHUR LESSER, CHILDREN'S BUREAU, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. LESSER. Yes. I am Dr. Lesser of the Children's Bureau in the Welfare Administration. I must apologize for the absence of Dr. Winston this afternoon. It was impossible for her to be here. This came up suddenly. Mr. Mulder is here from the Bureau of Family Services. He is directly involved in the administration of the title 19 program.

Mr. ROGERS of Florida. That will be fine. Will you identify yourself.

Dr. HILLEBOE. Before Mr. Mulder speaks, could I give one example. I think this is a critical issue on which we need to have some resolution. What we are talking about, Mr. Mulder, is section 1903 of the amendments to the Social Security Act. Just to identify this we are talking about section 1903 of the amendments to the Social Security Act.

In New York State where I have been involved as one of the advisers to the administration, as a representative from the School of Public Health. The administration in New York State occasionally asked the great University of Columbia to give advice on what is going on. It does not want political advice; it does not want personal advice; it wants impersonal advice.

In this particular instance, to give you another example, the State of New York is quite prepared to introduce legislation to give the administrative responsibility to the welfare department because the welfare department must of course determine eligibility according to the law. The administration is also perfectly willing to have the welfare department make a contract with the health department to handle the entire medical part of it so that the welfare department does not duplicate the work.

In the first place, it would be nonsense for the welfare department to try to find 200 physicians who are experts in the field of medicine to work in the welfare department and do that sort of thing. Now we have been told again, informally about duplication. I think that Mr. Mulder will have something more to say about this. I would like to tell you of the situation we find ourselves in right now.

Our legislature is in session, we want to do something about this problem. We want to have the best program. We have been told informally that if the welfare department has the administration of the program and makes the contract with the health department, that it is very likely that the welfare department will receive 75 percent reimbursement for those expenditures it makes but for any expenditures controlled by the health department this will be reduced to 50 percent, which immediately runs into several million dollars. So, we are in this difficult position of not knowing how to proceed if we want help. We look to you people for guidance.

Our legislature is in session. Within the next 2 or 3 weeks it must make a decision. This is a very critical issue in many States where this is coming up.

Mr. ROGERS of Florida. Fine. Maybe you can enlighten us now on the approach.

You may proceed, sir.

STATEMENT OF CARL MULDER, ASSISTANT CHIEF, DIVISION OF MEDICAL SERVICES, BUREAU OF FAMILY SERVICES

Mr. MULDER. The law is very clear that it leaves to the States the choice, if the program is to be administered by a welfare department or by another agency designated by the Governor or the legislature as the State law or constitution may require.

To my knowledge, we are not pushing one way or the other with respect to this question. We leave this entirely up to the States. The statute, however, does have a few provisions which result in certain fiscal disadvantages such as Dr. Hilleboe just now mentioned. For instance, there is a provision that the agency that administers the program with respect to the medical professional and supporting staff is entitled to 75 percent reimbursement of the administrative cost but it has been determined by counsel that where such a service is not provided by staff of the agency but is provided through a contractual arrangement, that it ceases to be staff employed by the agency and becomes a regular administrative staff subject to matching only at the rate of 50 percent. This is not because of any administrative determination that we prefer to pay less to the one agency than to the other, but results from the language of the law.

Mr. ROGERS of Florida. Now let us read the law. I think it says:

> An amount equal to 75 per centum of so much of the sums expended during such quarter (as found necssary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency (or of the local agency administering the State plan in the political subdivision).

Mr. MULDER. The key words are "staff of the State agency"; and the services that are provided under contract are not provided by staff of the State agency.

Mr. ROGERS of Florida. That has been the interpretation assumed by the Department which I presume would be reviewed if it were determined that these costs are attributable to compensation or training of skilled professional medical personnel.

Mr. MULDER. All I can do here is to——

Mr. ROGERS of Florida. Yes, I understand.

Well, I think this is something that the committee can take up with the Secretary and the Counsel.

Dr. HILLEBOE. Mr. Chairman, this is something that really your subcommittee could be a great help in. We were offered an alternative approach. It was suggested, why not create a commission which includes social welfare, helth, and, if you wish, mental hygiene. If you have such a single agency then you can do what you want to do. Any one who is a student of administration and knows the first principles of organizational theory knows that you do not do service to the people by creating additional organizations within State government. We already have hundreds of agencies reporting to the Governor on these things and I think we should cut down the number of separate agencies rather than increase them. So this is no solution, really.

Mr. ROGERS of Florida. Let me ask this: What is the reason, or the basis, for the law to be written this way, would you say, and I presume this draft came from the Department? It usually does on these basic laws and changes.

Why would it be necessary to reimburse the welfare department 75 percent and the health department only 50 percent to do the same services?

Mr. MULDER. This is only the case where there is a contractual arrangement. Now under other provisions of the law the State health department can be designated as the State agency and in that case the professional staff of the health department will be reimbursed at 75 percent.

Mr. ROGERS of Florida. But even so, why would there have to be a change in the support? Is there any reason for this that you can think of?

Mr. MULDER. I wouldn't know. The statute was introduced before I was connected with the Department of Health, Education, and Welfare.

Mr. ROGERS of Florida. Can you think of any reason why there should be?

Mr. MULDER. It is quite possible that in drafting this the contractual relationship was not even considered as a possibility. I don't know. This is just a guess.

Dr. THOMPSON. Would the reverse be true if the State health agency were designated under the statute by the Governor and then the welfare would only get 50 percent to do the eligibility determination which the law provides? Would the reverse be true or would they still get 75 percent?

Mr. MULDER. The welfare department for determining eligibility will get 50 percent; to the extent that welfare department staff provides social services to the recipient, it may get 75 percent.

Dr. THOMPSON. By statute they must provide the eligibility service so they could get the 75 percent even though the health agency were designated.

Mr. MULDER. They get the 75 percent only if they meet the requirement under the 1962 amendments with respect to social service. It is not automatic.

Dr. THOMPSON. I am not quite clear that you have not put an "if" in the answer to my question.

Mr. ROGERS of Florida. Yes. Here is what we are trying to find out. Under the law as written, say that the Governor designates the health department to carry out the program, I guess they would have to administer the whole program.

Mr. MULDER. The whole program.

Mr. ROGERS of Florida. What would the welfare department get in reimbursable funds if the health department is designated by the Governor to administer the program?

Mr. MULDER. Where this designation is made to the health department, the welfare department under the statute must determine eligibility on the basis of standards set by the health department.

The health department has to set the level of income, resources, and so on, that people may have in order to be eligible. The welfare department applies these standards to individual applicants. For this job the welfare department would be reimbursed to the extent of 50 percent except as this job also involves social services in a system which conforms to the requirements of the 1962 amendments.

Mr. ROGERS of Florida. Which would be what kind of assistance?

In other words, what would they have to do? You say perform social services in determining eligibility? What would that encompass?

Mr. MULDER. They would have to determine if the individual or the family has a problem situation which needs more than medical care for its resolution and which requires social case services.

Mr. ROGERS of Florida. And you gave that social service?

Mr. MULDER. Right.

Mr. ROGERS of Florida. From welfare.

Mr. MULDER. That is right, through welfare staff.

Mr. ROGERS of Florida. Then you could get 75 percent?

Mr. MULDER. Then you could get 75 percent. But it is not automatic and it is not because of title 19, but it is because of the provisions in titles 1, 4, 10, and 14.

Mr. ROGERS of Florida. Now let me ask you: If the Governor selects the health department to administer the program you say the law also has a requirement that eligibility must be determined by the welfare department?

Mr. MULDER. That is correct.

Mr. ROGERS of Florida. But on standards set by the health department?

Mr. MULDER. Right.

Mr. ROGERS of Florida. What in the law requires any part of this program to be administerd by the health department?

Mr. MULDER. There is no such requirement at all.

Mr. ROGERS of Florida. In other words, there is a requirement that eligibility must be determined by the welfare department but there is no like requirement that health functions should be carried out by the health department.

Mr. MULDER. There is not.

Dr. HILLEBOE. That is correct. And this, I think, is a defect that we are concerned about.

Mr. ROGERS of Florida. How does the Surgeon General feel about that? We are getting into this discussion on why the welfare department would receive 75 percent reimbursement if they administer the program. Yet if they contract to the health department the health department gets only 50 percent. So every State is going to say, "Well, there is no point in getting into that." If a State can get 75 percent, of course it will do it through welfare, unless it designates the health department to do the whole program; but then you get into the problem of setting eligibility standards in the health department which have always been set in the welfare, which is not the way we normally determine eligibility. What is your thinking?

Dr. STEWART. Mr. Chairman, I think it would be amiss if the health department tried to administer the whole program. I think the competence to determine eligibility, the machinery to pay the bills, and this type of thing has been well developed in the welfare departments.

Mr. ROGERS of Florida. I would think so.

Dr. STEWART. However, there should be an arrangement of some nature between the health department and welfare department whereby the professional input into the health programs of the welfare agency can be carried out. This applies to standards and the design of the benefits and those things that Dr. Breslow listed this morning, I think, are important. Now there are certain roadblocks to carrying out this type of arrangement. You have mentioned one of them: the

75 and the 50 percent. There are probably some others that could be listed too, but I can't think of them right at the moment.

This goes back to what I was trying to say this morning, that there has to be a health agency at each level of government which has responsibility for health programs. There will be other agencies with health programs in order to carry out their functions. The welfare agency is trying to support people who are in bad straits. Part of this support is to take care of their illness and injuries. But in designing those programs and deciding what benefits will be paid, in deciding at what level the benefits will be paid, in talking about who will be the providers of services, one is really talking about standards and the kinds of care that are given. This, I think, is a professional health job.

Mr. ROGERS of Florida. Now why is it that this cannot be worked out in the Department by administrative action, so that a contract arrangement with the existing health agency could qualify for reimbursement of 75 percent? Has that been pursued at all?

Dr. STEWART. Not to my knowledge, Mr. Rogers. I know the problem of the 75 and 50 percent has been discussed. This is where I happened to hear about it first when comments began to come into the Department about this. But as to what kind of legal problem this is, and as to what it would take to correct it in Congress, I am not yet knowledgeable.

Mr. ROGERS of Florida. Otherwise, this would require, would it not, the welfare department to set up an entire medical department within welfare, would it not?

Mr. MULDER. Yes.

Mr. ROGERS of Florida. Does the welfare agency contend this is a good procedure?

Mr. MULDER. Well, under the provisions of the statute we have amplified on the requirement of the law that the administering agency must utilize professional medical and supporting staff. We have been translating this into a requirement that there must be an identifiable unit that formulates the policy and which must employ physicians, medical care administrators and social workers who are experienced in medical care, as well as the other specialties in the field of health care that the program scope may require.

There is a requirement that medical health advisory committees be drawn on a broad base and that the health agencies of the State must be represented. Also we have a requirement that there must be a written agreement between the welfare department if it administers the program and the health department with respect to its programs as to the development of standards jointly and the utilization of the respective services of the agencies.

A great deal more is being done under title 19 to facilitate the collaboration between the health and welfare agencies than was done under the previous enactments, including Kerr-Mills.

Mr. ROGERS of Florida. Of course you set this medical expertise up on a State level, you say. Does this go down to local levels, too?

Mr. MULDER. There is a pending requirement which the Secretary has not yet adopted but which is a staff recommendation, that there must be a progressive development of these medical care units starting with the large metropolitan areas until ultimately the entire State

and each administrative agency within the State has the necessary professional competence of its staff.

Mr. ROGERS of Florida. Is this not a duplication, actually, within the State?

Mr. MULDER. That is a duplication, yes, in the sense that having central hospitals in a community is a duplication.

Dr. HILLEBOE. No, this is not the same thing. I am sorry, I don't agree with that. I respectfully disagree with my colleague. Having many hospitals in a State where you have hospital review and planning councils, where you have reasons for duplication, is a different thing. Those of us who have worked in welfare, as I have, for 10 years and who have worked in health departments, look at both faces of this coin. Although I am sure I am prejudiced as a physician, the fact remains I am no longer a health officer or welfare administrator. It comes down simply to this, Mr. Chairman, that either we get an interpretation from the smart lawyers in HEW that this contractual arrangement can be done or you gentlemen should change the law to make this possible. Now there are no alternatives.

Mr. ROGERS of Florida. I agree with you. This seems to be a complete duplication and brings about a tremendous waste of money. I am amazed that it has gotten through. I am sure the committee will consider it very definitely.

Dr. HILLEBOE. I think if no other thing comes out of this meeting than this, this will be a major contribution to the welfare of the people in the country.

Dr. FRECHETTE. Mr. Chairman, the question that we were discussing in Massachusetts, that even with a contract between the welfare and health departments, there still would need to be a duplicate medical care administrative unit in welfare. I take it that it has been answered that there would be. Am I right?

Mr. MULDER. No, that matter has not been decided. There has been some concern that where the health department administers the program——

Dr. FRECHETTE. This is a contract between the welfare department and the health department. The welfare department is the administering agency.

Mr. MULDER. The welfare department is the administering agency?

Dr. FRECHETTE. That is right. It wants to have a contract with the health department for the medical portion of this program. Does the welfare department in view of this contract still have to have a medical care administrative unit?

Mr. MULDER. It has not yet been decided.

Dr. FRECHETTE. According to our man it has been decided.

Mr. MULDER. In each instance where this matter has come up it has been my recommendation that there be no such requirement.

Dr. HILLEBOE. This should be included in the prerogatives of the lawyer's opinion from HEW or the legislation which you gentlemen produce.

Dr. Mattison, you are allowed three words, not three minutes.

Dr. MATTISON. I protest. I am not a lawyer, I am a health officer. As an executive in the national professional organization I would like to tell the chairman that this is not just a few isolated States that are raising this question. We have had this question raised at our

headquarters by many States in some of which the Governor has tried to designate the health department as a contracting agency to do the health part of this program. Then this has been met with a whole series of what sounds like de facto rather than de jure decisions where this must be. I would like to make just two comments on it.

First of all, this is not an attempt by health departments to start medical care programs. Health departments have had some of the most successful medical care programs in the history of public service. Tuberculosis programs, venereal disease programs, crippled children's programs, done in cooperation with the Children's Bureau. These have been health department operated programs.

I do think the record might well show that there is pretty general agreement, not just among the health department people, that the quality of service given under those kinds of medical care has been perhaps a little better than the kind of services given by outpatient departments and by welfare doctors to indigent patients.

Now there is one other point which I think is important here. That is, that as I listened to you read the law, it sounded to me as though the decision was really a departmental decision, a Secretary's decision. My question is, and I am sorry that Dr. Winston is not here to hear me ask it, is the decision about these contracts—I am not talking about health department being a single agency—I think this is, under the law, a rather ineffectual answer—but where the welfare department wishes and the Governor wishes to contract this to a health department, is the decision made by the welfare administration or is it made by the Department with the health and welfare people getting together on the thing? Because, obviously, if it is made by the welfare administration there is a natural tendency to put it where they are most familiar, where their interests lie, primarily. Is this really not a departmental decision?

Dr. HILLEBOE. Mr. Breslow wanted to say something.

Mr. ROGERS of Florida. Maybe we can get an answer to this.

Dr. HILLEBOE. Mr. Mulder or Dr. Stewart.

Mr. MULDER. All decisions in these matters in the program are made in the name of the Secretary and delegation to the Commissioner. The Commissioner here was faced with a legal question, namely, does the language of the law as it is written permit payment of 75 percent where such a contract exists.

The General Counsel for the Department was consulted and the General Counsel says the language of the statute is clear it is limited to 50 percent because under such arrangement these people do not constitute the staff of the agency. Therefore, this ended the discussion and the decision of counsel was taken as final and the policy was developed accordingly.

Mr. ROGERS of Florida. Well, I can understand that. I was wondering, did the health people confer with the General Counsel on it?

Mr. MULDER. I do not know if they did. We did not consult with him because we felt it was a legal question.

Dr. STEWART. The lawyers have not consulted with me on this point.

Mr. ROGERS of Florida. I think the committee would be very interested in pursuing that.

Dr. THOMPSON. This is a point I would like to make, Mr. Chairman. That it seems to me at the same time we attempt to clarify this matter

from the State agency we need to clarify it at the Federal level too. Unless the Public Health Service has some active participation in these discussions, we come up with a biased decision.

Dr. Stewart just gave the answer, he has not been consulted in this legal decision and I think there are a lot of factors in the legal decisions as you know, having sought them on many occasions.

I would like to say one more thing here. Last November I think it was, I was on a committee of State-territorial health officers on title 19. We met with the Welfare Administration people. At that time we were told that even though the administration of the medical component was placed in the health department the welfare department must have a medical component of their own. This was questioned at the time and challenged at the time as sheer duplication but there was a sort of brushoff, this was the answer, gentlemen, thank you very much.

Mr. ROGERS of Florida. Congressman Younger stated he would like to have an opinion of counsel on this point for the record.

Mr. MULDER. We did not receive a written opinion but I will refer the request to our office.

Dr. HILLEBOE. Dr. Breslow, from one of our Western States, California, would like to comment.

Mr. ROGERS of Florida. Yes, and I see Dr. Richmond is back with us, too.

Dr. BRESLOW. With reference to California, I would like to point out that not only are 2 members of your committee Californians but 5 of the 10 panelists are either present or former Californians.

As the only present Californian on the panel, I would like to emphasize again that Governor Brown and his State administration in California have solved this problem so far as we are concerned. My remarks are not directed to our own present experience, but rather to the general problem in the Nation.

I would like to point out a bit of history. In the original versions of title 19 there was no provision for State option by the Governor to designate the health or the welfare or any other department. It was written strictly as it had always been, for welfare administration. The authority for the Governor to select the department for administration was provided after one of the congressional committee hearings when health people, both some in medical practice and some in medical administration, impressed the committee with the fact that there should be an option. But, gentlemen, that option has not been enough. The fact is that the Welfare Administration is continuing what I think it is only fair to call an antagonistic attitude toward health department participation at the State level. The only resolution that I can see, as one who has been involved in these matters for some years, is to have the Congress write in the legislation a requirement that the medical components of these programs shall be a responsibility of agencies with medical competence.

Mr. ROGERS of Florida. Now you say you worked it out nicely in California?

Dr. BRESLOW. Yes.

Mr. ROGERS of Florida. How did you do that?

Dr. BRESLOW. We did it by having established several years ago a health and welfare agency similar to HEW at the Federal level. The

overall responsibility for title 19 has gone to the administrator of the health and welfare agency. He established an office of his own to guide the program. Then the responsibility and budget for the welfare aspects of the program go to the department of social welfare and the responsibility for the medical components of the program to the department of public health.

Mr. ROGERS of Florida. So you get 75 percent?

Dr. BRESLOW. That is my understanding, because we are all a single State agency.

Mr. ROGERS of Florida. All right.

Dr. HILLEBOE. Dr. Stewart.

Dr. STEWART. Mr. Chairman, I think the solution that California found portrays the problem very clearly. First, I would like to defend my colleague, the Commissioner of Welfare Administration a little bit. The congressional committees that developed this legislation certainly had in mind raising the standards of medical care within the public assistance programs. This was what they were trying to do.

The Commissioner of Welfare has said many times that this is a goal she has. So we all have the same goal. We are trying to get high quality medical care for this group of people. We are arguing over method.

Mr. ROGERS of Florida. Let me ask you this: Is duplication a way to get higher quality?

Dr. STEWART. No, sir. That is why I say we are arguing over method of getting this goal met. We really are faced with the situation where we have two organizations in government at Federal, State, and local level, neither of which can do the whole job. They have to get together on this program. One of the solutions is given in California. There may be other ways of doing it. Where we really need to concentrate our attention, is on how to get the high quality care of these people who are eligible under title 19.

Dr. THOMPSON. New York has another solution, if they can get 75 percent. Their solution is very adequate, too, if they get the 75 percent.

Mr. ROGERS of Florida. Doctor, I would think we should bring this to the attention of the Secretary and the Under Secretary. Perhaps the ruling of the counsel can be reviewed and some plan made that would be feasible, to save the money of the taxpayer.

Dr. HILLEBOE. The thing that is critical is the time factor because negotiations are going on with State legislators. The time factor is extremely critical. It is not a matter of months but a matter of weeks.

Dr. Kimmich from Michigan.

Dr. KIMMICH. I wanted to give another example.

The California example is a fortunate one in view of their recent reorganization of this department. Whereas in Michigan we may be in a more typical situation where we have different departments that are not a super agency.

Thinking of our discussions of fragmentation this morning we have had no problem of fragmentation at the State level in regard to titles 18 and 19 where it was our decision in Michigan to cooperate between welfare, health and mental health to carry out these programs. And each to do a part of the package. Then we ran into the same kind of block where the reimbursement formulas and the eligi-

bility for reimbursement of personnel necessary to implement titles 18 and 19 became a question, where the health department and the mental health department could not really get either the same formula or anything at all in terms of the additional personnel necessary to get going, whereas our machinery set up by the Governor and with the total cooperation by all three departments, was all ready to go.

I think probably we are in a more typical situation than California because of their special arrangement. We are ready to go. We are being penalized, however, by the present arrangement.

Mr. YOUNGER. Where the State has followed the process of the Federal Government in setting up the two departments, I think they followed the Federal process which has been mentioned here before.

Dr. HILLEBOE. Mr. Chairman, Dr. Sowder from Florida would like to make a comment.

Dr. SOWDER. I would just like to say that there is something that is as important as money against duplicate staffs at State and local levels. There are not enough people for duplicate staff. We have had a hospitalization program since 1954 in the health department in Florida. Later the legislature decided to put on a hospitalization program through welfare for public assistance recipients and later for the Kerr-Mills clientele. A law was passed that the welfare department, since it had to receive Federal funds, should subcontract with the health department for the administration of health services. And this was done. Nevertheless, the health department never got any Federal matching funds, although we understand it is available. There seems to be a disinclination on the part of regional and State welfare officials to do any more than the law forces them to do. It is a question involving very strong feeling. Their philosophy is, of course, that welfare is an overall thing and that it embraces all services to their clientele. Health authorities, of course, feel that health services should not be fragmented or dispersed.

I think the problem will have to be settled by the highest policy-making authority, which is Congress.

Mr. ROGERS of Florida. There is no reason why welfare could not contract with the health people?

Dr. SOWDER. The alternative would be to create positions half of which would always be vacant because manpower is not available to staff duplicate sets of health agencies.

Mr. ROGERS of Florida. What about offices in OEO in those areas where you operate? You do not operate through the local health people?

Dr. RICHMOND. We have a variety of alternatives, Mr. Chairman. We, in general, do not support programs in a community without the community indicating to us that they are utilizing the resources of the local health and welfare departments.

At the national level we have consulted with Commissioner Winston and with Dr. Stewart concerning the potentialities for having funds, for example, that might become available for patient care through title 19, come into any program that we develop or support in order to help utilize and integrate existing resources to do that program, so that we are not coming into a community with new funds and displacing those funds which are already available.

This is what I meant earlier this morning, Mr. Chairman, when I

indicated that new institutional forms may serve as a stimulus for the integration services rather than for further fragmentation. That is what we have been hoping to do.

I think on the surface it may appear that we are developing competing services. But we support no programs without the community indicating to us how they are utilizing all the existing resources through existing agencies, including the funds that are going to become available through title 19.

Mr. ROGERS of Florida. That is a good procedure, and certainly should be done rather than trying to set up another, a triplicate setup.

Dr. HILLEBOE. There is another mechanism that should be mentioned in the event you make contractual arrangements. As a moderator, I am not supposed to say anything but direct conversation, but I would like to give this example.

It is possible, as is done in New York City, to have the health department assign a top deputy to the welfare department to be chief of all of the medical services. He is on the payroll of the health department. He sets policy. He physically is located in the welfare department. He takes administrative direction from the welfare director. He is professionally responsible to the Commissioner of Health. This is a mechanism on a contract basis that is highly efficient because it avoids immediately having two medical directors of welfare. This was also tried, Mr. Chairman, in New York State back in 1955 and for 5 years a deputy commissioner of health was assigned to the welfare department and the Commissioner of Welfare was delighted with his services, new programs were developed. This was the first time in the history of our State that a competent medical administrator and not a physician who happened to want a job in the welfare department, was in charge of the program.

This was discontinued only for the reason that a new commissioner of welfare came in and he wanted his own physician to come in and be the man in charge. I wanted to bring out this mechanism which is one of the several things that can be done if you have a contract.

Mr. VAN DEERLIN. Did I understand correctly from Mr. Mulder that the Secretary is preparing a reorganization order that would expand medical structures within the welfare department?

Mr. MULDER. What I said was that the handbook of public assistance administration, which is the guide to the States and which contains the minimum requirements they must meet will be issued by the Department within the next 6 weeks. This is now in the process of final development.

Mr. VAN DEERLIN. It might be well to hope that the Secretary wait until this question is resolved before he issues such an order.

Mr. ROGERS of Florida. I think that is a good point. I would hope, too, that the Secretary would, before issuing any such order would have an opportunity to discuss with the committee some of our strong feelings about this.

Dr. HILLEBOE. Dr. Peeples.

Dr. PEEPLES. Yes. In Maryland the Government has designated the health department as the agency to conduct this program, with the welfare agency doing the eligibility determination. I hate to shoot down your alternative, Dr. Hilleboe, but we had a meeting the other day with the regional welfare people to review the preliminary plan

that we had written up. The question came up as to whether we could do exactly what you mentioned which was to assign a physician to the welfare department from the health department, and accomplish this same thing you mentioned.

We were told at that point that we could not, that this would not suit the conditions of the law which I do believe state that there must be a physician and a medical social worker in the welfare department if some other agency is named as the one to administer title 19. So this is provided for in the law. But the interpretation is that an assignment of a full-time physician will not be permitted. At least that is what we were told.

Mr. MULDER. Dr. Peeples, there is no provision in the law that where the health department is designated as the single State agency, there must be a physician and welfare worker in the welfare department. That is under consideration a proposal that under such a system there must be in the welfare department, in order to collaborate with the health department, certain types of personnel in the medical and medical social work fields. This has been objected to by the Association of State and Territorial Health Officers as duplication and has not been finalized. We still have the matter under consideration.

Mr. ROGERS of Florida. May I ask now just for our information, how many doctors do you estimate would be required to carry out this plan, having the welfare department administer these programs throughout the United States? What is your estimate of medical personnel needed?

Mr. MULDER. This is extremely difficult to estimate because we are not just dealing with physicians but we are dealing with the other competences that must go into program administration.

For instance, for the head of the units in the administering agency there must be by 1970 a medical care administrator with a degree in medical care administration. It need not necessarily be a physician. So we don't quite know how many physicians you would anticipate there. The other question is, when will all the States get to a title 19 program, and will it be comprehensive so that it will require all the specialist knowledge that is required for a comprehensive program? It would be impossible for me to even approach an estimate as to the manpower that will be required.

Mr. ROGERS of Florida. Take one State that is functioning, getting ready, can you give us a breakdown as to what would be required by one State?

Mr. MULDER. It again depends on the number of metropolitan areas in the State.

Mr. ROGERS of Florida. Let us take California.

Mr. MULDER. California has a minimum, there would have to be a medical care administrator and a physician if the medical care administrator is not a physician, and an associate worker that is experienced in the medical field. That is the top of the structure. Then in California because of the size of the State and the local administration which we find in California, the regional offices need to be staffed, of which there are three, and in each one there should be a minimum of a physician. I understand at the present time they do not have area medical staff. In the large metropolitan areas there must be at least

duplicate of what is at the State level in matters of medical care administration and social work.

Mr. ROGERS of Florida. In every metropolitan area, or in every area designated as a metropolitan area?

Mr. MULDER. It would be the latter.

Mr. ROGERS of Florida. Having a designation with the Census Bureau as a metropolitan area.

Mr. MULDER. These standards have not been developed because they are being set forth for requirement by 1970. The instruction to the States is to develop their own patterns of what they consider adequate administrative coverage of this program.

Mr. ROGERS of Florida. How many doctors in an area, other than just your administrator, would be required?

Mr. MULDER. There need to be at least part-time consultation in certain specialist areas like in pediatrics and in the various specialties of medicine as well as in areas of specialized administration, like hospital care and nursing-home care and so on. I must admit that whatever manpower would be required, with the possible exception of the apex of the triangle, for a well administered program would be about that same no matter through what channel the program is administered.

Dr. HILLEBOE. I think we should ask Dr. Breslow to comment. He is involved in this.

Dr. BRESLOW. To show you how unfortunate this would be in the State of California, I would like to point out that the California program provides for contracting with the same fiscal intermediaries that the Social Security Administration is using for title 18, namely, Blue Cross and Blue Shield, and ultimately going to a prepayment plan similar to what other people in the community have.

The local responsibility for administration should go to organizations that have the long-standing competence. We are not endeavoring to build up our medical empire in Government, State, or local. If there is going to be a Federal requirement that this be done all the way down through the welfare chain you can see what a tremendous waste there would be.

Mr. ROGERS of Florida. Could someone by tomorrow give us some examples of duplication and what cost might be involved?

Dr. HILLEBOE. I think we can arrange to have some of our members do that.

Mr. ROGERS of Florida. It would be helpful to the committee to give us a perspective.

Dr. HILLEBOE. Mr. Chairman, I don't want to intervene with this marvelous discussion because it can go on all day. There are two or three questions you and Mr. Younger asked and there are a couple of others. If you want to keep us on schedule we had better stop the discussion. But I think you got our message all right. If this is true, then I think we can go on from there.

I would like to come now to Mr. Younger's question which is a very pertinent one in view of the fragmentation and many numbers of categorical grants: Would not a general grant to the States with proper monitoring to see that the moneys be spent properly be better than having all these categorical grants which led to fragmentation?

I shall be glad to invite discussion of this by any one of the mem-

bers of the panel. Did I interpret you correctly, Mr. Younger? Would some of you like to discuss this particular point?

Dr. SOWDER. I would just like to say yes.

Dr. HILLEBOE. Dr. Sowder saying yes is wonderful. Who is the next one?

Dr. THOMPSON. My experience is in the small States, Oregon, Montana, Idaho, Utah, personal experience at the State end. I have been at the Federal level, too. Certainly in the rural States, the smaller States, all of the intermountain States, the Pacific Coast States, this would be particularly pertinent because when you get a grant of $12,000 how can you distribute this to 29 counties, except you come up with $1.46 in some county. I would think the same thing would apply to the larger States but I would like to keep my comment to the smaller States.

The general grant is the only answer, but we ought to be accountable on some program evaluation basis. It seems to me the Public Health Service has within their staff the competence to come to the States from time to time and periodically review the achievements instead of gearing it to how many nursing units did you visit and the nursing visit may have found nobody at home and therefore did not do anything or may have found somebody at home.

In further answering the question, on the other hand, I believe you might have difficulty by the nature of the bill before you to grant latitude percentagewise. Some reasonable modification might give the flexibility without going all the way to a completely bloc grant without any controls whatsoever because you would probably want to be sure that the State did not ignore cancer, for example, just because they had a bloc grant when obviously cancer deaths are real in the State and they ought to be doing something about it.

Dr. HILLEBOE. Dr. Philp.

Dr. PHILP. As a city health officer, I would like to support the concept of a bloc grant or general grant to States. I think in terms of overall administration this would greatly simplify things. However, I would put two or three conditions or two or three things that would need to be considered in doing this.

I think first of all there needs to be a plan. I would like to see this as a problem-centered plan so that the plan which is developed by the State to meet the problem is really that kind of plan and then the plan can be partially funded, through this kind of general support grant to the State.

Dr. HILLEBOE. Will you say what you mean by problem, so that it is clear what you are talking about?

Dr. PHILP. Yes. If there is a disease or certain health problem centered in a certain part of the State or confined to a certain geographical area the plan ought to include doing something about the particular problem in that area. The plan ought to be comprehensive so that no element of the problem is left out. This is not an easy job but this would be a prerequisite to any block grant.

No. 2, I think, Mr. Younger, you could then evaluate this. You could see from year to year to what extent the State could meet these problems which they have identified and which are part of the plan. This is your evaluation. This is a problem centered plan and to what extent the problems are being diminished could be measured periodically.

I would like to emphasize again I think you will find many of these special problems are located in the metropolitan areas and these will have to be considered in the State plan.

Mr. YOUNGER. One of the best programs we have had, the Hill-Burton, which depends on State plans, has been most satisfactory in the relationship between the Federal Government and the States or to the satisfaction of the people in general.

You have had also to work out some kind of formula so that the smaller States would have probably a little better share than the larger States.

Mr. ROGERS of Florida. Following up your comment, we had the testimony from the city of New York that they have had an increase in their tuberculosis problem.

Dr. HILLEBOE. Twelve percent among children. It was not followed through in the succeeding year but I think you can discuss it anyway.

Dr. PHILP. In 1963 there was a 10 percent increase.

Mr. ROGERS of Florida. He said it was difficult for him to get money from the State for this. What they had to do was to come to Congress and ask that the over-all appropriation to fight tuberculosis be increased and they then got a slice of it. The point you are trying to make, in the same plan the problem areas must be identified and included in those State plans or your State plans are not worth much.

Dr. PHILP. This is the point I was trying to make. I believe I mentioned an example this morning, forgetting about the rise and fall of incidence of a particular disease from year to year but I think you will still find in the city of New York, which has 5 percent of the population of the United States, you still find about 9 percent of the tuberculosis.

So there is an extra concentration of certain illnesses in metropolitan areas. This is one example of the type of thing that has to be considered in a plan.

Dr. HILLEBOE. To keep the record straight, there is no question but what we will need to consider the cities' needs in the next 10 years because of the fact that 70 percent of our population is in the metropolitan areas.

Let us not talk about the cities. Let us talk about the metropolitan areas. This is a distinct thing. Secondly, Dr. James talked about the increase in tuberculosis rate. It so happened the succeeding year the rate went back to normal.

I think it should be made clear that the voluntary health association in New York City came forth with $100,000 to take care of anything that was necessary, which I think is an excellent example of the voluntary agencies fitting in. It was not necessary to go to the Federal Government or anybody else.

Mr. ROGERS of Florida. That is not what the health doctor said from the city of New York.

Dr. HILLEBOE. I happened to have been the Commissioner of Health when this went on and I know what went on.

Mr. ROGERS of Florida. He said you did not give him any help.

Dr. HILLEBOE. You bring Dr. James back. I just want the record to be clear. Dr. Stewart.

Dr. STEWART. Mr. Younger, I think moving from a categorical toward a more noncategorical grant—a block grant—as you describe, is very desirable, particularly if you are talking about the formula grant to the State. There are two dangers in this which we recognize and have recognized before. One is the block grant does not have nearly as much glamor as a grant for heart disease or cancer. It is more difficult to dramatize a general health program than it is to dramatize a program broken down into cancer, heart, and various other kinds of diseases which people see and are worried about.

The second point is that when one talks about a block formula grant what one is really saying to the State health officer is that here is a block of money which will form a pool when matched at the State level and which is available for you to develop the health programs to meet what you see are the major needs in your State. I hope that the program is problem oriented, as the doctor said here.

We are talking about big money when you say this, because you are talking about a Federal appropriation which will be divided by 54. If it is too small, a State like Utah or Idaho or Montana will get too small a share of this money, and they really can't do anything about it. There is a conventional wisdom in the scientific world right now which is related to the "critical mass." They say that you need to have a certain number of laboratories and scientists together before anything really gets moving. There is the point at which it starts to move.

The same thing is true here. Below a certain level of funds in any one State—and it will vary in amount depending on the State—I don't think it will move. It has to be large enough so that the State health officer really has something to work with to meet the problems. Project grants on the other hand, are more targeted affairs. They are not continuous things. They are trying to solve something in a period of time which is quite pinpointed. It could be a disease that is only in one county in one part of the State or in one city or in one ward of a city, for example, or it could be that you are trying to develop a kind of health service that is only needed in one area of that State because it is an insolated area or a slum area of the city. So project grants, I think, lend themselves to being targeted and lend themselves to have more categorical names. Formula grants I think lend themselves more to a base support, something that allows the responsible operating organization to carry out a total program over a period of time.

Dr. HILLEBOE. Mr. Chairman, I think Dr. Richmond would like to make a comment in this area, if I might call on him.

Dr. RICHMOND. I find Congressman Younger's question very interesting because in a sense in the Office of Economic Opportunity we have the kind of charge that you suggested might be given to the States, with one exception. The only category that we have is that the programs, however they are developed, must be targeted at the poor population. But with that one constraint we really are free to encourage communities to request funds to be utilized in whatever way they deem to be most desirable, granted, of course, we review these programs for their professional content and potential contribution to the communtiy. So that I find this also a very desirable approach.

I think I would also have the same reservations that have been expressed. First, we need to build a system of evaluation into programs so that we have some measure of what we are doing—the final words

on how to develop programs of evaluative research really have not yet been spoken. We need to learn much more about how we evaluate programs short of the very obvious criteria of morbidity and mortality. I would suggest that this committee and perhaps others might do well to look into the matter of putting some money into research, evaluative research, because it seems to me we need to know much more about how we can deliver services in a more dignified and more effective way, particularly for poor populations.

Second, if funds are to be made available in this way that communities ought to be permitted to develop priorities in whatever way seems to make most sense to them.

In connection with the comment that Dr. Stewart has made about the critical mass, it may very well be that we have the appropriate critical mass for high quality services for more affluent groups in our population in this country. Certainly this is not true in relation to low-income groups. It would seem to me that such a priority ought to be built into any program which is developed.

There is one other point which I would like to comment on which I think would be an extremely important fringe benefit to such a development. I would anticipate that it would bring into the field of public health and public health administration many young, creative, imaginative, innovative minds that now tend to bypass the field because they see it as a categorized program which is predetermined and which does not provide for administrative, creative opportunities in the way that most of these young people would like to see. I don't think it is a lack of interest on the part of the young physicians but it is my opinion that when they find few opportunities or see few opportunities for exercising alternatives and creative possibilities in relationship to the development of health programs, then they are repelled from this as a career opportunity and in turn are drawn to other career opportunities.

Dr. HILLEBOE. Mr. Chairman, I am trying to keep to the schedule; we are now at 3:45. Would you permit me to make the suggestion that your very pertinent question about measuring and evaluating results and not just activities could be laid over until tomorrow afternoon, when we finish up. I think this is a critical issue and I would not like to rush it.

Mr. ROGERS of Florida. Fine.

Dr. HILLEBOE. If this is satisfactory, we will take a break for 15 minutes for coffee and we will reconvene at 4 o'clock.

(A short recess was taken.)

Mr. ROGERS of Florida. Let us continue our panel discussion. I will turn the discussion over to Dr. Hilleboe.

Dr. HILLEBOE. Mr. Chairman, our topic "B" is the alleged tendency of Federal authorities to bypass State health authorities when sponsoring health projects and activities within our States.

I might say to our two panelists, Dr. Kimmich and Dr. Peeples, we would like to limit our panel's presentation to about 10 minutes. So if you will gage yourself accordingly.

Dr. Kimmich is the director of the Michigan Department of Mental Health.

Dr. KIMMICH. I am Dr. Robert Kimmich, director of the Michigan Department of Mental Health. My department is responsible for

planning of services and preventive activities in regard to persons suffering from mental disorders and mental retardation. As in many States, we are the largest department in Michigan State government, and employ over 12,500 people. Our annual operating budget is in excess of $100 million.

I am representing the National Association of State Mental Health Program Directors. The members of our association are responsible for administering the mental health programs of the various States, and were responsible for the administration of nearly $2 billion of State appropriations in the year 1965.

Besides our responsibilities for administering programs for treatment and prevention of mental disorder and mental retardation, we also are responsible for planning and guidance of many community programs which are partly funded from other sources, such as the Community Mental Health Services Act of Michigan, the New York State Community Mental Health Services Act, the California Short-Doyle Act program, and others. A great deal of research and training is also done in our programs, with a significant portion being funded through Federal grants.

Although we are the direct State operating authority in our field, we are constantly in a working relationship with personnel from the Department of Health, Education, and Welfare, and others. We have seen a great deal of creative leadership from the Federal level, and in the psychiatric field we have particularly enjoyed our relationships with the National Institute of Mental Health. Major contributions to the fields of mental health and mental retardation have been made, both by State operations and Federal programs. The increasing number of Federal appropriations, which we relate to the broad field of mental health and mental retardation, has brought many advances in the field, but has also brought massive administrative problems.

In my experience, the State and Federal objectives and program goals have been similar, if not identical. In many cases, the preliminary work which led to the Federal development and policy began in State programs and demonstrations. Our concern is primarily the effectiveness with which the Federal and State systems interact in achieving mutually acceptable objectives in the most efficient way.

We perceive an increasing tendency toward Federal centralization of decisions concerning overall mental health programs and individual parts of mental health programs. Separate from the issue of authority, there is the fact that the types of decisions being made require an extensive amount of knowledge, not only about the nature of given projects, but about the communities and administrative structures from which the projects are submitted, and the relationships of these communities and applicant agencies to the larger context of mental health operations within a particular State.

Information concerning this knowledge must be prepared and forwarded in great quantities and in great detail, to Federal offices to make possible reasonable decisions when the decisionmakers are so far removed from the scene. Long-range mental health plans and mental health facility construction plans, produced at the expense of thousands of dollars of paid and volunteer time, are required to familiarize the Federal decisionmakers with the overall conditions within which projects are to be developed. After the plans have been approved, the projects themselves must be forwarded, with additional

collections of information and agreements, which will allow the Federal decisionmakers to judge the fit of the project with the plans and regulations by which they are guided.

In addition to enthusiasm about the goals of programs, the promotion of Federal projects at the State level is probably more realistically understood in terms of the very strong public pressure on State agencies to use Federal appropriations when all possible funds are not applied for.

One central point is that, in most cases, we are talking about State programs which have Federal support. We are concerned, however, that the situation seems to be developing where the relationship is treated as Federal programs having State support. It falls to us at the State level to analyze and put in a meaningful relationship the various pieces of Federal legislation so that they apply to our citizens in such a way that more people are helped. It is we, however, who must carry out and supervise the day-to-day activities stimulated by the Federal grant. The basic point I wish to emphasize during these opening statements is that the responsible persons at the State level are not being sufficiently involved in Federal policymaking, program writing, and regulation review prior to the "hardening" of such policies and regulations. It should go without saying that those who must do the work not only should be consulted about any proposals, so that their suggestions for implementation may be included, but also for the probable significant contribution to the ideas themselves.

A number of problems have arisen out of the tremendous interest in the health field at the Federal level. Although much good is being done, there are major difficulties in implementation which occur at the State level. Timing is frequently a problem. When new programs are developed at the Federal level, it is not possible for a State to anticipate the program and its administrative regulations in such a way that staffing levels can be set, recruitment done, and staff obtained quickly so that the program may be adequately responded to.

When a State has nothing to say about the timing and activation of a Federal program, it may be nearly impossible to begin a desirable program, even in the next fiscal year, when a Federal act is passed and the new opportunities are announced in April, since the normal budgeting process of a State has already been completed for the coming year or two.

For example, a major Federal program requiring implementation at the State level in Michigan, if announced this month, could probably not go into effect until July of 1967. There are, of course, exceptions to this, particularly with small programs or those which are 100 percent supported by the Federal Government.

There are times when interpretations of rules and regulations at the Federal level are changed without prior consultation with the States, or even warning. A Federal decision was made last year changing the availability of Hill-Burton funds for mental health construction. This decision was announced after many States had already completed their mental health center construction plans, and had them approved by their advisory committees.

In the case of Michigan, this particular point contributed to invalidating the State's plan, and required a great deal of discussion, reevaluation, appeals to Washington, and finally revision of the plan.

At best, a great deal of confusion was created at the State and local level.

A great deal has been said about the State-Federal partnership and development of projects which are mutually esteemed but frequently depend very heavily on the raising of State crops from Federal seed. A genuine partnership would imply that the State could be regarded as a sincere and trusted participant in planning and in decisions to be made regarding the development of program and moneys to be spent or committed for later expenditure.

If this were the case, we might eliminate some of the problems involved in the size of the information flow, and might allow States to more effectively integrate and deploy their resources in achievement of State-Federal goals.

I do not feel, however, that a partnership is symbolized by merely offering the States greater degrees of flexibility in carrying out regulations formulated solely at the Federal level.

I believe that the regulations themselves should be a product of Federal and State negotiations, which insure that State governmental structures, schedules, and existing circumstances will be taken into account in the development of such regulations, without distorting the aims of the program.

Senate bill 3008 appears to me to be generally sound in its aims. However, this is true of many pieces of legislation. We at the State level frequently find the difficulty in the fine print, rather than in the aims and goals of the legislative action.

Senate bill 3008, among other things, requires that a single State agency must administer the State's health planning functions. This may work well in certain States, but in others it would probably create difficulty. Health planning, with particular reference to the mental health field, involves not only mental health and public health agencies, but involves special education, welfare, and vocational rehabilitation programs, the courts, and others.

It thus becomes the responsibility of the Governor's office to coordinate such planning, where a number of agencies are involved. It is conceivable that a special health planning agency could be created, but the real work would have to be done by the professionals in the various departments involved in providing services.

To impose the difficulties which must ensue from Federal legislation simply to achieve a uniformity of statement and to simplify Federal administrative procedures seems unnecessary. Nor can I see how this arrangement can represent a satisfactory Federal-State partnership for those States in which it clearly does not fit.

Besides problems of timing and active seeking of consultations from State authorities, a few other developments have given us concern. One is the growing tendency for Federal offices to direct programs to local communities without availing themselves adequately of the State agency's role as the mental health or health authority.

This role, to be meaningful, requires that the State should approve or disapprove all local plans which are to be sent to Washington. Merely to ask for the commentary on the part of State authorities is not only condescending, but also makes the planning and implementation authority meaningless. It is our consensus that no grants should be made for mental health programing without the approval

of the mental health authority of the State. This is not necessarily true in the case of training and research grants.

I want to mention, also, what seems to be a major problem at the Federal level of coordinating legislation and regulations so that regulations are not in conflict, creating service gaps, or impossible administrative tasks at the State level.

In one State, a psychiatric institute of a university had to file three separate applications for three related parts of a new construction. They received three different site visits from three different teams of Federal personnel.

It is clear in this instance that thousands of dollars were wasted. It also tends to strain the relationships between Federal and State personnel because of the seemingly senseless activity into which they are forced.

In the field of mental retardation, there are many parts of the Public Health Service and the Department of Health, Education, and Welfare which are involved in making grants. It would seem useful if grants could be cleared through a single office at the Federal level, both going in and coming out, so that the applications could be integrated and action taken more expeditiously.

The proliferation of "fine print" and the highly detailed regulations which accompany grant programs often hinder program development as much as they help. I feel that clearly stated program goals, with a high quality review at the Federal level, plus accountability at the State level, would be sufficient to guarantee that money is used correctly, and still to allow the necessary imaginativeness and special fit necessary at the State and local level.

The many hours spent in attempting to interpret regulations and to understand how conflicting State and Federal administrative structures may be made to mesh are wasteful and discouraging.

Without going into further detail, I would like to summarize. I believe the development of satisfactory channels and systems, which provide continuity of purpose from Federal levels through the State to local levels, can only come about through an adequate system of face-to-face dialog between the proper State and Federal authorities.

This dialog must take place in such a way that the opinions and recommendations of State level responsible officials must be considered before policies and regulations are crystallized.

In addition to the necessity for prior consultation by Federal officials with State officials, it is also, in my opinion, necessary to undertake State-by-State negotiations for most important programs.

I can see no substitute for this by occasional regional or national conferences, public discussion, or circulated memorandums.

It is absolutely certain that the more detailed the legislation and the regulations attached to a program, the greater the likelihood that it will not fit a number of States.

It is for this reason that many of us feel that program aims should be stated in the greatest possible breadth, negotiations carried out on a State-by-State basis, and accountability for program control required.

It is our plea that ways will be found to stop the increasing flood of paperwork and the untold number of hours required to understand and interpret Federal programs.

It is we at the State level who must do the work and apply our expert judgment and skills. The Federal Government cannot afford to do without our consultation, in spite of the top quality of personnel who staff the Department of Health, Education, and Welfare.

Dr. HILLEBOE. Thank you very much for the plain words spoken by a psychiatrist.

You took 3 minutes of Dr. Peeples' time, so we will tell Dr. Peeples to cut his time down by 3 minutes.

Dr. Peeples is commissioner of the Maryland State Health Department.

Bill, if you will proceed, we will be glad to listen to you.

Dr. PEEPLES. During the first several decades of State health agency formation, State health departments were almost entirely responsible for public health. In 1930, 72 percent of all health programs in the States were conducted by health departments, but by 1950, only 27 percent of health programs were in health departments.

Though definitive figures are not available for the more recent years, there is no doubt that the percentage has continued to decline.

After World War II, diversion of health programs from State health departments to other agencies began within the States. The proliferation was compounded by new laws enacted by the Congress and the Public Health Service.

These laws required the designation of State agencies to administer programs, but consolidation of programs into the health agencies seemed to be the exception rather than the rule. The U.S. Public Health Service did not strongly encourage health program amalgamation.

Funds provided by the Congress in laws enacted were often earmarked to provide for vocational rehabilitation in departments of education, medical care in welfare agencies, mental health in departments of mental hygiene, and occupational health within departments of labor, industrial accident commissions, and welfare agencies.

Further, public health administrators failed to accept programs offered to them, thrusting them on other agencies rather than to violate their "tried and true" concepts of the scope of public health.

Mental health was a foremost example of such a failure. I sat in the office of one antiquated hidebound administrator who turned down the offer of funds to begin a mental health program because, "It's not public health."

Later Congress progressively appropriated funds for neatly packaged disease programs in cancer, heart disease, tuberculosis, venereal diesease, water pollution, radiological health, and at least 35 others.

Medicare, the Office of Economic Opportunity, regional medical programs, Appalachia, and public works improvement programs are more recent examples involving disease control and other concepts, such as regionalization and community action programs.

Each of these laws contains provision for important health program components, but health agencies in most cases were again the victim of the bypass.

Our major highways today, when approaching a city, have developed the bypass to avoid city congestion, stop lights, and ponderous inner-city traffic snarls. A number of agencies in the Department of Health, Education, and Welfare have utilized the bypass in avoid-

ing the official health agency, taking a leaf from the highway engineer's book.

Let me cite several examples where the State health agency has been in a partnership arrangement with the Federal public health agency, and others where it has not.

The Hill-Harris/Hill-Burton hospital construction program was given to health agencies in all but six States. The program was implemented only after a statewide survey with plans developed for hospital construction under a priority system. Each State health agency involved worked in close harmony with the Public Health Service, jointly adjusting and improving the operation of the program to its present high standard of performance.

In almost all States the Children's Bureau has related intimately with the health agency to produce imaginative, high-quality medical programs for children and mothers. Only in those States who established other agencies for this purpose was there any exception to this relationship.

Another striking success is in the National Office of Vital Statistics, which has uniformly associated closely with State health departments to carry out vital statistics registration. There is little evidence that this has not been a successful jointly administered partnership.

The other side of the coin is tarnished by a partial to complete bypass of the official health agency of the State.

The National Institutes of Health in their research and other programs have encouraged close relationships with medical schools and other clinical investigators. The only notification that State health agencies have received was by way of a yearly catalog of projects financed.

The National Institute of Mental Health was responsible for a schism within the Public Health Service itself, finally winning its way to both community and research programs.

The Hill-Burton program was further diverted from health agencies in the construction of mental health facilities, funds in 25 or more States going to the mental health authority.

Few health agencies have benefited from funds allocated by the National Institute of Mental Health, since emphasis has been institutionally rather than community centered.

The Vocational Rehabilitation Agency program, a major portion of which is medical in nature, has detoured far from the vicinity of the health department. They have employed their own specialists, duplicated diagnostic and evaluation facilities, and discouraged cooperation by the health agency.

The Food and Drug Agency has been completely autonomous, unwilling to contaminate itself with State health agency contact except by letter or telegram, and an occasional invitation to a conference. State food and drug activities are completely devoid of any Federal fund support.

Departments of education and welfare have conducted their own intramural health programs with azimuths directed as far as possible from the official health agency. Those welfare agencies who have had medical care programs have sought no advice, consultation, or participation from the official health agency.

In most instances the Kerr-Mills program administration is a good example of this.

There are enough exceptions to this statement, however, to make the fact worth noting.

In the Headstart programs sponsored by departments of education and the Office of Economic Opportunity last summer, health agencies, State and local, were bypassed until roadblocks were encountered, resulting in a U turn, a hasty trip back to the health agency for a curbstone consultation, and subsequent program, involving the health agency. I know of several examples where this took place.

Regional medical programs have tended to bypass the health department in favor of the medical school to carry out regional programs to fight heart, cancer, and stroke.

Several health agencies, as in Maryland, New York, and California, have taken the bit in their teeth, however, stepping out boldly in joint planning with medical schools and the community.

Appalachia, another regional program, seeks to woo the medical school and schools of public health into developing health program demonstrations. Little attention is paid to the health agency in its attempts to provide improved basic medical care services on a comprehensive basis.

The Public Health Service has detoured State health agencies widely in planning cooperative need-meeting programs.

I would cite two examples: Vaccination Assistance Act, and medical rejectee programs.

These were begun without consulting States about their needs, and specified conditions under which the programs could begin, which was not necessarily the way the State wished to operate the programs.

Mr. ROGERS of Florida. Which are those programs?

Dr. PEEPLES. The Vaccination Assistance Act, and the medical rejectee examination program, a rehabilitation program.

Dr. HILLEBOE. Selective service rejectees.

Dr. PEEPLES. Had these programs been planned ahead with the States, the legislation that created them could have been written to allow for local innovation and initiative.

The Federal plan should reflect, it seems to me, State plans, in both funding and operation.

New legislation imbued in H.R. 13197 and S. 3008 could conceivably change this picture to one of true partnership.

Someone has said, "The preservation of States rights depends upon the exercise of States responsibilities." The Federal Constitution recognizes such rights of States with regard to protecting the health of their populations. State statutes provide for it.

I submit that if Federal agencies, including the U.S. Public Health Service, continue to bypass the official State health agency, that atrophy will prevail as a result of lack of exercise.

Dr. HILLEBOE. Unless there are some questions, I would like to have Dr. Breslow start the discussion. He has some comments. I think it would be very nice if he started it.

Dr. BRESLOW. In recent years the considerable realinement of relationships between Federal, State, and local government in the United States has begun to affect the planning and development of health services.

The origin of the general realinement in governmental relationships probably lies mainly in the vast changes in distribution of population and commerce. However, as these relationships evolve, it is highly desirable that we maintain as smooth working channels as possible.

In these remarks my concern will be with the apparently growing tendency of Federal health agencies to bypass the State health agency in the development of new health programs.

While experience in California will be the basis for these remarks, similar events have been occurring around the country.

At the outset let me emphasize that California, as well as the other States, has gained tremendously from the health programs adopted by Congress and administered by the Federal health agencies.

My intent today is solely to indicate a source of difficulty, to express the hope that better relationships can be achieved, and to suggest one step in this direction.

In the case of some earlier health programs, for example venereal disease control, and hospital planning and construction, the Public Health Service adopted the policy of building State health department responsibility and competence. Several of the older health programs still function well, in part at least because of that policy. Everything is channeled through the State health agency, to good advantage.

In some of the more recent programs, Federal health personnel have tended to bypass the State health agency, and to deal directly with local government and communities.

This is not only irritating to State personnel, and confusing to local personnel; more important, it detracts from long-term program accomplishment.

It is understandable that certain eager Federal health personnel, feeling responsible for the new programs and inexperienced in Federal-State-local relationships, want to get "directly" to the communities.

It may seem direct, but we in the States note that these programs ofen flounder because they fail to take advantage of State resources that could assist in administration.

A few examples may be helpful in understanding the situation.

In November 1965 the National Institute of Mental Health, without prior information to the States, sent letters to county medical societies, hospitals, clinics, and other local agencies, announcing the availability of Federal funds to aid the construction of community mental health centers. These letters referred to a range of 33 to 66 percent in the Federal matching formula, and other items which are important from a national standpoint, but simply do not exist within a particular State.

In California, for example, the pattern from the beginning of the hospital planning and construction program has been a one-third Federal, one-third State, one-third local matching.

The letters from the National Institute of Mental Health caused considerable confusion and difficulty in our State—and presumably in other States—where those concerned have become accustomed to obtain pertinent information and assistance from a State health agency.

Would it not have been better for the National Institute of Mental Health to work through the State health agencies, who are in regular, frequent contact with the agencies that might develop community mental health centers? Would it not at least have been desirable to

check the accuracy and pertinence of information sent to local groups within a State?

In February 1966 a consultant in nursing for occupational health from the Public Health Service entered into direct arrangements with a group of occupational health nurses and schools of nursing in one of our California cities, without informing the State department of public health occupational health nursing consultant.

Subsequently, the local nurses attempted to follow up the recommendations made by the Federal consultant by seeking assistance from the State personnel, who maintain regular and frequent contact with the local nurses.

However, our State personnel were unaware of the visit by the Federal consultant, and the recommendations that had been made.

Was that visit by the Federal consultant in the long run useful, or disruptive?

The California State Department of Public Health for some years has been carefully building relationships with the medical schools, especially the departments of preventive medicine, and the schools of public health, to the great advantage of health programs, medical education, and research.

For example, we sponsor annual conferences with the professors of preventive medicine, enter into their teaching programs, utilize them in our projects, and engage in other mutually advantageous joint work.

In January 1966 we learned through a casual conversation that the Training Resources Branch of the Division of Community Health Services, Public Health Service, had been making independent visits to these same schools in California.

This time, in January 1966 a representative of the State health department was included in the visit by the Federal personnel—with a resultant opportunity for followup to promote improved teaching in public health and preventive medicine in the medical schools. It also enhanced the opportunity of engaging the medical school people in community health programs.

A few years ago the Public Health Service established in San Francisco headquarters field stations for research in community aspects of heart disease, nursing, and other fields.

Just one experience may illustrate the difficulties encountered when a Federal agency undertakes direct health projects in a community without coordination with the State department of public health.

The Public Health Service heart disease field station participated in a blood cholesterol study with a local health agency, without knowledge of the State department of public health. At the same time, arrangements had been made for identical support to the local program by the State department of public health. The duplication of effort was expensive and, carried out without coordination, had no scientific advantage.

We believe that it would be much better for the Public Health Service to build up the State health department resources for working with local groups, rather than, in effect, competing with them.

These examples indicate the nature of the problem. Many other examples could be cited, each one minor in itself but in toto appearing to indicate that the tendency is growing. It involves not just the

Public Health Service, but other Federal agencies with health programs.

These remarks are not meant to suggest that all Federal health work be channeled through the State health agencies. For example, support of basic laboratory research in medical schools probably requires direct national channels. However, all health programs involving persons or health resources in the community should be coordinated through the State health agencies.

What can be done to resolve the difficulties? Passage of H.R. 13197—S. 3008—would be a great step forward. This bill would strengthen the State health agencies under guidelines established by the Congress and the Public Health Service, to formulate comprehensive health plans for each State.

The substantial Federal requirements for planning in the hospital construction program have been a major element in the remarkable success of that program. Extension of this type of planning to embrace all health programs would be a tremendous advance in health administration in this country.

In particular, it would reestablish and enhance the Federal-State partnership in health matters, which has proved so useful to our Nation.

Dr. HILLEBOE. Thank you very much, Dr. Breslow.

Unless you have some questions, Mr. Chairman, I think that the other members of the panel could contribute greatly to the work of the committee if you would give us any other specific examples of bypass that have come up.

I look over here to Dr. Philp.

Dr. PHILP. When we are talking about bypassing, we might also talk of bypassing some of the city agencies and some of the local community agencies. Let me give you a specific example which is in the mill right now.

I am the health director in Kansas City. This is an example of what is going on in maternal and child health. The health department, which I direct, operates well baby clinics. At the present time there is an application, I understand, that has been submitted by the Children's Mercy Hospital to extend their services to provide comprehensive health services to children through an extension of the outpatient service.

I have not seen this application.

I understand, also, that the General Hospital in Kansas City is developing a proposal for the expansion of maternity care programs. I have seen one draft of this application.

The board of education is responsible for the Headstart program, and I really don't know at this point in time what their plans are for the medical programing.

I cite this as an example, because they are the same mothers and children that we are talking about, and there is a direct pipeline and direct planning going on that somehow has bypassed to some extent the State, but also within the community the agencies which legally and also morally should see that total comprehensive planning and implementation take place.

Dr. SOWDER. I would like to strike one cheerful note.

In Florida we have lots of problems with respect to grants-in-aid. But the matter of bypassing the State has not been a major problem

with us. It happens occasionally, and we regard it more as a treatment situation than anything else.

Our regional people have been very good about working through us.

Dr. HILLEBOE. Dr. Dennis.

Dr. DENNIS. I have been waiting for someone to mention medical school in relation to regional center programing.

I would like to point out that medical schools have been by law designated as one of the essential components of such a program.

Mr. ROGERS of Florida. Medical schools?

Dr. DENNIS. Yes, medical schools. A medical school and a community hospital.

Mr. ROGERS of Florida. Or a medical center?

Dr. STEWART. One or the other. Then it defines the medical center. It could be a hospital with a research training component.

Mr. ROGERS of Florida. When we were considering the legislation, we were thinking also of a hospital, a major medical center.

Dr. STEWART. The original proposal had it defined as a medical school. I believe it was the House Interstate Commerce Committee that added the other.

Dr. DENNIS. Regardless of the semantics, most States would leave the university medical center as the core institution, and I think this is appropriate.

This brings us to the point that Dr. Breslow so beautifully stated, that basic laboratory research in medical schools should be by direct support, whereas health programs involving community health personnel and resources should be coordinated through State health programs.

Only last week, I had the privilege of sitting down in one room at the same time with the director of State welfare, the commissioner of health, the director of mental hygiene, and the dean of the school of medicine. For the first time we actually communicated in the same environment in regard to our mutual problems.

This kind of interagency communication at the State level is exceedingly important to accomplish the goal that we are striving for today, and a communication that simply does not now exist.

The medical schools are usually not directly involved in community health services. Indirectly we are very, very much involved, with the tremendous responsibility of producing health personnel. We need to actively engage in pragmatic research in the packaging and delivery of health services. We have never done this in the past.

Dr. HILLEBOE. Dr. Frechette.

Dr. FRECHETTE. There have been several references to the need for comprehensive health planning. We have spent a good deal of the day here discussing fragmentation.

I just want to call attention to the fact that our planning in the health field has been badly fragmented.

With the Hill-Burton hospital construction program we provided funds for planning for hospital construction on a regional basis, without paying any attention to other health services.

Three years ago funds were provided for planning for mental health as a special health area. Most of these plans were carried out by the departments of mental health, in States that have them.

About 2 years ago we had funds for planning for mental retardation, again as a separate activity, and currently funds are available for planning for the regional medical programs aimed at heart, cancer, and stroke.

A variety of planning operations, carried out by different groups, with different objectives, and without an attempt to really have comprehensive health planning.

There was a good deal of discussion about general support for health service versus the categorical approach.

I want to support Dr. Philp in his statement that this is fine, everyone likes to have the freedom of the general support grant. On the other hand, this will not work unless we have comprehensive health planning.

Dr. THOMPSON. I do not want by silence to indicate that I don't have lots of examples of bypass, but quite a few have been stated, and I will not state any more. I think I could take 5 minutes to enumerate a half dozen.

Dr. HILLEBOE. Give us some examples in Utah.

Dr. THOMPSON. I will just mention two.

This happened a few years ago, when we were developing a program with the three universities, three principal universities, in connection with a hearing program. Without our knowledge, one of the Federal representatives related himself to one of the universities, and the first thing we knew, we had a project, an application.

This proved to be embarrassing to us, who had to work with the other universities, which are just as important, in their own mind, and as to size, they are almost comparable.

This took a lot of doing on our part, to save the face of the Federal agency, as well as our own, and get this back into some kind of triangle relationship, which was essential, which would not have been necessary if they had consulted us before they went to the university on their own.

The other example involved one of the Federal agencies which had the concept that they would like to develop a program for children in need in a portion of one of our counties.

They went so far as to initiate these discussions, without our knowledge, and then approach me on it. I said:

> I am sorry I can't agree with your approach, although the need is there, but I want the approach on the total county need, not on a part county need.

We had disagreement on that.

It was unfortunate that the Federal agency had gone to the trouble to visit the local area, talk to the local people, and then see us afterward, without exploring the possibility of doing it on a whole county basis in the first place, when there is a total county need.

Dr. HILLEBOE. I wonder if Dr. Yolles would like to speak about this.

Dr. YOLLES. I would like to comment.

I would like to start off by putting my comments in perspective.

When I appeared before the parent committee of this subcommittee 2 years ago, I spoke of the size and magnitude of the problem. I think, in terms of perspective, it ought to be mentioned again.

There are still 19 million people in the United States who need some sort of attention for mental or emotional problems.

Mr. ROGERS of Florida. How many?

Dr. YOLLES. 19 million. One out of every three families has this problem.

Half of the beds in the hospitals in the United States are still occupied by patients with mental or emotional disorders.

This Nation spends $3 billion for direct care services for the mentally and emotionally disturbed, and another $3 billion is lost in taxes and other indirect costs, making a total of $6 billion as cost, annually, for mental and emotional disturbance.

In addition, three-quarters of a billion dollars per year is spent in the United States today for tranquilizers, sedatives, and other psychoactive drugs.

This amounts to quite a handsome sum of money per year.

In the face of this extensive problem, which had existed for quite a number of years, and in the face of a rather antiquated system of taking care of our mentally ill, which had existed in the United States for quite some time, and in the face of newer developments in Western Europe and in Eastern Europe, which had outstripped many of the developments in the United States, the Congress in 1955 authorized a nationwide study of the status of mental health in the United States.

The result of that study I think you all know, as published by the Joint Commission on Mental Illness and Health.

This was followed by a secretarial committee appointed by the late President Kennedy, to suggest implementation of a national program. This was done, and it was presented to the Congress, and the Congress authorized an unprecedented new national mental health program.

The direction, gentlemen, I think you all know, was away from these outmoded custodial institutions, into the community, with the development of community mental health centers.

There was a certain urgency. We were 25 years behind time. There was a certain urgency to the development of these community facilities. There was a certain national disgrace involved in the way we were taking care of our mentally ill citizens.

In the face of this, this program was developed, and consisted generally of building community mental health centers, so that patients could be taken care of close to their homes.

An interim program we developed improving the staff of the mental hospitals, so that patients could be adequately cared for until the custodial program could be phased out, and the new construction program, the new community health centers, could be phased in.

The Congress also authorizezd the hospital improvement project program to demonstrate within every one of the institutions in the United States, mental hospitals and institutions for mentally retarded, new methods of care for the mentally ill.

All of these programs, in the face of the comments made today, require, whether by law or by regulations, or whether written into these programs by administrative rule, that the State mental health authority play an active part in passing on the elements of the program, both the plans and the individual grant applications.

I might add that this is in keeping with the tradition of the National Institute of Mental Health.

I am sure all you gentlemen can testify to that, since we have been in a partnership for many, many years, working very closely with the States.

Even in our research and demonstration programs, where there is no requirement by law, we have insisted that any applicant working in a community indicate on his application what his relationship to the State is, what his relationship to other community programs is.

We take this partnership very seriously.

I would agree with Dr. Kimmich that we need a very close and lasting partnership, and we are constantly seeking to improve that partnership.

Now, may I comment also on some of the comments made on the regulations.

We have tried in a spirit of partnership to consult with all relevant agencies, both private and public, in the development of our regulations.

Before we developed the regulations for either the construction program or the staffing program for community mental health centers, representatives of the State and territorial mental authorities, the State mental health program directors, representatives of the national professional associations, were consulted as to the regulations.

They were formally presented to a formal meeting of the State and territorial mental health authorities assembled by the Surgeon General in Washington, and appproved by that group.

I would remind you, gentlemen, that just like organization components are not fixed in perpetuity, regulations are not fixed in perpetuity.

This is the first year of the operation of a new mental health program. As new methods and better methods are developed we will be happy to discuss them with any and all concerned.

Specifically in regard to Dr. Kimmich's statement that perhaps regulations should be developed and tailored to suit the individual needs of the States, we have always given credence and a sympathetic ear to the individual needs of the States, but by law we are precluded from developing special regulations for any one State. They must be equally applicable across the board.

In reply to the comment about sudden changing of administrative regulations in midstream without prior notice, I think Dr. Kimmich referred to "fine print." Now, the "fine print" has always been there, gentlemen.

The "fine print" was spoken of at long length, in the legislative history, in the development of the community health center programs, when the relationship of title VI of the Public Health Service Act, the Hill-Burton Act, was related to the new Centers Act. A nonduplication clause was written in by the parent committee of this subcommittee.

This is the principal difficulty that came up, the nonduplication clause.

As to State plans, and the difficulties of writing State plans, I would like to make one comment about that.

I am sure Dr. Kimmich would agree with me, and I know Dr. Richmond knows for sure, and many of you who are mental health authorities know this, too, that in the development of the mental health program over the years there have been many false starts in

terms of each community wanting to build a clinic of its own, and many of the clinics failed in the past because there were no supporting services.

One of the principles in public health is that you have to have supporting service. The rationale, the reason for State plans and careful review of State plans, is that we want to insure that the State has carefully looked at all of its resources. This is written into the law. It looks at its resources, inventories its resources, before it develops a plan for the construction of community health centers.

We would insist if there were no review, that there be a review by the State, because we would want to see that there was adequate distribution of mental health services within any one State.

Now, as regards the famous letter which was sent out, I think in fairness to the people who are sitting around the table, and to the gentlemen here may I read this letter into the record, so that we all know what the letter was.

In the first place, this is the covering letter, which in this case was addressed to Dr. Kimmich:

DEAR DR. KIMMICH: In our joint efforts to make available broader and improved services for the care of the mentally ill and prevention of acute illness, the Institute is sending letters to various organizations and facilities in your State. For your information, the enclosed letters are samples of those that will be going to every State to reach groups and individuals who may be concerned with the community mental health centers program.

As one of my responsibilities I am informing independent persons of their eligibility for centers grant under the Community Mental Health Centers Act, in an effort to make available the maximum amount of information to all potential participants in the program.

To this end, letters mailed to county medical societies, the American Association of Counties, District Branch of the American Psychiatric Association, Health and Welfare Council, general hospitals, psychiatric clinics, National Association of Social Workers, American Psychological Association, and State and local affiliates of the National Association of Mental Health.

As a result of the mailing, you may be receiving inquiries concerning details of eligibility for both construction and staffing of centers.

I will greatly appreciate your cooperation in this matter, as we work to improve mental health services for everyone who needs them.

I will just quote one paragraph from the letter, the individual letter:

The appropriate agency designated by the Governor of your State (see the attached list) can provide you with complete information on procedures relating to construction grants. The Mental Health Director in the Regional Office of the U.S. Department of HEW may also be of assistance. Since the State mental health authority will be involved in a program for staffing centers, I am including a State-by-State list of these agencies.

These letters were sent out in response to a number of inquiries we received at the National Institute of Mental Health for information about this new program.

In order to carry out the responsibilities, and informing the public, and prospective applicants, these letters were sent out.

Dr. HILLEBOE. Thank you very much, Dr. Yolles.

I think there is a question here that we need to discuss a bit, Mr. Chairman, among members of the group.

We have been going into some of the details of bypassing. I think it is quite evident that this sort of thing has been going on.

Mr. YOUNGER. I would like to ask this question: Where do you get the figures about the 19 million?

Dr. YOLLES. They are estimates, Mr. Younger. They are based on a number of surveys, perhaps a dozen surveys, that have been made in different parts of the country.

Mr. YOUNGER. When they speak in millions, I am getting a little disturbed.

In 1961 we were fed figures that there were 17 million people that went to bed hungry every night. Now, we have 35 million that are poverty stricken.

There has been no progress made at all in the last 5 years. In fact, the poor people have doubled, according to those massive figures that we were given all the time. I am wondering what is back of them.

Dr. YOLLES. These are pure professional estimates made of the number of persons who might need, or who are felt to need, help with mental and emotional disturbance, based on surveys.

Mr. YOUNGER. Who determines whether you need it? There are a lot of people I think need it, and a lot of people who think I need it. Who is going to be the judge?

Dr. YOLLES. These surveys are not made of the whole country at one time, but made on a sample. They are done by psychiatrists and other mental health personnel on samplings of groups of people around. They then project these estimates on the national population.

I might say this, that in the face of these staggering figures of 19 million who need some sort of help, a recent survey, not so recent any more, found that 75 percent of the population in New York City needed help of one kind or another. I might add that I heard the finest commentary on that by an epidemiologist who got up and limited his remarks to the following: "Even for New York that is too high."

Dr. HILLEBOE. I think Mr. Younger has a very good point, here, because it is very difficult to define mental health. If you can't define mental health for a particular time and place, how can you define mental disorder?

This is the basic question we are facing. This is a question that England has faced up to, and very frankly has questioned whether or not mental health and mental disorder do not only vary with time, but with place.

In visits to Russia, you talk to some of the Russian doctors about how much mental illness there is over there—in distinction to mental retardation—and you will be told there is very little of it. When you ask about how much high blood pressure there is, there is a tremendous amount of high blood pressure.

Your comment is a pertinent one. This 19 million very definitely has to be considered just an estimate.

I think, Mr. Chairman, while we are on this question of mental disorders, there is a basic question that we should face up to. We have psychiatric representatives here, and health officers, and other people.

That basic question has to do with the overlap of mental health activities and public health activities, or nonmental health activities.

As we look into the history of the development, mental health has developed into a major category. Perhaps we should consider it even a supermajor category, because the head and body seem to be the two most important things to consider when we consider health.

It is understandable to consider mental health and physical health on a parallel, rather than in the same category as crippled children's problems, and heart, and so forth.

Obviously, from an administrative viewpoint, there would be many advantages in having these under the same umbrella, but things have not developed that way.

Dr. Yolles states that many of the mental health authorities are separate from health departments. I think we should have the number on the record.

Dr. YOLLES. There are a number of States which are in transition at the moment. If it goes in the direction it is pointing, by the close of business at the end of fiscal 1967 there will be only 11 States that will have the mental health authority in the public health department.

Dr. HILLEBOE. It is quite obvious that the pattern has been set. I see no point in trying to change it. I don't think we should attempt to have one swallow the other.

We do need to have a look at the basic concept of where we are going in the next 10 years. I wonder could we have some discussion from the psychiatric members of the panel, as well as the public health members, of some way of pulling these two units together in very specific ways.

I am talking about more than cooperation and coordination. These are wicked words, and weasel words, and I am not quite sure what they mean.

When you coordinate something, you pull it together by mutual agreement. If you both want the same thing, of course you are not going to coordinate it, and somebody from above has to do it.

Maybe there are two or three areas to explore in improving the relationship administratively of these two groups.

There is no question about professional relationship. I am not talking about that, but there is a specific area that affects legislative responsibilities, and that affects the administration of these programs.

This is what I referred to very specifically, and I should like to have this discussed, because I think it is a conceptual problem of great import.

That is this. We see the development now of community mental health centers. I think this is excellent. There are many community mental health centers that are far superior to the public health centers, because public health centers have had great difficulty getting money.

You usually find the public health unit in a small State or community in a garage or in a basement of a house, or inadequately housed.

Because of the great interest in mental health, this has changed, and we are now getting the kind of centers we need.

I wonder if this panel would consider the feasibility of trying to bring together the community facilities, exclusive of hospitals?

I am not talking about hospitals. I am talking about clinics and centers and half-way houses, and things of that sort.

Could we not at least bring the mental health community centers and the public health centers in the same geographical location, so that we could cut down on overhead, so that we can have an opportunity to have these groups together?

It seems to me, Mr. Chairman, this gets into the very important business of Federal funds going into these tremendous centers. There are some examples throughout the country, and I am sure I can give you several, and Dr. Stewart and Dr. Yolles could. Let me give you

a practical example of a little community of Ithaca, N.Y., where we had a TB hospital of 200 beds no longer needed.

It is an excellent structure. The county decided to take it over as a county hospital, which it needed very badly, and was in the process of financing.

The county very wisely looked at the total problem of health in the community, and said, "We need a community center for health, we need one for welfare, we need one for mental hygiene. Why don't we put these people in this same area?"

This did not interfere in any way with the jurisdictional responsibilities of mental health or public health, but these people are now seeing each other in the corridor. They are eating lunch together. They are talking to each other each day. They are in geographical proximity.

You cannot get together coordinately unless you are close.

I wonder if we might have some discussion of this possibility of pulling these together consistently on a nationalwide basis, and not just by chance?

Dr. STEWART. As far as the mental health movement goes, I think that it is moving in the direction of doing this now.

There have been three major things that have happened. One was the change in attitude, so that mentally ill people could enter into general hospitals. It has only been in very recent times, really, that general hospitals would accept the admission of a mentally ill person. They had to go somewhere else.

Second, there is the beginning of coverage under prepayment programs for the care of the mentally ill in the general hospitals, so that there is a mechanism for payment, just like there is in physical illness.

Third is the development of the community mental health center, which includes as one of the component parts of the center the in-hospital care of shorter term stays.

Therefore, they are beginning to develop around general hospitals in many instances.

In the public health movement, as you remember, Dr. Joe Mountain suggested 20 years ago that for public health to really move into the modern age, public health centers should be developed as part of the hospital in the community, too.

There were a few attempts but it really never took hold, never moved in this direction.

I think that the goal that Dr. Hilleboe states is a very desirable one. I think the mental health field is moving in that direction, if we get the development of the new types of treatment that we are talking about.

I think that just in the last few years the public health movement is moving in this direction, too, but it has come later, really, even though the concept was developed earlier in the public health movement.

Mr. ROGERS of Florida. How many mental health centers have been developed, community mental health centers, under our legislation?

Dr. YOLLES. There are 20 that have been funded so far. This is only the end of the first year of appropriations for it.

Dr. HILLEBOE. What do they consist of?

Dr. YOLLES. They all contain the five essential services. All are located in general hospitals, where in-patient services are provided.

There have been suprises. We had expected that many of them would have just the five essential elements, and no more of the comprehensive elements. Actually many of them have services for alcoholics planned, services for drug addicts, children's services, and a number of other special services included in the list of comprehensive services. There are various patterns of financing, various approaches, two hospitals joining together to have in-patient services, and so forth.

I might add that the two States that have led the way in the number of centers approved so far are California and Florida.

Mr. ROGERS of Florida. We have the most problems.

Dr. YOLLES. California has six centers approved, and Florida four.

Mr. ROGERS of Florida. I have heard criticism of the way we set up this law because we require the five services. Now, many areas have advised me that they could get started maybe offering three services to begin with, and maybe in the second or third year bring in the fourth and the fifth.

Is this possible under your interpretation of the law as passed?

Dr. YOLLES. Let me answer the question this way. This has come up many, many times. Our regional office consultants and our central office consultants have faced this problem with many applicants.

In every case where there was a wholehearted attempt at a working partnership, where both were cooperating, we have ended up with a center with the five essential elements.

Let me point out what this really means. Most applicants come in with a request for constructing an in-patient service in a general hospital. This is by far and away the largest cost in the construction of a center. Having once established an in-patient service, it is a very easy step to take to allow some of those patients who come into that in-patient service to go home at night. In so doing you have a day-care service. The same personnel that are treating patients on the in-patient service will treat them in day care.

The emergency service that is required is the emergency service you would expect in any general hospital for any general medical case.

We would expect that the same services are given to patients which have an emotional disturbance in the middle of the night as is given to a patient with acute appendicitis.

So that those three are taken care of.

Consultation and education to the community, the fourth element, this is something that any mental health staff in any center can give about patients, and give consultation to other agencies.

The cardinal principle on which the community mental health center was established was continuity of care. We have all seen fragmentation of care. I am sure all the gentlemen here have seen fragmentation of care, where a patient was admitted to the hospital, and treated, and then discharged, and it was no longer the responsibility of the physician or psychiatrist to follow up that patient.

In all the testimony given in 1963, this was the point that was stressed most often, continuity of care. If a patient has a problem and needs to be in a hospital for that care, he can be followed as an outpatient thereafter.

What is to preclude, in the development of such a service for those

physicians, whether they be psychiatrists or what-have-you, who treat that patient in the hospital, from having him come back to that hospital as an outpatient?

Following this minimum module, you have accomplished and taken care of all five essential elements. It is for this reason that we have resisted just building one element of service, because you can give continuity of care to a patient by building all five without great cost.

Mr. ROGERS of Florida. Let me ask one other question.

We are concerned about the policy established without consultation. Why could there not be liaison—maybe there is that I am not aware of—between the State organization and, say, the Surgeon General's office, or the Secretary's office, before legislative proposals are made, before initial drafts are submitted

Dr. STEWART. There is, actually. I don't know in the case of the mental health legislation what happened at that time, but in the present legislation which is before the Congress on State grants, there was consultation with the Association of State and Territorial Health Officers.

We talked with them about the concept, what problems we were trying to reach, what would be the mechanism.

Mr. ROGERS of Florida. What would be the problems in the States?

Dr. STEWART. That is right.

Dr. SOWDER. I have been in six meeting with Public Health Service, I guess, the last calender year, working on grants to States. I was a member of a task force on that.

Mr. ROGERS of Florida. Knowing the present Surgeon General's philosophy of trying to build up the Public Health organization, I would think he would be amenable to this very definitely.

Dr. STEWART. I would not want to claim we don't slip once in a while because we do.

Mr. ROGERS of Florida. I would think the organization could initiate a request to the Surgeon General from the organization itself, which would be helpful in this area.

Now what about a single office to deal with grants? What would be the general feeling of the group on that?

Dr. HILLEBOE. Dr. Kimmich.

Dr. KIMMICH. This problem of the multiple agencies to deal with grants is one that I don't feel I have any easy answer to. Obviously there must be many offices to deal with special aspects of grants and the various kinds of programs involved.

Mr. ROGERS of Florida. It would be good to have a central clearinghouse?

Dr. KIMMICH. There has been a suggestion on the part of a number of people in our association, discussions about if there were a way of collecting, which indeed there may be, we might put these together in their component parts at the Federal level and somehow coordinate the course of these things through the Federal offices and back out again to simplify the number of agencies with whom the State authorities must be in contact. Whether or not this would be a workable system it is hard to say because these are fantasies from one level to another. There are some other things I want to say but to answer your particular point, I don't know what else I can suggest at this point without having some considerable exploratory discussion.

Dr. RICHMOND. We at the Federal level try to integrate our activities with that of other agencies. When we receive proposals that we think are relevant to the Office of Education or to the field of mental health or to health generally, we refer these or send them for joint review.

Mr. ROGERS of Florida. Do the applications for grants come to you first or do they go to the agencies?

Dr. RICHMOND. They must represent a consensus in the community through the community action agency in that community.

Mr. ROGERS of Florida. It does not come through your central office here, necessarily, is that correct?

Dr. RICHMOND. It goes to the regional office or the central office if it clears the local community action agency.

Mr. ROGERS of Florida. Suppose it clears, and they want to make a request for funding, does this come to your Washington office?

Dr. RICHMOND. To the regional office first.

Mr. ROGERS of Florida. Then to your Washington office?

Dr. RICHMOND. Yes, in the case of demonstration proposals, and some other types of grants.

Mr. ROGERS of Florida. Then you farm it out from there, from Washington? Or is that farmed out at the regional level?

Dr. RICHMOND. Now that the regional offices are beginning to gain experience in doing this they are trying to relate to the regional HEW office.

Mr. ROGERS of Florida. The regional office of Education or Public Health, whatever it may be.

Dr. RICHMOND. That is the developing pattern now, sir.

Dr. HILLEBOE. We have four health officers who want to speak, Dr. Thompson, Dr. Breslow, Dr. Frechette, and Dr. Sowder. Our time is limited. We are going to stop in 10 minutes. I am telling these gentlemen we would like to hear from them if they will take into consideration the time. We want some time at the end.

Dr. THOMPSON. There are several things that concern me which I thing are basic to the answer to the question you just asked, Mr. Chairman.

For example, Dr. Yolles has indicated that he predicts in 1967 there will be only 11 State health departments with mental health programs. He did not say of the remainder that they are in mental health departments because I don't think this is true. They are in welfare departments. There are in departments of institutions. In other words, a mental health program, in some of the States now, I predict, in 1967 will not be in the mental health department, they will be in some other structure with a different focus of attention.

Some of the States have organized around the concept of institutions, they put them all in institutions, including the State prison. This to me is a very poor way to think of how to structure mental health program but it is the other part of the picture.

I wish he would give us the full picture. Secondly, in connection with this I think that the National Institute of Mental Health may prefer, they may be giving inspiration at least to separate departments of mental health. I am concerned too about the impact not so much at the Federal level because at least in the Public Health Service I assume Dr. Stewart has some influence here with the National

Institute of Mental Health but I am concerned with the States where they are small, particularly the local communities that are even smaller, when they can hardly afford, because they have a small population base; to support a health program except by a multicounty arrangement and pulling all the health things together for professional and administrative direction.

The implication that goes down to the grassroots when you separate out mental health into its own entity is to separate it at the grassroots, making it difficult to set it up on a feasible, economic and beneficial basis.

To answer your question, there must be some single place to put it, certainly there should be some single place to put it in the small population.

I think this is economically necessary, professionally sound. When I hear the argument made by the mental health people it sounds to me like the crippled children people 30 years ago. It is the same arguments that only the specialist knows how to do it.

In those days it was the orthopod who was the specialist. Today we know the orthopod constitutes less than 50 percent of the impact on crippled children.

Dr. HILLEBOE. He is speaking of an orthopedic surgeon.

Dr. THOMPSON. The implication that 19 million people are emotionally disturbed and need assistance is a tremendous number.

I would also point out that, and I will ask Dr. Lester, how many children need crippled-children care? In the millions, too. But we are not advocating a department in the State to handle this even though it is a big problem.

Not all these 19 million should receive their services through these mental health clinics any more than a hundred million are going to receive or the 200 million are going to receive their medical care services through public health facilities. Many of these 19 million will surely on their own want to go to their own private resources for care. This is appropriate. So I am not sure what percentage of the 19 million really are going to need or are to be permitted to have these public clinics and programs at their disposal. I think it is a much smaller number.

Dr. HILLEBOE. Dr. Breslow, you are next.

Dr. BRESLOW. In response to your double question about coordination of submission of project applications, I would like to suggest very sketchily, in an oversimplified fashion and thus with many imperfections, a scheme for submission of these applications. First, all the Federal health program administrators might agree to establish a centralized and uniform system, including forms, for these applications. At present the forms and procedures are so diverse and you need a specialist in the forms and procedures to keep track of them.

Secondly, in the submission of the applications, if they involve the community, either the people living in the community or community health resources, they ought to come through the State health department to determine whether they are in compliance with the State health plan which we hope to develop when H.R. 13197 passes. Then they should go to the regional offices of the Public Health Service; we believe the regional offices ought to be strengthened even more than they have been in recent years because we find this is a very

desirable service to the States. It brings us closer to the Federal establishment.

We don't have to go so far as Washington. We can get a lot of things accomplished right in our regional office. We should like to see this expanded.

Then the applications should go on to the Central offices in Washington for final consideration.

This might take a few more days, or even two or three more weeks, if you want to look at it that way. However, in the long run this would make, as in the case of the hospital construction grants which we all consider the ideal system, a good way of getting out project grants for health services as well as for construction.

Dr. HILLEBOE. Dr. Frechette.

Dr. FRECHETTE. The relationship of the department of public health and mental health is a very intriguing problem, particularly in a fairly large State. I think we need to consider the development, the historical development of these departments which has been quite different. The department of mental health started primarily as hospital operating departments, as a State service. Public health, contrariwise, started as community programs. It is only in the last few years that departments of mental health have developed community programs and departments of public health now are developing hospital programs. So that originally where we were quite separate and there was no real problem of duplication, now we overlap in many areas.

The question of merging the two is often seriously considered. In a fairly populous State, if you merge them the first thing you would do is start breaking them up into operating units of reasonable size. I question whether it makes much sense to merge two such large departments. On the other hand you might divide the sub-units somewhat differently.

I think that what we need is joint planning. I don't think we necessarily need joint operation at the State level but we do need joint planning. I would hope to include public welfare and rehabilitation in this joint planning. On the other hand, at the point of service, where the services are actually given to people, not at the State level, we do need more integration.

I don't think we can continue to have separate mental health centers, public welfare service centers which we are now developing, public health centers and separate facilities for rehabilitation.

Dr. HILLEBOE. In other words, at the service level if you had your public health clinics so that the people could come to the same place this really is something which would have great influence. Actually, it is rather interesting that here we are asking mental health to let public health get on its coattails because of its big funds for centers. This is a nice thing to do.

Dr. SOWDER. I simply want to comment on Congressman Rogers' question about a central office for grants at the Federal level. I would be a little cautious about endorsing that idea too much. I would like to see more emphasis put on reducing the number of types of grants and simplifying them rather than concentrating on having one channel to go through because I think traditionally we like to deal with the professional and technical people who are directing the program.

In our State health department we have to have an office to handle

project grants. Our planning office reviews all applications for funds for projects.

Mr. ROGERS of Florida. What I was thinking was where you were trying to give more flexibility to the State so that you might have a general purpose grant. Then for all the others to have a grant which would in some degree, I presume, reduce the number that you need.

Now, I wonder if the State Association of Mental Health Officers has considered having a representative paid by the organization in the Surgeon General's office.

Dr. HILLEBOE. Have you considered this at all, Dr. Thompson?

Dr. THOMPSON. Not to my knowledge, but it is not a bad idea.

Mr. ROGERS of Florida. I don't know how the Surgeon General would feel about it. But to be here and to be available, to keep close liaison.

Dr. THOMPSON. I think it is fair to say, Mr. Chairman, that we do have a pretty splendid relationship with the Public Health Service. It is so good that we can fight among each other and go out afterward and enjoy our personal relationships. I do think we could solve these problems with our relationship with the Surgeon General except he is not always able to do this in the areas we have been talking today.

Dr. HILLEBOE. This is worth considering. I think we will pass this along to the group.

Mr. Chairman, as your moderator, we are at 5:30. There are two things, there are two gentlemen who want to speak. I think Dr. Richmond and Dr. Kimmich both have something to say. We also need to talk a little bit about what do we do about this bypassing because we really have only explored the problem. We have not come to crystalizing this specific point. What are the suggestions from the group? Would you like us to take a half hour in the morning?

Mr. ROGERS of Florida. I think if we could continue in the morning. It is 5:30. All of you have been patient and my colleagues here have been patient. It has been a most interesting and I think constructive session today. I congratulate all of you on the manner in which our panel has been conducted and we are very grateful to you for your valuable time. I think you are making a real contribution to the consideration of this.

Dr. HILLEBOE. What time do you wish to start in the morning?

Mr. ROGERS of Florida. At 10 o'clock.

Mr. YOUNGER. I think a remark ought to go into the record that this is the first group of doctors that I have seen before our committee not one of whom smoked a cigarette.

Dr. HILLEBOE. The thing you have to remember is that the vices of an individual add up to the same thing. If you have three vices and you don't smoke, then the other two I will not ask about.

Mr. ROGERS of Florida. We stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 5:30 p.m. the committtee was recessed, to reconvene at 10 a.m. Friday, April 22, 1966.)

INVESTIGATION OF HEW

FRIDAY, APRIL 22, 1966

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON HEW INVESTIGATION
OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. ROGERS of Florida. The committee will come to order, please. We will continue with our panel discussion. I will turn it over to you again, Dr. Hilleboe.

FURTHER STATEMENT OF THE PANEL COMPOSED OF DR. HERMAN E. HILLEBOE, MODERATOR, SCHOOL OF PUBLIC HEALTH AND ADMINISTRATIVE MEDICINE, COLUMBIA UNIVERSITY; DR. G. D. CARLYLE THOMPSON, DIRECTOR OF PUBLIC HEALTH, STATE OF UTAH; DR. JAMES L. DENNIS, DIRECTOR AND DEAN, UNIVERSITY OF OKLAHOMA MEDICAL CENTER; DR. JOHN R. PHILP, DIRECTOR OF HEALTH, KANSAS CITY, MO.; DR. ROBERT KIMMICH, DIRECTOR, MICHIGAN DEPARTMENT OF MENTAL HEALTH; DR. WILLIAM J. PEEPLES, COMMISSIONER, MARYLAND STATE HEALTH DEPARTMENT; DR. LESTER BRESLOW, DIRECTOR, CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH; DR. ALFRED L. FRECHETTE, COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH; DR. WILSON T. SOWDER, STATE HEALTH OFFICER, FLORIDA STATE BOARD OF HEALTH; DR. WILLIAM STEWART, SURGEON GENERAL OF THE UNITED STATES; DR. STANLEY F. YOLLES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; DR. ELLEN WINSTON, U.S. COMMISSIONER, VOCATIONAL REHABILITATION ADMINISTRATION; MISS MARY E. SWITZER, COMMISSIONER, VOCATIONAL REHABILITATION ADMINISTRATION; DR. JULIUS RICHMOND, PROGRAM DIRECTOR, PROJECT HEADSTART, OFFICE OF ECONOMIC OPPORTUNITY; AND DR. BERWYN MATTISON, EXECUTIVE DIRECTOR, THE AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. HILLEBOE. Very good. Mr. Chairman, you remember we had decided we would spend perhaps a half hour talking about some of the things we were discussing yesterday afternoon and both Dr. Kimmich and Dr. Richmond would be asked to comment. Dr. Richmond has

been called to a special meeting so we will hear from Dr. Kimmich on what we should do about bypassing.

Dr. Kimmich, you have the floor.

Dr. KIMMICH. Thank you, Mr. Chairman.

I have to get back into the swing of what we were discussing. I am a little cool on it right now. But as we terminated yesterday afternoon we had been talking about the issue of what we termed "bypassing." That is bypassing of the State authority by the Federal authorities in the formulation of some of their programs and the regulations, going directly to urban areas without sufficient involvement of the State authorities and so on.

Those were some of the topics that were brought up. Dr. Yolles spoke regarding essentially a disclaimer that there had been any significant bypassing. That is just about where we wound up as I recall.

I do not want to take much time, the time that it deserves, in fact, to say that neither I nor the rest of the people here so far as I can tell are out for blood or complaining that the Federal programs, either on the part of the Congress, the administration, or the HEW have not been helpful and are not welcome.

We are talking about some of the great difficulties in efficiently carrying out these programs so that the goals which we mutually want at the State, Federal, and local levels, can be achieved without excessive blood and perspiration and without blocking some of the programs so that they don't even get off the ground.

Some of my colleagues here have said that there are times when the effort of undertaking the administrative aspects of a given program do not seem to be warranted for the amount of money available and the particular local situation.

That, of course, is a local option, or a State option.

One point that I did want an opportunity to speak about was in regard to the word Dr. Stewart chose in one of his remarks, to which I subscribe, and that was the word "participation," meaningful participation on the part of the States in the development of Federal programs, regulations and so on, which is what I was talking about in my prepared remarks.

I think that is what most of us mean when we are discussing the matter of so-called bypassing. It is one thing to be informed, to use a word that Dr. Yolles brought up, "we did inform you that we were going to circulate such a letter, or we did inform you or we did expose to your group certain proposed regulations," and what have you.

This is true. The information was there, there was a certain amount of information exchanged and so on. However, beyond information, beyond consultation there is a matter of actual planning and full participation which is what I am talking about. I am asking for the involvement of State authorities in the development of Federal undertakings and before the last "t" is crossed and the last "i" dotted, where we would participate at such a time and to such a degree that there would be a true contribution possible from the State level.

Obviously at a very late date in a new program it is not very likely that the points of view of other people are going to be able to be considered since there is not time to rework regulations or legislation in any significant way.

What I am really saying is that we are hoping and we have spoken along this line and have expressed this kind of feeling and I have some bibliography here which I won't trouble you with at the moment, but this topic comes up over and over from the Governors, from the health people, and from the welfare people and others.

At any rate, a regular system for meaningful participation by authorities at the State level in the early stages of Federal programs is what I am talking about.

Mr. ROGERS of Florida. How would you recommend that this be done?

Dr. KIMMICH. Well, it was mentioned yesterday, for example, there are such organizations as two of which are represented here and which have been used—the American Association of State and Territorial Health Officers, the National Association of State Mental Health Directors are examples of ways. This is one approach. Representatives could meet at certain specific times in such a way that real dialog can be undertaken and real discussion and give and take can be had.

I am not talking about a quick informational meeting where somebody says, "are you going to support it when we put it out in two weeks?" That is one way.

Another way of supporting it is by some other kind of opportunity to meet on an ad hoc problem basis with the State authorities themselves here when a new program is contemplated, that it be put out to the State authorities for study and recommendations and possibly coming up with some kind of small committee structure for review.

Mr. ROGERS of Florida. In the State organization of public health officers do you have a legislative committee as such?

Dr. HILLEBOE. Yes, there is, Mr. Chairman.

Mr. ROGERS of Florida. Is there any reason why, Dr. Hilleboe, there could not be some close liaison there?

Dr. HILLEBOE. Not at all.

Mr. ROGERS of Florida. If that was initiated by the State organizations the Federal authorities would give it consideration, and that is a good suggestion to try to bring in the State health departments so that they can explain freely the practical consideration in their States and the problems envisaged in the legislation as drawn.

Dr. KIMMICH. Yes. What you are saying just now is that we, the State level group and so on, should request audience. What I am saying is that the Federal people should request our participation at such a time because we don't always know what is being done, or contemplated or when to ask for such an audience.

Mr. ROGERS of Florida. What I am saying is, and I agree with you, that you should have your organization make a formal request that the Federal authorities keep you advised on these programs in the planning stage and that your legislative committee set up a schedule to meet with the authorities and discuss whatever programs they have developed.

I should think this could be done periodically. Your suggestion is good.

Dr. KIMMICH. May I say one more thing about that?

This to my mind still does not do the whole job since it is still my feeling that there are a number of programs which should be negotiated on a State-by-State basis. Now this has been done by the

Surgeon General, the USPHS, and NIH to my specific knowledge in many, many projects; research and training, HIPS for matching, and so on. It is taken on a State-by-State basis based on the problems at hand.

I realize in a broad national program it is not always possible to do this. But to the extent that it is possible and to the greatest extent a number of us feel that the State-by-State negotiations are probably going to wind up with less struggle, less difficulties in the long run, less having to go back and get reinterpretations, and we will have fewer troubles and arguments.

Mr. ROGERS of Florida. I thought the purpose of the State plans was to insure that the State itself had first given consideration to the development of a program within its own borders and that State plan is then presented so that you do have the individual State's program forwarded up. At least that was my thinking when we passed the legislation.

Dr. KIMMICH. Yes, and I think it is an excellent approach. The State plan, of course, must conform to the regulations which we feel may be there could have been more involvement in in the first place. We got the regulations, then the plan, and then the application.

I have one more point and then we have to get on I know.

In regard to the State plans it brings up another issue of the so-called bypassing which we mentioned yesterday. If you are going to have State plans it seems to me they should be meaningful. They should indeed be State plans and guidelines for implementation. If the State authorities are going to develop the plans, have them be meaningful, then this, I think, requires that with only certain specific exceptions, like research and training, that the State authority must be the funnel through which the local negotiations must go.

When we are talking about mental health centers or whatever they happen to be, health service in communities, that you have a State plan, the State health authority, mental authority, whatnot, should have the right and the power for approval or disapproval of the applications, otherwise your State plan becomes only an exhibit.

Dr. HILLEBOE. Dr. Philp, do you want to comment on this? Dr. Philp is a local health officer in charge of a large city as you recall.

Dr. PHILP. I am afraid that what I am about to say has been said, but I will repeat a little bit. It seemed to me yesterday that we did cite a couple of good examples of programing and these are examples that involve the development of the State plan.

The Hill-Burton program for hospital construction and also the mental health program in planning. Both of these required State planning and within that State plan there was a requriement for regional planning within the State or community planning so the State plan itself was really a sythesis or summary of the community plan with a high degree of community participation at all levels.

I think this is important because this is probably the key to the success—the long-range success and the particular success of these two programs. Now hopefully we move into this in the general health field. Whatever problems have been encountered in the planning process in the past, some of which Dr. Kimmich has just mentioned, I hope will be taken into consideration so that mistakes will not be repeated if they have been made.

I also feel there will be some special barriers as we move into general planning for health because I don't think there has been this kind of planning before, either on the State level or community level and it is going to be an awesome concept to some.

There may be a particular kind of resistance within some people to do it this way. Also, we run into the very special problem of what I will refer to as the metropolitan area. I am in one of these. The metropolitan area I am in now involves 6 counties, about 12 different municipalities and 2 States.

This is not too uncommon in this country. Certainly the New York situation is similar if you take the whole metropolitan area. How you develop planning which is a State plan, which represents a summary of community plans, and at the same time takes care on a coordinated basis of the need of the metropolitan area that crosses many lines, is going to be difficult to figure out.

It may be necessary to require in situations like I mentioned that more than one State get together on planning for these certain metropolitan areas.

Dr. HILLEBOE. Are there any other comments?

Mr. Chairman, I might just add a couple of things before we close this unless you have some other comments you would like to make. I think it has come up from the discussion that two or three things perhaps should be considered in the development of general grants and in the development of the program that Dr. Stewart mentioned yesterday. What bears repeating is that we do have need of a national health policy; we do have need of a principal health agency in the Federal Government.

Not that this agency will not do all the things that need to be done but it could serve as a bit of a clearinghouse because this is exactly what we need just as we have to have a clearinghouse for bank checks.

From what has been said, bypassing of State health departments by Federal agencies could be minimized by having some kind of clearinghouse, preferably in HEW if this turns out to be the unit in which the principal Federal health agency is located. The minute you have a clearinghouse then not only those units in HEW who use this but the Defense Department, the Interior Department, all the other departments concerned could use this.

We know this sort of thing works because in the field of radiological health which is a very important part of environmental health service, the Federal Radiation Council acts somewhat in this manner. The Chairman of this Council is the Secretary of HEW.

So that idea of having a clearinghouse is very good.

When you have a clearinghouse you have to have some way to see if there is money in the bank. Then again the regional office of HEW could serve a useful purpose in monitoring this system. Let us see if there is money to draw on if there is question about it.

The other point, Mr. Chairman, is that at the annual conference of the State and Territorial Officers and National Association of Mental Health Directors this would be a good time to review with the HEW what the transgressions were during the year and what corrective steps should be taken.

It is some of these things that we are putting forth as suggestions to consider in developing the kind of planning that goes on.

I think the final point to be made is that direct assistance to local areas by the Federal Government is not necessarily improper nor inefficient but if it is going to be done it should be done on a planned basis. It may well be that the State government and the local government, the city and Federal Government might not agree on everything but if they would at least discuss it and decide to disagree and to proceed accordingly this I think is the kind of thing that would be useful.

I would sum up this discussion this way to leave it on a positive note.

Mr. ROGERS of Florida. Thank you. Now, also I might mention that the committee has before it a chart which we would like to make a part of the record.

(The document referred to will be found in the subcommittee report as appendix C.)

Mr. ROGERS of Florida. Also there are some charts that are in the room which will be reduced to be put in the record showing the various agencies in the Department and the various recipients of grants from these agencies.

The lines are drawn to show the vast number of them and the possible bypass of State authorities that can occur. These will be made a part of the record without objection.

(The documents referred to will be found in the subcommittee report as appendixes D and E.)

Dr. HILLEBOE. I think we should proceed now to our topic (3), the desirability of allowing the States greater flexibility in spending Federal grant money.

We have only two papers to present this morning. We are going to give these gentlemen a little extra time because this is an important area to cover.

The first speaker is Dr. Alfred L. Frechette, the commissioner of the Massachusetts Department of Public Health.

Dr. FRECHETTE. To a State health commissioner, the answer to the above premise, the desirability of allowing greater flexibility to the States spending Federal grant money seems self-evident.

It may be that to the Federal agency making the grant a different answer may seem equally valid. Actually, in order to examine this question one has to think about the objectives of the Federal grants, the manner in which Federal grants are used to attain these objectives, the general responsibilities of governmental agencies in the handling of public funds, and the traditional relationship of the State and Federal Governments in the health field.

The subvention of public health work in the States by means of Federal grants is a rather recent phenomenon. One of the early programs was the Sheppard-Towner Act for maternal and child health, enacted soon after World War I. But the real impetus of Federal support for health services came with the passage of the Social Security Act in 1935 with its sections dealing with maternal and child health and crippled children's services under the Children's Bureau; and with general health under the Public Health Service.

The original justification for these Federal grants was to enable the States to deal with serious health problems affecting the entire country, and at the same time to assist the poorer States to provide at least a minimum standard of service.

This was an attempt to move toward the equalization of the opportunity for health; or to state it in the opposite sense, an attempt to lessen the hazards of illness in States with fewer resources or less well developed health programs.

More recently, the apparent ability of the Federal Government to raise funds through its tax structure, and the growth of the Federal tax revenue with the growth of the economy, has given support to the concept of sharing this revenue with the States on a continuing basis.

To prevent confusion in this discussion, we should differentiate between research grants and program grants. The great bulk of research grants are made to nongovernmental institutions on a competitive basis and are for a specific purpose. In supporting the thesis of greater flexibility, I am primarily concerned with grants made for program support.

In the area of program grants, the Public Health Service has sought to control what it considered serious health problems and to correct deficiencies in the existing health programs of the various States. Using comparatively small sums of money, it has encouraged States to initiate new programs and has supported new activities.

At the same time it has maintained philosophically that these activities and programs were basically the responsibility of the States and that the Federal funds were of a temporary nature and would, in due course, be phased out as the States accepted their responsibilities.

The Children's Bureau has had a somewhat different attitude. It has seen the Federal grant relationship on a more long-term basis. Although there has been constant pressure to keep improving and developing new programs by the Children's Bureau, there has not been the same tendency to withdraw from programs and to turn them over to the States.

And further along this continuum, the Welfare Administration has accepted a joint responsibility in dealing with the social problems of poverty and has developed formula support grants on a continuing basis without thought of gradual withdrawal and turning over complete responsibility to the States.

The Federal grants in all of the above areas have had an important and beneficial effect on programs. They not only provide the services which were financed directly by Federal funds, but have improved the quality of these services and often have established new standards in the facilities providing them.

The States and localities have been encouraged to spend greater amounts of their own funds in the health field; and this effort has been successful as shown by the greatly increased budgets for these purposes.

In view of the acknowledged accomplishments of the Federal grant programs, why is it now desirable to change them? What is the problem? Why is there a need for more flexibility?

First, I think that I should stress the need for a new philosophy of long-range continuing support of health programs with Federal funds, rather than to limit funds to the initiation of new programs which are turned over to the States or local communities for continuation.

Many of our health problems are of such wide scope that they are in fact national in character. Obviously, such things as air pollution control and water pollution are national problems; but not so evident as a national problem is, for instance, the lack of adequate home health

services. This lack is now being vividly brought to light by the medicare law. It is a national problem and needs a national effort to deal with it.

Our present medical technology permits us to aspire to new goals of disease prevention, health maintenance, and longevity. These new goals will not be reached without a strong continuing partnership between Federal and State resources.

Also, the Federal Government, through its grant in aid, has an opportunity to provide a better distribution of the resources available for health services and to share its increasing revenues in an expanding economy. All of these factors justify Federal support on a continuing partnership basis.

In order to have this partnership most fruitful, it is desirable that we have a national health policy. We need to establish goals and objectives to achieve that policy and periodically determine progress being made toward the objectives.

Such a policy would determine the general shape, direction, and character of our health programs. Within this framework the States then should have the responsibility to develop their own objectives and methods of implementing them. The States are the agencies most familiar with local situations and local problems, and are in the best position to work out local solutions.

Local and State funds actually constitute the bulk of expenditures for health services. Without flexibility in the use of Federal funds on the part of the State, there is the possibility that these two sources of funds will not be mutually supportive—they may even work at cross purposes. And what may be serious health problem areas, may be entirely neglected.

Does money allocated for a specific program give greater assurance that it will be more wisely spent and carry out the mandate of the people as expressed by the Congress? Actually, the opposite may well be true. Money that is available only for a narrow specific purpose is often money that the administrator has no incentive to avoid wasting because he cannot apply any savings to any other program. If he saves it, it is nevertheless lost to him. Saving just to be able to return the money loses much of its incentive. Moving toward the objectives of having funds available for a broader purpose gives the administrator a reason for saving (or not wasting) money. It is then available for other programs needs and he has the satisfaction of seeing his available resources accomplishing much more than had been anticipated.

Lack of budget flexibility is one of the greatest promoters of wastefulness. Not only has the administrator little incentive to save, but as the end of the fiscal period approaches there is often an attempt to deplete the account so as not to leave an unexpended blance—which is always an invitation to cut back on that particular item in a succeeding year.

Greater flexibility for the States is necessary in order that a proper foundation of basic health services may be developed. A series of unrelated specialized health programs further accentuates the fragmentation which is the bane of our health services.

It is true that special effort is needed to deal with special health problems, that is, venereal disease control. But it is equally true that

such specialized programs need the basic support of a well-rounded health department.

For instance, it is a distortion to establish and support a glaucoma screening program in a community which literally does not have a health department. And I have seen this happen in many parts of Massachusetts.

Although such efforts give the illusion of great concern with health problems, these programs are subject to rapid obsolescence and to the pressure of changing health fads. Such specialized programs have a place in our health armamentarium, but the basic health organization, whether State or local, has to be strong enough to maintain the structure of specialized programs.

In summary, it is clear that Federal grants for health program support are here to stay and will undoubtedly increase greatly in magnitude. A partnership relationship needs to be developed between the Federal and State health agencies.

The Federal Government needs to develop a national health policy; and within the framework of that policy, support the work of the State and local health agencies. The actual program development and implementation within the broad guidelines of the national policy should be a responsibility of the State agencies. Good administrative practice calls for maximum flexibility in the use of Federal funds at the State level.

Limitations on the use of too narrow categories encourage wastefulness, stultify planning, and negate initiative and innovation. Federal funds should permit for alternative methods of accomplishing policy objectives. Only in this manner can wasteful, inefficient, and ineffective methods be recognized and eliminated. And only in this manner can we identify and accept better ways of accomplishing our goals.

Dr. HILLEBOE. The next panelist is Dr. Wilson Sowder, the State of Florida medical officer.

Dr. SOWDER. Mr. Rogers, if it is all right, I will not read every word of my statement but add a few statements ad lib as I go along.

Mr. ROGERS of Florida. We will put your entire statement in the record at this point and if you will just continue.

(The statement referred to follows:)

STATEMENT BY WILSON T. SOWDER, M.D., M.P.H., STATE HEALTH OFFICER, FLORIDA, FOR PANEL DISCUSSION, FEDERAL-STATE-LOCAL HEALTH RELATIONSHIP, APRIL 21–22, 1966, TO THE SPECIAL SUBCOMMITTEE ON HEW INVESTIGATION, HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

I have been asked to present my views on the broad issue; the desirability of allowing states greater flexibility in spending federal grant money. I am delighted to be able to participate. My public health colleagues at all levels of government—federal, state, and local—can profit from the attention and consideration being given to a candid look at the relationships between various health agencies and levels of government. Some of these problems are not easily solved. But there is great enthusiasm among public health professionals for reviewing *all* administrative arrangements for the delivery of health services to the people of the country.

State health departments are faced with increasing rigidity and loss of flexibility in the use of federal funds; and to such an extent as to impair the most efficient utilization of these funds. I believe there are three main reasons for this:

1. The multi-plicity of federal agencies and units involved in the administration and granting of federal public health funds. Other panel members have or will discuss this.

2. A tendency to hold down flexible general purpose health grants, in favor of increases in the categorical grants; and to hold down grants-in-aid by formula in favor of dispensing funds on a project basis.

3. The categorical and project grants are administered by various units of the Department of Health, Education and Welfare with different regulations and guidelines for their use.

In fact, it appears that those responsible for each categorical program tend to resist efforts to develop general, uniform guidelines, regulations and procedures applicable to all programs.

During the 1940's and 1950's, the formula grants to states thru the Public Health Service and Children's Bureau developed in an orderly manner. In consultation with state health authorities, rules, regulations and procedures, and requirements for planning documents, and program and financial reports were coordinated. States could develop an adequate accounting and reporting system to satisfy state and federal authorities. Yet they still had considerable flexibility in budgeting, rebudgeting, and summary reporting within the framework for approved program objectives.

I think that the rapidly developing shift towards the project type fund mechanism as a means of providing federal funds as grants-in-aid has led to most of today's difficult situations about which both state and local health authorities are complaining.

There is a need, but a limited one, for project funds. These are needed to stimulate, to experiment, and to demonstrate and assist with problems of a limited geographical nature; and to provide support for specialized training. But in recent years they have been used to provide funds for disease programs and other problems which are common to all or most states, which could be provided for better with grant-in-aid funds. The rigid detail necesary in an experimental or demonstration project application and its control has been transferred to a field where it is neither necessary no desirable. Apart from the areas where project funds are suited, these have very limited effectiveness in assisting in the financing of health service for the following reasons:

1. It is not possible to make long range state plans, since so many of the decisions are made at the federal level.

2. Any possible planning has to be compartmentalized and piecemeal in nature, depending on what is of current interest nationally.

3. Inequities are inevitable in awards to states; and, in turn, within the states, since no determination can be made of needs in a given state on a state wide basis.

4. State agencies experience considerable lost time in planning or reviewing projects in detail which are never funded.

As a matter of fact, it is most difficult for the states to actually do any real planning of its own at all for programs of the project type. I say this in spite of the volumes of documents forwarded to Washington each month bearing the name of plans for projects. Such planning as is done is at the federal level, and is handed down to the states in the form of guidelines, liberally supplemented by oral and written suggestions as to the type of project that will be "entertained". This situation is not fair to the states and local health departments, and discourages the development of real state and local plans based on their needs.

In addition to this, project funds are:

5. Expensive to administer because of the many small administrative processings rather than a few major ones, and,

6. Project funds tend to reduce the amounts that might otherwise be available, and more effective, as formula grants.

The logical role of project funds is limited. I believe that effective use of grant dollars requires that most funds be formula in nature. This gives the state greater opportunity to meet recognized public health needs within the state. After all, who knows the health needs within a local area or state better than the local or state health authority? In view of this, I deplore the trend toward more and more project type grant funds being awarded in other than the limited fields I have just mentioned; and I urge that the states be allowed more independence and flexibility in applications for, and in the use of project funds.

With respect to the effective state operation of federal grant-in-aid programs, there are six impediments that I feel I must list:

1. *The Variety of Reporting Forms and Reporting Periods.* Reporting requirements vary wth the type of project and fund source. The requirements in

reporting differ even within similar project areas. The frequency of reports varies from monthly to quarterly, to semi-annually, to annually. This is further complicated by reporting periods differing from regular calendar quarters or other periods (such as a quarter consisting of February, March, and April rather than the traditional January, February, and March). Such exceptions make use of automated equipment extremely difficult.

2. *The Variety of Project or Fiscal Years.* Approximately one-half of our current projects have fiscal years other than July 1 to June 30. Why not have projects on the fiscal year now observed by both state and federal governments? Under the present system of awarding projects for periods different from the July 1–June 30 year, the accounting and auditing problems are multiplied. Either two sets of records must be maintained or we must constantly deal with records from two separate years—one currently in use and one usually in vault storage.

3. *Detailed Reporting Requirements.* Project type grants have led us backward to detailed "line item" expenditure reporting. Some projects require the quarterly reporting of amounts paid for each personnel position, detailed travel or other expenditure data. This requires manual accumulation of the information from source documents, rather than through the use of automatic equipment by general categories of personnel, travel, equipment, and so forth.

Furthermore, why should it be necessary to report in such a detailed manner when the records will be audited in detail later by a federal auditor.

4. Laws and regulations, or interpretations of these, requires us to veer from meeting current public health needs as we see them; and force us toward narrow and specific programs for which funds happen to be available. This involves *difficult and costly methods of proving effort and/or time* devoted to categorical programs or projects. More emphasis has to be placed upon staff time devoted to a project rather than to accomplishments.

5. *Validation of Categorical Funds.* The requirements of federal health agencies (mainly the Public Health Service and the Children's Bureau) on validation of categorical grants and projects have become increasingly more restrictive and demanding. Some activities lend themselves to cost accounting of individual program items; but in the broad public health field a great portion of the total activity does not. Over-restrictive validation causes constant uncertainty on the part of the state as to acceptable criteria for federal approval of state plans and also acceptable post audit requirements. Those activities that do lend themselves to measurement of cost pose validation problems due to the overlapping of program content. In using federal categorical funds such as those for Chronically Ill and Aged, Home Health Services, Medicare, Maternal and Child Health, Maternal and Infant Care Projects, and Vaccination Assistance, it is impossible to operate programs in all these areas without overlapping.

Several years ago in order to help a well organized and vigorous but struggling Visiting Nurses Association in Jacksonville, the Florida State Board of Health arranged to purchase services from it on a per case visit basis with federal Chronically Ill and Aged funds. This assistance has been continued since that time, although from the beginning great difficulty has been encountered in explaining to this nonofficial agency the necessity for separating records of visits to persons with heart disease, tuberculosis and other diseases from records of visits to those ill with other chronic diseases. This problem became more difficult when as agents for our State Department of Public Welfare, we began also to pay for home visits under the Medical Assistance for the Aged Program. Recently our problems have multiplied with increasing fund resources. How can we manage to fit together and properly identify payments to the Visiting Nurses Association of Jacksonville under the fund categories previously available, and the new ones such as Home Health Services, Maternal and Child Health and Medicare? Is it permissible to continue to use Chronically Ill and Aged funds when we now have specific categorical funds available for Home Health Services? Should we find that this is not appropriate, then the Visiting Nurses Association will get less aid rather than more because of these new funds. Exhaustive time and effort reporting procedures seem to be required. But I question whether it is worthwhile or in the national interest to develop such procedures merely for the purpose of so called fund validation.

6. Currently, federal grant-in-aid statutes, appropriations, and regulations carry us farther and farther away from our goal of attending to all health problems in the community in proportion to need. These make it difficult to attend to the needs of the entire family in all communities. Consider, if you

will, the problem of a public health nurse entering a home to administer to a patient with a heart problem, and where other members of the family may have cancer, tuberculosis or other ailments, and where there may be children. This nurse, financed from heart funds, is not supposed to render aid to the cancer and tuberculosis patient. Instead she is supposed to refer cancer patients to a second nurse who specializes in cancer and tuberculosis patients to a third who specializes in tuberculosis. This necessitates three visits by three nurses when one could have rendered the service. Not only is this sort of restriction inconsistant with our ideal for public health nursing; but it is also a great waste of valuable personnel time. But it may not seem too bad that three specialized nurses may be employed to visit the same families if this were the only problem. An unfortunate fact is that in most places there is only enough money from all three categorical funds to pay for one nurse; and the inhibitions against the use of multi-purpose nurses result in having no nurse at all. This situation is quite wide spread in the middle-sized and smaller counties and the more thinly populated sections of our state. About one-third of the population of our state gets little or no assistance from federal funds under the Tuberculosis Program or the Vaccination Assistance Programs, for example, for these reasons. The difficulties in using generalized nurses paid from specialized funds becomes real when a federal auditor reviews salary payments and activity reports. He takes exception to that portion of a nurse's time devoted to an activity different from the special category of funds from which she is paid. He is directed to do so either by the federal statute authorizing the funds, the regulations attached to the authorization, or to interpretations of the statutes and regulations by the federal agency.

State and local health departments are responsible and mature branches of their levels of government. Understanding and cooperation between them and their governing bodies and the public, as well as with medical societies, dental societies and voluntary health organizations are generally excellent. Health departments are staffed by career specialists from many professional areas. They are employed under Merit System or Civil Service rules. Political interference is largely a thing of the past and plays no more of a role than it does at the federal level. State and local legislative bodies constantly review their total health program, and their total resources. There is effective state and local control and stewardship of health department activities. Certainly the federal health agencies have no monopoly on trained, experienced personnel. Much is being said about the partnership between federal and state health authorities and the states desire very much to be recognized as parts of a federal system of government, rather than as numbered districts of one monolithic central government.

Why then should there be the feeling that the delivery of the right kind of public health services must be tightly supervised and controlled through rigid administrative measures from the distant city of Washington? Federal requirements for Merit System standards limiting political activities, and prohibiting discrimination are reasonable, and are accepted. But we want to have more responsibility for program planning. We have no objection to requirements for statements of our objectives, or for descriptions of our proposed techniques for carrying these out. We accept responsibility for the accountability of funds expended. But we do not understand the need for the rigid fiscal controls, involving the "chasing the federal dollar", as the best means of accounting for our expenditures, or for showing that program objectives have been accomplished. There are now in effect review procedures whereby the federal regional office staff and consultants work together with state health departments as a team to evaluate programs to insure that legal and regulatory requirements are met; and to measure conformity with the approved plan, and to make sure that program content being carried out is of recognized professional caliber. We believe that these procedures should be given greater emphasis.

May I comment on just a few cases that have come to my attention in Florida that may illustrate some of the issues being discussed:

1. Our state was recently notified that since VD project grants for next year will be less, no funds will be approved in the continuing projects for several type expenditures which were approved in the past. A surprising item in this category was that of health educators and educational consultants. We have always felt, and still feel, that a vigorous health education program is basic to any attack on the venereal disease problem. This point of view, incidentally, is repeatedly emphasized in a joint statement agreed upon by the American Public Health Association, the American Social Health Association the American Venereal

Disease Association, the Association of State and Territorial Health Officers and the American Medical Association, and published at Public Health Service expense, I believe, only two months ago. We felt this prohibition rather keenly because one of the most valuable workers in our Venereal Disease Program in Florida is affected. She is a fine young Negro woman and health educator whom we employed for the Venereal Disease Program about eight years ago. Both of her parents had worked at the State Board of Health and she had been educated first as a school teacher, but had not at that time been able to get a job in that field. We employed her and sent her off to a school of public health where she got a Masters Degree in Health Education. Now her future in the Venereal Disease Control Program is jeopardized because of a directive from the Public Health Service. We received an additional surprise a few days after this notification when we got a request from the Public Health Service to make a survey of the schools in the state regarding the feasibility of participating in a pilot study to evaluate a book, "Facts About Syphilis and Gonorrhea". We are at a loss to understand how we can continue the excellent liaison we have developed with our school system if we cannot continue to employ health educators.

It is emphasized, incidentally, that the rules of the federal agencies apply not only to federal funds, but also to state funds used for matching purposes. The point I make here is that state and federal partners should agree on program objectives and once agreed upon, the state is committed to carry them out. Rigid details on staffing, and what staff can or cannot be paid from project funds has no place here.

2. Florida's so-called coordinated TB Control Program is a Public Health Service Project Grant administered by the state health department in nine counties. There is an overall approved budget by expenditure categories and "sub-budgets" for each county. No such "sub-budgets" are mentioned in official regulations. We are restricted to each sub-budget with no transfer between them without approval of the federal agency. The project file contains quite a bit of correspondence back and forth with the federal regional office shifting small amounts back and forth between sub-budgets, although there is no need to change the overall budget. County health department nursing facilities are heavily involved in this project, but the nursing services are generalized; therefore, time equivalencies and effort reports are required, as well as hourly time reports for other than professional staff. We have some problem with the "expenditure code". The budget items differ from the state's code of expenditures and two sets of records are maintained. Quarterly expenditure reports are easily prepared, but the Annual Report cannot be prepared from retrieval of data from ADP system. It is necessary to laboriously refer back to each individual payment voucher to extract and accumulate information for the Annual Report, such as, name of each position and employee, inclusive dates worked, annual rate, total paid, travel of each employee in detail, equipment description in detail and amount, and so on. We have had wonderful and sympathetic cooperation from federal regional office staff, but is all of this detail really necessary? Is this the way to determine program performance and conformance?

3. Our project for development of health services for migrant workers is another example. This project is administered at State Board of Health level in 14 counties with sub-budgets for each. The same details of fund rigidity apply here as in the previously discussed TB project. We were recently instructed to write to Washington for permission to transfer $2,500 between sub-projects.

4. Another type of project requiring minute detail is the maternity and infant care project administered through the Children's Bureau. There is such a contrast between the requirements of that federal agency as to the state's planning, budgeting and reporting of maternal and infant care projects and the state's MCH program financed by regular federal MCH funds. For years the regular program has developed so that the plan material, the summary budget data and the reporting can routinely be programmed, and latest Automatic Data Processing methods used extremely well. However, Maternal and Infant Care projects require the most rigid line item control, and prior Children's Bureau approval of very minor budget revision. In fact, a single minor revision cannot be handled by simple letter form; the entire budget as amended must be presented for consideration. This method would be satisfactory if change in program and objectives were involved, but simple technical changes such as annual rate of a position from $4,500 to $4,800, a Merit System increment, imposes unnecessary red tape.

My comments here reflect, I believe, the feeling expressed by health authorities from many states and I am sure the subcommittee files bear this out. The Public Health Service and Children's Bureau, after consultation with states, have previously adopted joint annual plan materials, joint budget forms and procedures, joint quarterly expenditure reporting and joint annual reports in summary form to the satisfaction of the federal and state partners. I am sure this situation can again be attained, and leave the detailed expenditures for audit review. I plead for reasonable flexibility to use federal, state and local resources to carry out the objectives of well conceived plans for health services and get away from "line item" budget control. It is performance and results that all of us want. We can obtain them more efficiently as real partners without the over-use of the "ear-marked dollar" control applied to each and every program decision.

Dr. SOWDER. Yes. I would also like, if you don't mind, to interpret the title as referring not only to the need for flexibility but also to the need for greater opportunities to plan at the State and local level, to participate in planning, to use the plan developed; and also the opportunity to dispense with the pseudo-planning or going through the motion of planning when the plans are already made for us at the Federal level and the States role amounts to something like signing an application for an insurance policy.

I am delighted to be able to participate in this conference. I am also delighted to say to the group that so far as I can see, our colleagues in public health at all levels of government, Federal, State, and local, can profit from the attention and consideration being given to our problems, and from a candid look at the relationships between health agencies in the levels of government.

Some of our problems will not be easily solved. But there is certainly, in my opinion, a great enthusiasm among public health professionals for reviewing all administrative arrangements for the delivery of health services to the people of the country.

State health departments are faced with increasing rigidity and loss of flexibility in the use of Federal funds, and to such an extent as to impair the most efficient utilization of these funds. I have listed two or three reasons why I think this is true.

The multiplicity of Federal agencies, the tendency to hold down flexible general health purpose grants, and the fact that categorical project grants are being administered by various units of HEW with different regulations, guidelines and so forth.

We in Florida think that the rapidly developing shift toward the project type fund mechanism as a means of providing Federal funds instead of grants in aid by formula has led to most of today's difficult situations about which both State and local health authorities are complaining.

Mr. ROGERS of Florida. This is the project-type grant?

Dr. SOWDER. Yes.

Mr. ROGERS of Florida. That is developing the difficulties?

Dr. SOWDER. Yes. We feel that there is a need but a limited one for project funds. These are needed to stimulate, to experiment, to demonstrate, and to assist with problems of a limited geographical nature and to provide support for specialized training. But in recent years the mechanism has been used to provide funds for broader programs and for continuing problems.

Apart from the areas where project funds are suited these have very limited effectiveness in assisting in the financing of health services for the following reasons.

It is not possible to make long-range State plans for their use. Any possible planning has to be compartmentalized and piecemeal. Inequities are inevitable in awards to States and in turn within the States.

State agencies experience a considerable amount of lost time in planning or reviewing projects in detail which are never funded.

As a matter of fact, it is most difficult for States to actually do any real planning of its own at all for programs of the project type. I say this in spite of the volumes of documents forwarded to Washington each month bearing the names of plans for projects.

Such planning is actually in most cases being done at the Federal level and handed down to the States in the form of guidelines, liberally supplemented by oral and written suggestions as to the type of project that will be entertained.

This situation is not fair to the States, and the local health departments and discourages the development of real State and local plans based on their needs. I believe that the effective use of grant dollars require that most funds be formula in nature and that they be given to the State and local governments as a right rather than as alms as a result of asking and beseeching.

With respect to the effective State operation of Federal grants-in-aid programs there are six impediments that I feel must be listed. I will read them by title.

One, the variety of reporting forms and reporting periods.

Two, the variety of project fiscal years. Three, the detailed reporting requirements. Four, laws, regulations, or interpretations of these that require us to veer from the current public health needs as we see them.

The requirement for difficult and costly methods of proving effort and, or time spent or devoted to categorical problems or projects. Then the requirement on the validation of categorical funds.

Some activities of course lend themselves better to cost accounting, than others. Now I am giving a few examples of some of the difficulties we have had because a great deal has already been said about the problems in general.

Some years ago in order to help a well-organized and vigorous but struggling visiting nurse association in Jacksonville, the Florida State Board of Health arranged to purchase services from it on a per case visit basis and to use the funds that we had available, these were new funds at the time, Federal chronically ill and aged funds.

This assistance has been continued since that time although from the beginning we have experienced great difficulty in explaining to this nonofficial agency the necessity for making separate records of visits to persons with heart disease, tuberculosis, and other diseases, from visits made to those who are chronically ill or aged.

In fact it is difficult sometimes to say what the difference is between an aged person and a chronically ill person, or to explain why a heart disease case is not chronically ill.

VNA officials don't understand this at all. This problem has become more difficult when as agents for our State department of public welfare we began also to pay this visiting nurse association for home visits under medical assistance for the aged program.

You see, we were trying to help pay nurses' salaries with chronically ill and aged money and then we got money, under the MAA

program, to pay them for some of their services. Recently our problems have been multiplied with increasing funds resources. How can we manage to fit together and properly identify payments to the visiting nurse association of Jacksonville under the fund categories previously available and the new ones coming up such as the ones for home health services, maternal and child health, medicare and so forth?

Is it permissible to continue to use chronically ill and aged funds when we now have funds specifically appropriated, specific categorical funds, under the home health service program?

Should we find that it is not appropriate, then the VNA of Jacksonville will get less aid rather than more because of these new funds.

These things make it difficult to attend to the needs of the entire family and whole communities. Consider if you will the problem of public health nurses entering homes to administer to patients with a heart problem where other members of the family may have cancer, tuberculosis, and other ailments and where there may be children.

This nurse who is financed from heart funds is not supposed to render aid to the cancer and TB patients. Instead she is supposed to go back and refer the patients to a second nurse who specializes in cancer, and TB patients to a third who specializes in TB. This necessitates several visits by several nurses when one could render the service.

Not only is this sort of restriction inconsistent with our ideal for public health nursing but it is also a great waste of valuable personnel time. Now it may not seem too bad to have three specialized nurses employed to visit the same families if this were the only problem.

But the unfortunate fact is that in most places there is only enough money from all the categorical funds to pay for one nurse. The inhibition against the use of multipurpose nurses results in having no nurses at all in many areas.

This situation is quite widespread in the middle-sized and smaller counties and the more thinly populated sections of our State and I believe in other States, too.

About one-third of the population of our State gets little or no assistance from Federal funds under the tuberculosis program or the vaccination assistance programs for these reasons.

Much is said about the partnership between the Federal and State health authorities. The States desire very much to be recognized as parts of a Federal system of government rather than as numbered districts in one monolithic central government.

Neither do we want to be treated as foreign principalities at the receiving end as a sort of AID program. We want to have more responsibility for program planning. We have no objection to requirements for statements of our objectives, or for descriptions of our proposed techniques for carrying these out.

We accept the responsibility for the accountability of funds expended but we do not understand the need for the extremely rigid fiscal controls involving the "chasing of the Federal dollar," blue, green, red, and so forth, all colors, as if they were different. We cannot accept this as the best means of accounting for our expenditures

nor of assuring that the program objectives have been accomplished.

There are now in effect review procedures whereby the Federal regional office staff and consultants work together with the State health departments as a team to evaluate programs to insure that legal and regulatory requirements are met and to measure conformity with the approved plan and to make sure that program content being carried out is of recognized professional caliber.

We think that these procedures should be given greater emphasis and more reliance placed on them.

Now I would like to give another illustration or two of some of our difficulties and they are not intended to put the spotlight too much on particular programs. I am using an example in venereal disease control because I started out my career in venereal disease.

I went to Florida on venereal disease control as an assignee from the Public Health Service. Twenty-five years ago at about this time I was posting red quarantine signs in Pensacola in its red light district. So VD control has made up a substantial part of my career and I am interested in it.

But recently we were notified that since venereal disease project grants for the next year will be less, no funds will be approved in the continuing projects for several types of expenditures which were approved in the past.

To some of these we had no objection. Some we even cheered. But a surprising item in this category was that of health educators and educational consultants. We have always felt and still feel that a vigorous health education program is basic to any attack on the venereal disease problem.

This point of view incidentally is repeatedly emphasized in a joint publication agreed upon by the American Public Health Association, the American Social Hygiene Association, the American Venereal Disease Association, the Association of State and Territorial Health Officers, and the American Medical Association. I thought it was printed at Public Health Service expense but I notice it says by the American Social Hygiene Association. This booklet is only 2 months old.

Now this prohibition against health educators I might say, is in the face of fact that on a certain page here it lists the result of a questionnaire to States and cities and out of 500 new positions that these agencies said they needed, 60 of them were for health educators and an additional 40 were for informational specialists.

The whole report is rather full of the expressed need for more health education as a means of controlling venereal disease. For that reason I was rather shocked at the ban on health educators. I personally talked to the people who operate that program at the regional office and got nowhere.

I felt it rather keenly personally because one of our most valuable workers in the State was affected. She happens to be a young Negro woman. She also is probably the best educated I think of all the 50 people, Federal and State, except for the physicians directly in the program that we have.

But she was placed at the low end of the priority rating for her salary being financed after next July 1. She is a fine young woman, a health educator whom we employed for the venereal disease program 8 years ago. Both of her parents had worked for us.

She had been educated as a schoolteacher but at that time had not been able to get a job in that field so we employed her and sent her off with Federal funds to a school of public health financed also to a large extent by Public Health Service funds. We sent her off to learn more about venereal disease control and more about health education.

Now her future career in the Florida State Board of Health is not threatened and she is not the least bit worried about that; but her future in the venereal disease program is jeopardized because of this policy not to support health educators in that program.

We had not quite gotten over the surprise of the low standing to which health education had gotten in the venereal disease control program when we got a request to make a survey of the schools in the State regarding the feasibility of participating in a pilot study to evaluate a book called "Facts About Syphilis and Gonorrhea." We could not figure out how to do that without using our health educators.

Then I wanted to see if I might be interpreting this thing wrong. I called on Dr. A. V. Hardy, Acting Director of our Bureau of Preventable Diseases, whom many of you know as an elder in the field of communicable disease control, to give me his views on this subject.

He gave me this memorandum on April 15. [Reads:]

MEMORANDUM

To: Dr. Sowder.
From: Dr. Hardy.
Re: Suggested addition to panel discussion (probably as added illustrations).

The U.S. Public Health Service provided much needed leadership in establishing VD control programs in the various States, but in the three decades of active promotion of this program there has been no evident design or effort to give responsibility for this program to the States; rigid control has been retained by the Public Health Service. The following are very recent illustrative examples.

A budget conference to review program and budget for fiscal '67 was arranged at the request of USPHS personnel. Our staff had prepared a recommended budget based on a critical assessment of needs and priorities for Florida. It was soon apparent, however, that decisions as to every dollar and each position had been made and that the State was being advised what the Federal agency would provide in funds and in assigned personnel. Emphasizing the need for building a strong State program to combat the high incidence of VD in Florida, there was a request that consideration be given to providing more grant funds and fewer assigned personnel. There was no indication of willingness to provide funds instead of personnel even should a service worker assigned to Florida wish to join the State staff. Also exploring possible means of overcoming the current feeling that the VD program is apart from general public health, the advantage of assignee trainees being authorized to attend the regular one week board of health orientation program was suggested and urged. Clearly this was not a matter for State decision but it would be taken under advisement by the Federal representatives. Florida has a progressively increasing incidence of primary and secondary syphilis and is one of the areas with high incidence. The State will need a strong VD control program for years. Rigid Federal control has not encouraged this development and has to a substantial degree tended to prevent it. High credit is due the Public Health Service for its early leadership in VD control but we believe the program could have been strengthened in our State and in many States if appropriate responsibilities were placed in State and local health departments, and the USPHS made its contribution through consultation and persuasion and through support with grant funds.

It is emphasized incidentally that the rules of the Federal agencies apply not only to Federal funds but to State funds used for matching purposes.

Now the VD program is on a project basis and at the present time we have in Florida 32 Federal positions, people assigned by the Public

Health Service, and paid directly; and we have 17 State positions financed by Public Health Service funds.

We have other similar problems but they have not developed quite so far in this direction. We have similar problems in tuberculosis control program. We have a health service program for migrant workers, a project administered at the State board of health level for 14 counties and with subbudgets for each. The same detail of fund rigidity applies here as in the previously discussed VD project.

We were recently instructed to write to Washington for permission to transfer $2,500 between two subprojects. And another type of project requiring minute detail was the maternity and infant care project administered through the Children's Bureau. There is a great contrast between the requirement of that Federal agency as to the States planning, budget, and reporting of maternal and infant care projects and the States MCH programs financed by regular Federal MCH funds.

For years the regular program has developed so that the plan material, the summary budget data, and the reporting can routinely be programed and the latest automatic data processing methods used extremely well. However, maternal and infant care projects require the most rigid line item control and prior Children's Bureau approval of very minor budget revisions.

As an example, a merit raise of $25 a month involves unnecessary redtape. My comments here reflect, I believe, the feelings expressed by health authorities from many States. It is my belief that we could make better use of the funds and the scarce people that we have and get up to, I think, a 25-percent increase in the efficiency of our health programs if our very scarce health people were not required at the Federal, State, and local levels, to fritter away too much of their time on ritualistic planning instead of real planning and on nitpicking and counternitpicking about minor things that should not be required at all.

So I plead for reasonable flexibility in the use of Federal, State, and local resources to carry out the objectives of well-conceived plans, plans in which we in the States and local communities have had a part at least in making; and that we get away from the line item budget control.

It is performance and results that all of us want and we think that we can obtain them more efficiently as real partners without the overuse of the earmarked dollar and control applied to each and every program decision.

Thank you.

Dr. HILLEBOE. Thank you very much, Dr. Sowder. Well, I think we have given the panel something to think about, something to talk about. We will be very glad to have comments or questions from any members of the panel.

Dr. Mattison.

Dr. MATTISON. Mr. Chairman, I would like to go back to one of the remarks that Dr. Frechette made. I think it is very basic to the one we are talking about; that is, that we no longer are talking about "pump-priming" through Federal sources of tax income. We are talking of some kind of continuing support for these basic programs.

There will be people who will oppose increased flexibility, and they

will oppose it on one or two primary points. The first one will be, "We can't give a blank check"; the second will be, "The people at the State leadership level are not qualified to make some of these decision."

Let me take the second first, and point out to you that around the table here today we have seven State health officers or ex-State health officers, all of whom were qualified not only by experience, but academically; not only in medicine, but through graduate work in public health. This is the usual pattern in the State leadership in the field of public health.

As a matter of fact, I think Dr. Stewart will agree with me that the caliber of preparation for State leadership, at least in the key positions, is not too different from the caliber of preparation in the Federal agencies.

Now, with regard to the first point, we are not suggesting in any sense of the word that there be a blank check. First of all, we are supporting the provisions of something like H.R. 13197, which would provide for comprehensive public health planning at the State level. It would be on this basis that the framework would be established for State service programs later on. So that you would have this groundwork of cooperative planning to start with, and it would be within that general framework that the programs would be developed. Secondly, you would have the other end of the check through some kind of program audit, presumably by the public health service or by the regional offices of HEW, which would enable you, through a professional program check rather than through all of these accounting procedures and the endless detail of reports, to be able to do some of the kinds of things which the committee members suggested yesterday; a check on results, not just on activity.

So I think these are two things which we have to anticipate, the greater flexibility will be attacked on the basis of either that the State leadership is not capable of handling it, or that we are giving them a blank check. Neither is true.

Dr. HILLEBOE. Thank you very much, Dr. Mattison.

Dr. STEWART. May I say something?

Dr. HILLEBOE. Dr. Stewart.

Dr. STEWART. I would like to emphasize the point Dr. Mattison has just made. The point that Dr. Frechette has in his statement is terribly important. The policy that the Federal Government has had on State grants since their inception has been that the grant was to initiate, to support for a while, and then pull out, and that the State would take over. That has been the policy under which nearly all the formula grants have been made since they began.

I think Dr. Sowder's presentation offers a good example of how this policy has not worked at all. After 20 years of venereal disease support from the Federal Government under this policy, he still has 50 people there on the Federal payroll carrying out the VD program. This is true in other programs in other States, too. This is not peculiar to Florida. I think we have failed to recognize—and really I guess it was not a failure but was a change—that the State and Federal Governments are in this together. It is really the extent of the problem that determines whether the Federal Government should help only for a limited time.

It is this concept, though, which has guided almost all of the think-

ing and the attitude in the Federal-State relationships in public health since 1935.

Mr. ROGERS of Florida. Now let me ask a question. I think it might be well to have a comment on some of these points that have been developed. For instance, in regard to nursing. When the general nurse could handle most problems, why is it necessary to require a specific nurse for TB to go into the home; a specific nurse for heart to treat a child? Why is it that arrangements cannot be made for one visiting nurse and the health officer to provide all the treatment? Why should this not be encouraged?

Otherwise, from Dr. Sowder's example, it appears that we are requiring three persons to go out to a home when one person can take care of the situation. So the critical shortage of nurses is actually being made more critical by the imposition of Federal requirements, and we are not using our manpower as we should.

Dr. STEWART. Mr. Rogers, I would think that if the job to be done can be done by a general nurse, it should be done by a general nurse and not a special nurse. But the problem we have is that even if it is one nurse that serves for the heart disease, cancer, and TB patient, since our money is appropriated for heart disease, cancer, and tuberculosis, we then have to account for how that money was expended. And we have to know whether that nurse was working on tuberculosis, cancer, or heart, because this is where the money is coming from. It is a good example of how, even with good intentions, we get into these rigid requirements by categorizing too tightly on programs that we are trying to carry out.

Really, what he is talking about is nursing service for people who require nursing service. If the categorization were centered around home nursing service, he would not have any problem.

Mr. YOUNGER. Doctor, isn't this accounted for by the fact that the movement was started because they thought they could get more money that way from Congress than you could any other way? Now that period, I think, has long passed. I see no reason for Congress to continue to put that kind of straitjacket on its appropriations. I think from the standpoint of the administration that they would so recommend.

In fact, Congress ought to take the bull by the horns themselves, whether the administration recommends it or not, and remove those restrictions.

Dr. STEWART. It rests on the whole public interest in the various categories. The people are interested in doing something about cancer, and doing something about heart disease.

Mr. YOUNGER. That is to get the public interested in the appropriation. You could say, for instance, here you had an aunt who died from cancer and here we want to appropriate money for research. Nobody is going to vote against the appropriation of money when his aunt died from that disease. That is the appeal which has been made on the floor time and time again. Now that period has passed.

Dr. STEWART. I am not sure it has passed, Mr. Younger. I think we will continue to have interest in certain categorical diseases, both in Government and outside of Government. The voluntary health movement is certainly an example of that. We have a voluntary health agency for almost all the diseases that the public is concerned about.

Mr. ROGERS of Florida. Of course, we realize that we have built up these categorical approaches. Now we are saying, in administering services this is not the most efficient way nor the most economical way to administer those services; at least, these are what the State health people are telling us. Nor is it a proper use of our manpower, and we have a critical shortage of manpower. So, we must look to some change in the way we are administering this.

I agree with you that undoubtedly we still are going to do much research in cancer, heart, and so forth, and we should. But why can we not now give appropriations, say, for nursing care to the States, with sufficient flexibility so that the nurse doesn't have to spend so much of her time, as someone testified, keeping records as to how much time she spent in checking somebody for heart or TB, and so forth, instead of providing nursing services?

I realize that certain records have to be kept, but probably not in the great mass of detail that begins to build up, because of a requirement that this be done simply to justify this appropriation for heart or for cancer. It seems to me that this is a very great problem that is going to have to be faced immediately by the Congress and by the Department. Otherwise, we are really going to be in bad shape with the programs that are going into operation under medicare.

Now let me ask for a comment on that. Can they spend these funds that are supposed to be for medicare as well as the chronically—what was that again?

Dr. STEWART. There is a formula grant to the States called "Chronically Ill and Aged Formula Grants," which started in the early 1960's.

Mr. ROGERS of Florida. What is the situation there? What happens?

Dr. SOWDER. We practice a little brinksmanship and we expect auditors to get after us, but the general rule is that when a specific appropriation is made for something, then you are not supposed to use any other funds for it. So we are a little afraid of falling into that trap in this situation. We have encouraged the director of the Jacksonville VNA to join the staff, on a part-time basis, of the county health department, and with a little supplementary salary to be the coordinator of home health services. We don't know what fund to pay her with, and we will have to select the fund depending on the rules we find. The VNA is going to be getting medicare funds. We have been paying for three or four nurses through the mechanism of payments for visits, from CIA funds. We now have the home health services fund, you know. That is a declining grant. It should be a grant that goes up.

So we don't know, we are not sure what the legal situation is with respect to the right to use these various funds. Can we pay, for instance, for the services of a nurse when we are already helping to pay her salary out of Federal funds? That is another thing we don't know. It is rather complicated.

Dr. STEWART. Mr. Rogers, I don't know the answer to that specific problem without doing some digging. We can look into it and provide it for you.

Mr. ROGERS of Florida. Yes. I would like to have your thinking on this.

(The information requested follows:)

CHRONICALLY ILL AND AGED FORMULA GRANTS

States have been permitted and encouraged to use part of their allotment of Chronic Illness and Aging formula grant funds to expand and support home nursing services for chronically ill and aged persons. With the inauguration in FY 1966 of the Home Health Services formula grant, States were encouraged to use these new grant funds to expand existing home nursing services and to establish new home nursing programs. The guidelines for the new grant program prohibited States from using these funds to reduce or replace other Federal grant or State or local funds for this purpose. Thus the policy was explicit that both of these formula grants could be used for costs of home nursing services.

When reimbursement payments under the Medicare program begins in July 1966, those agencies which are certified as Home Health Agencies under the Medicare program will need to establish a system to ensure that the costs of services rendered to Medicare beneficiaries and for which they receive reimbursement from the Trust Fund are not also counted as costs to be paid with Federal grant or matching funds.

Dr. STEWART. Could I make another comment, Mr. Chairman?

Mr. ROGERS of Florida. Yes.

Mr. STEWART. Going back to the point you made prior to this on the need to stop all this categorization. I think Dr. Frechette stated it very well in the latter part of his statement. He said you can't put specialized programs into effect unless you have a strong base on which to build them. What we have been doing is building a specialized program and ignoring the base. This, I think, is what you were emphasizing in saying that we really have to make it possible for the nurse, when she is providing services, to spend as much time as she can in providing nursing. This is the base. If you have this strong base, then you can mount special programs for special things or in special areas.

Dr. HILLEBOE. Mr. Chairman, Dr. Peeples and Dr. Thompson would like to comment, too.

Dr. Peeples.

Dr. PEEPLES. Mr. Chairman, one recent example of this detailed accounting that we have to go through has taken place in the social security agency with regard to the implementation of title 18. Now, at least in our State, we had previously been licensing all hospitals, nursing homes, extended care facilities. The only thing new, as far as we are concerned, were home health agencies. We did, then, have the base for certification of providers of services.

But in our attempt to establish budgetary support for the additional work that would have to be done to meet the requirements under title 18, we simply asked if we could agree on a certain percentage of what this work would be. We were told very definitely, no. So that all of our people then would have to go to a nursing home or to a hospital to make a routine visit for licensing or inspection, would have to account for their time; and we have to charge a certain portion of their time toward a billing to the social security agency.

So here is a further very detailed accounting that we have to go through. If a nurse, let us say, goes out to western Maryland to inspect a hospital and to see that certain parts of the hospital meet the requirement under title 18, we can charge for part of that visit. If she makes a visit to somebody else for somebody else on the way back, then she has to account for that under a separate bit of accounting.

I think this type of detailed accounting is really restrictive. It is costly to the agency which has to do it, because most of their time is spent, as you say, not in the service itself but in the accounting for it.

Dr. HILLEBOE. Dr. Thompson.

Dr. THOMPSON. First, I would like to add my support to Dr. Frechette's and Dr. Sowder's statements; and to emphasize Dr. Sowder's statement, I would like to say only a few weeks ago I signed my name to a form transmitted to the regional office asking for approval for a $200 amendment—not $2,400, Dr. Sowder.

In connection with the question, Mr. Chairman, that you are pursuing about generalized nursing service versus specialized nursing. I happen to have here excerpts from a letter in which I attempted to secure approval after we failed on our brinksmanship effort, as Dr. Sowder referred to, in connection with the use of heart funds to support the generalized nursing.

We do keep account of nursing visits by category, and a reasonable amount of this accounting can be done; put on IBM machines, it comes out very rapidly and it is very valuable. In the State of Utah we have a small heart grant. It started at $34,000. It is now up around $35,000. During this time, we gradually increased our expenditures to develop our State staff in order to give impetus to local development, and we reached finally, in 1964, the expenditure of $31,000, compared to $15,000 in 1960. Obviously we could not tool up as fast as the Federal funds were made available. During this time, however, in terms of the impact on the counties of Utah where the public health nurses were making visits as a result of the educational program with the nurses, meeting with physicians and developing program concepts, the local generalized public health nurses' visits for heart activities in 1960 were 5,563, and they rose to 8,246 in 1964, a relatively short time.

We wanted to use only $14,000 of this whole grant for aid to counties to recognize their increased participation in heart disease activities. It was denied. We appealed it and reappealed it, and it has been constantly denied because, they said, we had to use the $14,000 for an identifiable nurse and we could do it in a county where we could put a nurse.

We only have one county in the State big enough to justify putting in a whole nurse on heart disease, but even this would not justify her devoting her whole time to heart disease, in Salt Lake County, for example. So here was an effort where we tried to use heart funds justified by increased program activity, and provide some tangible base to measure activity; but it was not acceptable.

We tried to do this in the immunization program and in the TB program, as Dr. Sowder has said, with the same degree of failure. The only reason we don't have as much trouble in immunization and TB is, that the grants are so large that the available five to eight nurses can be spread around the State by assignment. This, as I said in my paper yesterday, has made it easier to cover the counties. But still it is unsatisfactory, because these nurses are still identified as specialized and they can't do anything but make a home call on TB or make a home call in the immunization program.

This presents a problem in an area where there are only one of two nurses, and even in an area where there are seven or eight nurses.

Mr. ROGERS of Florida. I notice here in testimony it says:

> Maternal and Infant Care projects require the most rigid line item control, and prior Children's Bureau approval of very minor budget revision. In fact, a single minor revision cannot be handled by simple letter form; the entire budget as amended must be presented for consideration. This method would be satisfactory if change in program and objectives were involved, but simple technical

changes such as annual rate of a position from $4,500 to $4,800, a merit system increment, imposes unnecessary red tape.

Would this be a normal procedure?

Dr. HILLEBOE. We have Dr. Lesser here from the Children's Bureau.

Dr. LESSER. I believe that our procedures in the particular program that Dr. Sowder refers to, maternity and infant care project grants, do provide for some discretion on the part of the State for budget amendments, for amending the budget without necessarily submitting all the forms to us. This is within a certain percentage change of the amount of money in the particular item. I think that what this percentage is or should be obviously leaves a good bit of room for discussion.

To what extent should simple changes be made without notifying the Federal agency? One could argue this should be 10 percent, 15 percent, 20 percent. Obviously there is room here for varying points of view. These particular grants for the support of comprehensive maternity care programs for women living in areas with concentrations of low-income families are supported to the extent of 75 percent Federal funds, 25 percent State and local funds.

So we do feel a considerable responsibility here for fiscal accounting. I think it is true that this is a very sensitive subject, and it always has been. In this kind of situation, I think Federal agencies are sometimes criticized on the one hand for being too rigid in such requirements. On the other hand, agencies within HEW have also been criticized by the Congress and others for being much too lax. So I think it is a matter of striking a balance. This is not always easy to do to everyone's satisfaction.

Mr. ROGERS of Florida. Let me ask you, what is your percentage of allowance?

Dr. LESSER. I don't have it with me at the moment.

Mr. ROGERS of Florida. Just in general?

Dr. LESSER. I think it is about 15 percent that can be changed without sending it in to us.

Mr. ROGERS of Florida. After that, he would have to submit the entire budget for amendment?

Dr. LESSER. A budget amendment would have to come in, just that page amending the budget with any changes in the total, but not the entire budget; no.

Dr. WINSTON. I am a little concerned about this point, too. Of course, one of the other problems we have is that policies can be translated and sometimes you have errors in translation or understanding. This illustration seems to me to be contrary to the approach we have taken. I would like to check through on it with Dr. Sowder.

Dr. SOWDER. Could I ask Mr. Ragland, who is our director of finance, to speak on this subject?

Mr. ROGERS of Florida. Yes.

STATEMENT OF FRED RAGLAND, DIRECTOR OF BUREAU OF FINANCE, FLORIDA STATE BOARD OF HEALTH

Mr. RAGLAND. I am Fred Ragland, director of Bureau of Finance of the Florida State Board of Health.

Mr. ROGERS of Florida. Just pull up a chair.

Mr. RAGLAND. Earlier this week we had an annual conference of public health officials in region 4, which brought the six Southeastern States together to discuss some of these things that we are talking about this morning. The Children's Bureau representatives from Washington and from the regional office in Atlanta were there. We had some discussions about maternal and infant care projects. It seemed to all of us from the States represented that there probably was more rigidity with these type projects than any of the other types that we had dealt with, insofar as strict line budgeting and accountability, and with little opportunity to make changes without budget amendment.

It is true that there is, as pointed out, some degree of minor changes that can be made. But the requirements still are far too rigid in relation to the types of accounting requirements that we have experienced through the years. These projects require very detailed quarterly reporting of expenditures by line item, individual salary, and job title. We are talking with the Children's Bureau officials to try to simplify these reporting requirements. The whole gamut of these type projects, to us, in the States—and mind you, these are fairly new and we are feeling our way along—are entirely too rigid and inflexible.

Mr. ROGERS of Florida. Do I understand that you make quarterly reports? Is that what you said?

Mr. RAGLAND. They require very detailed expenditure reports quarterly. In some of the discussions we had earlier this week at our regional meeting, the States seemed to think that summary reports quarterly, with the detailed report at the end of the year certainly would give proper accountability control and program evaluation.

Mr. ROGERS of Florida. Is your project grant given quarterly, or on a yearly basis?

Mr. RAGLAND. There is an annual award and funds are drawn through a letter of credit system as needed.

Mr. ROGERS of Florida. But it is made on the basis of a year?

Dr. LESSER. On a monthly basis, letter of credit.

Mr. RAGLAND. The award is for the year.

Dr. LESSER. But you draw on the funds.

Mr. RAGLAND. As needed monthly or even more frequently than monthly.

Dr. LESSER. Mr. Chairman, may I say this? I have been looking at Dr. Sowder's example here. It does seem to me that there is a misunderstanding, but I really don't believe we require a budget amendment to increase somebody's salary from $4,500 to $4,800. I don't understand that.

Mr. ROGERS of Florida. I could not conceive of it. But I think it would be well to talk it over.

And also if it is possible to reduce paperwork, I am sure it would be welcome.

Dr. SOWDER. It would by us.

Mr. ROGERS of Florida. I think this would be helpful to pursue with the department.

Is there any other point along this line that anyone else would like to make? I was interested too in the statement that the funds for venereal disease are being reduced and shifted.

I had read reports and I have not checked this out, that we are having an increase in the venereal rate in the United States. Is there any comment on this? What about the restriction on funds?

Dr. SOWDER. I was told last night or this morning that the appropriation is the same but it so happens maybe they had a little fund to carry over last year. But the effective funds this year are expected to be less after July 1. That is about all I know.

We will have fewer positions in the State.

Mr. ROGERS of Florida. Could you furnish that for the record?

Dr. STEWART. I will be glad to.

(The information requested follows:)

FEDERAL APPROPRIATION FOR VENEREAL DISEASE PROJECT GRANTS, 1967

The Federal appropriation for venereal disease project grants proposed for FY 1967 is the same as for FY 1966 ($6,229,000). Because of increased salary levels and higher costs of related items, however, this amount of appropriation will pay for fewer personnel and a smaller level of venereal disease control activity.

Dr. HILLEBOE. I think it would be nice to hear from Dr. Sowder as to what he thinks should be done in the health field in connection with VD. This is a very critical issue particularly in the large cities in every State.

We are having more trouble with our teenagers. We have had some surveys in our school health education studies which show that young girls between the ages of 13 and 15 who are unmarried are having babies and do not know where babies come from and do not know where venereal disease comes from.

They think a lot of times VD is inherited. There is a problem of education that is a great one. It would be more useful if Dr. Sowder and some of his colleagues would say what they would like to do in this area as well as in other parts of the program.

Dr. SOWDER. We would like to carry out some of the recommendations made in this manual and actually some of the things that the people in the VD program, the Public Health Service, ask us to do, to encourage the schools to be teaching as much as possible about venereal disease control and to publicize the facts through radio and television.

We are doing that. The disagreement seems to be that they don't think you need health educators to do that. I don't believe they would get in a large public health assembly any votes at all for that attitude because that is what health educators are for.

I think as best I can make out and yet I am not very clear about the policy, that they feel that the money should be pinpointed on the people, lay people essentially, who actually do the detective work, the lay epidemiologists who go out and find the one who infected the patient and breaks the chain of infection.

I would put a greater value on mass education through the schools and through the press media. I would certainly put it up at least even in priority with case finding. I just cannot be reconciled to lowering the priority on health educators.

They did say: "Well, we don't say that health education is no good, and we don't say it is a low priority. We merely say it is a lower priority."

I said: "Well, it seems to me that if it is priority No. 51 out of 50 available positions, that that is a low rather than a lower priority."

So when the only health educator position comes when the funds run out, I think that is an unreasonably low priority for health education in the venereal disease control program. I would emphasize health education more. I would put it right up there at the top in priority and keep making noises about the problem.

Dr. HILLEBOE. What about in a large city like Kansas City, Dr. Philp?

Dr. PHILP. I remember more of the experience when I was working in New York City when we did a survey of teenagers. I believe it was high school age youngsters on a citywide basis, a sampling.

As I recall the figure we found, 75 percent of these youngsters were absolutely and totally ignorant of venereal disease. They did not know what it was, how you got it; they did not know how to prevent it.

They did not know how to treat it. Yet in our clinics we were seeing large numbers of young people who were showing up with the disease. This pinpointed to us what Dr. Sowder has mentioned, the urgent need for educational programs at the school.

Mr. ROGERS of Florida. Done by the health department.

Dr. PHILP. It has to be done cooperatively. The health department can take a lot of leadership but I think it involves cooperation of the board of education and parent groups and many others to do this effectively.

Dr. PEEPLES. I was health officer in Montgomery County just north of here several years ago. We did a similar thing out there. We had sessions in a number of high schools and asked the children there to submit their questions in writing.

The questions they asked were frankly those of almost total ignorance about the whole problem, not only of venereal disease but of general sexual relationships and how this went on.

These questions were taken to the superintendent of schools, who had been somewhat dubious about instituting a program of education on the venereal diseases among high school and junior high school children. But this convinced him and his board very thoroughly that this should be done.

Our health educator had been working with the schools to try to do this. The point is that I think the health educator is one who is particularly adapted and educated and equipped to do this type of work. Someone has to do it. The schools generally don't have health educators. They each have teachers but not health educators.

Mr. ROGERS of Florida. Do I understand, Dr. Sowder, that funds will be reduced for health educators?

Dr. SOWDER. Cut out entirely.

Mr. ROGERS of Florida. Where did that decision come from?

Dr. SOWDER. From CDC.

Dr. STEWART. The venereal disease program is located in the Communicable Disease Center in Atlanta. The decision was taken there.

Mr. ROGERS of Florida. Mr. Younger.

Mr. YOUNGER. I just want to make one comment. I think you gentlemen from the States would get tremendously discouraged when you see the millions of dollars that are being pumped into the States on the poverty program, loosely, without accountability, without any apparent supervision or anything.

I am thinking especially of Massachusetts where they have had a tremendous case. They can't even find where the checks were or to whom they were issued or anything else. I should think you would get terribly discouraged with the Federal Government on the one hand, penny wise and pound foolish with the health program, and then going ahead with this other program which probably has more votes in it—I don't know—loosely going into your State with millions and millions of dollars.

I don't blame you for getting very discouraged on this kind of program and losing some faith in the ability of the Federal Government to handle tax money.

Dr. HILLEBOE. Mr. Chairman, I think that this is a very honest statement and there is no question about the discouragement and the frustration. We are quite accustomed to fighting against both windmills and Niagara Falls.

Niagara Falls usually comes from Washington, D.C. But as we go along we make some movement. I think some of the recent developments that have been occurring in proposed legislation begin to present—to bring some order out of this chaos for two reasons. First of all, the proposed bill to bring planning and grants into one pocket.

The second one. There are now such a tremendous number of new health programs that out of sheer necessity somebody has to straighten the thing out. It may be that the new legislation will be helpful in that.

I would like, Mr. Chairman, just to mention a bit about school health education. For the last 4 years I have had the privilege of serving as chairman of a school health education study. We had several hundred thousand dollars of private funds to make this study. We surveyed schoolchildren throughout the country on a probability sample.

We had wonderful cooperation from the educational group, the National Education Association, and from the Public Health Service, and the Department of Education. We found out really for the first time on a sampling basis how little schoolchildren in the 6th, 9th, 12th grades know about health.

You asked the child, "If you had something wrong with your eye what would you do?" The child in the 12th grade would say go to a drugstore and get some drops for my eyes. To another child in the 12th grade, you ask, "If you had a backache what would you do?" "The first thing I would do would be to go to a chiropractor." The question is asked, "Is venereal disease catching or something else? Two-thirds of the 12th grade said "No, it is inherited; you get it from your parents and there is not much you can do about it." When the question was asked, How do you treat it, the answer came, "We are told it is like a bad cold; with new medicines you can take care of it."

We have a great dichotomy, a great separation between school health services and school health education. This is something that needs correcting.

It can be corrected within HEW. As a result of the studies that were made by the school health education group material has been provided to the Department of HEW to look into this problem of improving the quality of school health education and of bringing school health service in consonance with school health education.

I think any of you who have worked or have been in large cities have seen the ignorance and poverty and unemployment we find among the young people who are going to be the future mothers and fathers now realize that all of the things we do for health and for welfare are of really no avail unless we overcome this ignorance about health.

There's not a chance in the world of changing the adults who come into our Harlem Hospital by the thousands because they have become set in their ways. Health education won't touch them; they believe certain things; they have cultural patterns and these cannot be easily changed. But I do believe that the little 5-year-old and 6-year-old youngsters coming into these schools, if given proper instructions in health, can be motivated if told about child health and development, if told about the interrelationship of people one with the other, if they are told about VD—where it comes from—if they are told about babies—where they come from—told about morality. These are the things that then need to be done. We need a national program. This should come out of HEW on a joint basis between education and health.

Dr. SOWDER. I would like to say that in venereal disease education we have two needs, one for community education and one through the schools. We don't question but that the schools should do the work in the schools but they look to us for resources and for materials and for films and for technical guidance.

One health educator can, by working through teacher organizations, stimulate them, 60,000 of them let us say, to do a great deal in this field.

Dr. HILLEBOE. Mr. Chairman, four of us have to go to a press conference at the White House. I hope you will excuse us. This was unknown to us before the meeting. We shall be back at 2:30 this afternoon.

Mr. ROGERS of Florida. Dr. Kimmich, would you act as chairman in the meantime?

Dr. KIMMICH. Dr. Sowder, were you finished with your comment?

Dr. SOWDER. I think I have finished.

Dr. KIMMICH. Dr. Thompson.

Dr. THOMPSON. I misread these charts, Mr. Chairman, but maybe in misreading them it was good, the charts that you had put in the record.

The captions are varied but I notice that all the charts have all the lines on them, but in many instances there were only two lines to the Health Department and none from the National Institute of Child Health and Human Development and nothing from the Institute of Neurological Disease and Blindness. But my point now after having misread it is that I think the Federal agencies are taking on relationships on exchange of information and participation exactly along these same lines.

Here is the physical evidence of it. It seems to me we ought to have additional lines at least for communication so that the health departments could be informed and in many cases could participate. I think these charts bring it out.

I would like to make a comment on another aspect of this matter which Dr. Mattison referred to in his comments. He noted that one of the reasons there would be objection to greater flexibility would be

the incompetence of State health departments. There are some people who believe that.

In fact, I was surprised just Wednesday morning before I left Salt Lake coming here, a representative from one of the agencies in my office asked me the question, "Dr. Thompson, what do you think about the weakening status of the health departments in the United States?"

So I presume that from the office from which this person came they have the impression at least, and this is in the Public Health Service, that health departments are generally weakening or weaker than they used to be.

I don't believe that. I think they are much stronger than they used to be. But there are still weaknesses. This is a point I wanted to make is that in the dialog we are exchanging today, stressing greater flexibility, we don't want to exclude the Public Health Service or any of the Federal agencies.

In fact, they are welcome. We would just like to know when they are coming and be able to plan for them and be able to utilize them effectively.

There is greater need than that. We actually need their assistance, their professional competence, their professional opinion, even their physical competence. We need it on a consultation and participation basis, not on a dictatorial basis.

So I would like the record to show that even the strong health departments, and certainly there are some that are not so strong, really need this and want it and it is welcome. Our dialog today is not intended to exclude them at all. I don't think that has been quite brought out adequately.

Mr. ROGERS of Florida. Thank you.

Dr. KIMMICH. On this point of flexibility, are there others of you who would like to expand on the matter?

There are several aspects that have been developed here, waste of funds.

Dr. THOMPSON. This is about the question of what we talked about yesterday, block grants. I am not so sure that we will find a full solution in the bill before the Congress without some identification of diseases or of conditions for which the Congress wishes something done and which the Nation knows something should be done.

In Hill-Burton categories, for example, the law allows you to transfer funds when you can show that there is no need for the fund or no way to use the fund in a particular category.

Then you may, after justification, transfer it, or a certain percent of transfer could be allowed in the category of funds. It seems to me that this is the further answer to your question, Mr. Younger, of yesterday because a total block grant may lose some public appeal.

It may lose it in the States too because we have legislators that we have to go on to. I was thinking here, Mr. Chairman, that some of the States don't have all the advantages that you do here in Washington. For instance, we don't have the capability, the manpower to set up these kinds of meetings or devote the time to it as well as you do.

So, we do need some tie to communicate to legislators what we need the money for. We do have to go on some program basis.

Dr. KIMMICH. Dr. Sowder.

Dr. SOWDER. I would like to make one comment about the assignment of personnel. I was happy to see in this proposed bill that that is provided for.

Dr. KIMMICH. Which bill, Dr. Sowder?

Dr. SOWDER. Senate 3008. I have been an assignee in both directions. I was assigned by the Public Health Service not only to Tennessee but later to Florida.

I have worked while in the Public Health Service at the national regional levels, at State levels, and at local levels, both city and county. During the fifties the practice of loaning Public Health Service career people to the States for training and orientation sort of died out and I think we are feeling the effects of that now.

A lot of rigidity that we are encountering is due to the fact that there are too few people in the Public Health Service that know the viewpoints of the State and local health agencies. However, I do think that abuses can occur.

I don't understand in our venereal disease control program how we got into a system where we have twice as many Federal people in the State as we have State people. I think that is undesirable. We would like actually to develop our own people but we are discouraged from doing that. We think that Congress under the present law, intended that this should be optional with the State, whether to take funds or people.

But in some of these programs we have no option. We either take a Federal employee assigned to us or we don't get the money. We understood that we could take a Federal employee in lieu of the money.

Then there is another point. When we want to report to our own State budget agencies the amount of assistance we are getting we have the money amounts but we have no way of knowing what is the cash value of the services of assigned personnel.

They have been reluctant to give that to us. I see no reason why we should not know the value of the services that are being given to us. I think that the loaning should be for training and so forth, and not to completely take over a service. That essentially has been pretty much done in venereal disease control.

Mr. ROGERS of Florida. In other words they will assign a Federal employee to work with the State or in a State office?

Dr. SOWDER. That is right.

Mr. ROGERS of Florida. But will not give you sufficient funds to hire a person?

Dr. SOWDER. When that assignee is transferred, let us say we would like to develop our own people and hire a Florida boy who won't be moving on as some of them do from Florida to Colorado to Maine. They say, "No, we don't have the money."

We will give you another assignee. We have about 30 Federal assignees out of the 50 on our staff in our venereal disease program. They are nice boys all of them and they mix and mingle. There is a difference in salary. We are trying to get out of that but we have difficulty in developing a program in venereal disease if it is going to be primarily a Federal program.

Dr. KIMMICH. Dr. Sowder, is this a matter of law, regulations or practice?

Dr. SOWDER. Well, I have been intending to look it up to see if the venereal disease program comes under, general Public Health Service

Act where it says that a State may elect to ask for a person in lieu of funds.

If it is, then it is a matter of law as to what can be done. In the Public Health Service law there is the language that the State can elect with the approval of the Public Health Service to get help in the form of personal service rather than in funds.

Dr. THOMPSON. Don't you think though that both methods are to be provided for as in the new bill, it allows them to be done either way because there are times in the recruitment process, in certain special cases, and situations, that the State will recruit a person who will accept appointment in the Public Health Service by assignment and not on the State staff because there are differences in benefits.

Dr. SOWDER. I don't think under the bill the Congress will go along with having twice as many State people here in Washington as Federal people, and I don't think on a State program we should have twice as many Federal people as we do State people.

Dr. THOMPSON. Certainly the State ought to have something to say about it and not be in the position of taking or leaving it.

Mr. ROGERS of Florida. Getting back to title 19 for a moment, from the testimony we have received it is my understanding that under the law as interpreted by the Department the governor has the right to designate which agency shall administer the program in the State, whether it will be the health department or the welfare department.

And under the interpretation of the law, if the health department were designated as the title 19 agency and the medical program is carried out by the health department, 75 percent of the administrative costs could be furnished by the Federal Government, whereas if the welfare department had been designated to carry out the program and tried to contract with the health department for the medical component only 50 percent of such costs would then be reimbursed to the State.

Dr. WINSTON. Under the law the State can designate the agency. This is the prerogative of the Governor, who will administer title 19. There are many variants on this all of which are perfectly legal and all of which we are very happy to work with. We have illustrations now that cover a wide range of arrangements so that we have I would say from State to State a different mix between health and welfare.

It is our belief that we must use all the available resources of the State in order to carry out the overall objectives of this very far-reaching legislation. The health department needs the help of the welfare department. The welfare department needs the help of the health department and as increasingly the State takes advantage of the option to pay for aged persons in mental institutions, the State mental authority will be coming into this mix.

Now actually as you well understand we administer title 19 as it is interpreted to us by the general counsel. It is a very involved and a very complicated piece of legislation. We have not had raised with us, although we have had many meetings with many States, the question about a differential in Federal matching for certain types of personnel until the question came up recently with regard to New York State where there is still debate going on as to how best to work out the program.

The question did not arise until this very week when we had representatives—the health director, the assistant director, and another top

ranking person—from the State of Kentucky coming in with representatives from the welfare department. In Kentucky the latter is known as department of economic security. This has come up then as a very specific issue because there is a very large area, I would say a majority area, of title 19 which will by contract be carried out by the Public Health Service in Kentucky. They have a very excellent history there because very early the State indicated it wanted this type of relationship.

So, on the strength of the question coming up there we did go to our general counsel to ask for clarification with regard to this matter. I understand that a representative from the general counsel's office will be here this afternoon because we are guided after all by what they say.

Now I do think that there are a few points around this that we should keep in mind. By and large the amounts of money involved are not very great.

There is no question around 50 percent matching. The issue comes around what positions can be matched at 75 percent and under any plan these are relatively limited because the law is quite specific that there are certain types of professional personnel and supporting personnel. This afternoon you should get the general counsel opinion on this and I would prefer to defer it until that point.

Mr. ROGERS of Florida. We will be glad to do that. We will have I think the Under Secretary, Mr. Cohen, and the General Counsel.

Dr. KIMMICH. We will bring up this topic again this afternoon, Mr. Chairman.

Mr. ROGERS of Florida. Yes, we will.

Dr. KIMMICH. Could I ask you at this moment sir, what is your pleasure about termination?

Mr. ROGERS of Florida. I think perhaps we should adjourn now until 2:30. Are there any other points to be made?

Dr. FRECHETTE. I don't know whether you want to bring this up at this time, Mr. Chairman. This was a question of the duplicate medical care administrative units in both welfare and health. I don't know whether you want to postpone this.

Mr. ROGERS of Florida. No.

Dr. FRECHETTE. Dr. Winston, the question came up yesterday afternoon, and this specifically applies to Massachusetts, where there is a disposition for the welfare department to contract with the health department for the medical component of the title 19 program.

We were told that if there was such a contract and even though the health department has the responsibility for title 18 and will of necessity have a medical care administrative unit, that there still would need to be a similar unit in the State welfare department. This was discussed at some length.

This appeared to be a policy decision, still in a state of formulation.

Dr. WINSTON. I would like to make one general statement here. It will take a few minutes if I might, Mr. Rogers.

Mr. ROGERS of Florida. Certainly.

Dr. WINSTON. About the extensive discussions that have gone on around title 19. We of course deal only with State agencies. We don't run into the problems that you brought up this morning with regard to dealing with local agencies around the State agency.

Now when the whole question of administration of title 19 was

worked out in the department there was a very careful plan worked out and approved by the Secretary, of which you have a copy here, which spells out what the responsibilities are of the Social Security Administration, the Public Health Service, and the welfare administration in connection with title 19.

That is a matter of official record. Then we asked the Surgeon General to appoint a liaison representative to the welfare administration so that we would have somebody on his staff that we would be working with constantly in all areas of mutual concern and policy. We have a very fine representative who serves in that capacity and he brings in his associates from time to time, so we have perhaps six to eight people in the Public Health Service that we have dealt with on a fairly regular basis.

We also requested that when any State, regardless of who was designated by the Governor to administer title 19, wished to come in to talk about its program there would be representation from both the health and welfare departments. Now this is absolutely essential in our thinking because both departments carry responsibilities no matter what the mix is in terms of the particular State.

So I would like for that to be brought out here because I think it is something that is fairly unique in dealing with the States and hopefully is a contribution we have been able to make that they would come in and talk with us. This has meant that there has been opportunity for the State health officers as well as the State welfare officers to counsel with us and to make suggestions.

I might say that out of this discussion with each State have come some changes in what we had originally thought policy should be. It has meant that there has been discussion around tailoring each individual program to the particular State. It is quite different, I can assure you, from Puerto Rico, where we have a State health department with a division of welfare service, to the kind of program in a State like Illinois where the State welfare department is really just moving over into title 19 from what was already a pretty extensive program for health service to needy people.

We also have some overall advisory committee. There is a continuing advisory committee on medical care to our bureau of family service which carries the major responsibility for this new legislation.

Dr. Teague, the State health director in Kentucky, has been a very useful member of that committee for a number of years. We have had an ad hoc group that met specifically with my office. Dr. Wilbar from Pennsylvania, the Pennsylvania State Health Officer, attended.

I am taking a little time on this to show there is quite a lot of very conscious interrelationship here. We have, not under our auspices, another channel that we treasure a good deal in the welfare administration and this is the effort of the executive committees of the State health officers and of the State welfare directors to get together periodically to discuss matters of mutual concern.

I am not sure that any one of the gentlemen here is a representative on the executive committee of the State health officers. But we have felt this gives us a channel for talking with them and having them bring to us areas which are of special concern to them. Quite frankly as we get into this legislation, as we have States bringing in their

differing proposals based on different State laws, different experiences, it is necessary to keep looking at all of the matters involved.

That is what I would like to get into the record because it is important in terms of the overall discussion here. Now let me come to this question about duplication. I do not know any agency that would be more concerned over possible duplication of staff than the Welfare Administration. We are so plagued with shortages throughout the program in all aspects that we certainly do not want, through policy or any other approach, to unnecessarily set up additional positions in connection with title 19, whether they be in the health department or in the welfare department.

There are a number of physicians, and I will limit myself to that category, who are already employed on a part- or full-time basis by welfare departments.

This is absolutely necessary because we administer a program of aid to families with dependent children where disability of the father is one of the factors and the program of aid to the permanently and totally disabled. You can not be found eligible unless you have a strong supporting medical record.

Through our vendor programs we have bought services from a wide variety of specialties over the years. It is necessary that the administrator have consultation in the areas in which we are paying for drugs and any number of other necessary services.

So there is already some of this. Now I think what has brought about the concern is that we have said that where another agency will administer title 19 there should be what amounts to liaison people. In other words, in the end we in the welfare administration are going to be responsible for the very substantial funds that the Congress appropriated for this program.

I know very well that doctors talk more freely to doctors and social workers more freely to social workers. We have felt in the interest of good administration there should be as a minimum—one part-time medical person who would serve in this liaison capacity, who would be available to counsel with the State director of public welfare about the medical aspects of the program.

We have this kind of thing going on all the time in many other areas. I am afraid that in general discussions this has got out of proportion because certainly there was no intent and there has been no policy suggestion brought to my attention which was more than the kind of skeletal arrangement you need so that there can be the proper liaision back and forth.

I referred yesterday to the fact that we have on my staff a person who works full time in a liaison relationship with the Office of Economic Opportunity. When policy questions come up involving those agencies we have somebody knowledgeable about our side of the program who can work with the other people.

So what I am winding up with here really is that apparently it has got tremendously out of proportion at some point.

Dr. KIMMICH. As I understand Dr. Frechette, the answer is "Yes." it is necessary to have duplication for the reasons that Dr. Winston has brought up.

Dr. WINSTON. I am talking about a liaison person and the fact that after all we are dealing with the same people, aren't we, to a very

large extent? The welfare department will determine eligibility under the program. You know, it is very much like my asking the Surgeon General to give us a liaison person so that there will be the necessary flow of information.

Dr. FRECHETTE. I was not sure whether the answer was yes or not. I think Dr. Winston indicated the desirability of not having duplicate units and still said she felt there was need of liaison.

Actually the commissioner of public welfare and myself are very close working partners. We do have excellent liaison. I don't know whether there would be much achieved by interposing a physician between us.

Dr. WINSTON. I think it is at the staff level. These people are not interposed between the two people who head up the agency, but you assign responsibility and you need somebody to handle the responsibility on each side.

Dr. FRECHETTE. As you undoubtedly know, Dr. Winston, this liaison has often been accomplished by assigning someone from the department of health to work in the department of public welfare and to represent the medical viewpoint and to make sure that the relationship with the medical profession and the hospitals and so forth is being carried out.

This has been very successful, particularly in New York City. I believe that you commented on this yesterday.

Dr. WINSTON. You are quite right. The point I would like to make on this is really that we are highly flexible in this. We have not had a proposal come in by the way from your State.

Dr. FRECHETTE. This is one of the reasons that we have been delaying because we are told that instructions from the welfare administration have been that there was a need of a separate medical care administrative unit in the welfare department.

Dr. WINSTON. Why don't you come in and talk with us instead of going by hearsay?

Mr. ROGERS of Florida. Yes. I think as Dr. Winston says. Otherwise it often leads to supposed policy which may not have been intended and may have been picked up by someone and their translation perhaps has been distorted.

Dr. FRECHETTE. I think this has been very helpful, Mr. Chairman.

Mr. ROGERS of Florida. They don't want duplication and they want to have it as a minimum. The discussion along this line has been helpful.

Dr. KIMMICH. Dr. Philp.

Dr. PHILP. My original comment which I was going to make a half hour ago was on a different subject. I will hold those until this afternoon but I would like to respond to this argument now.

One of the reasons—one of the problems that some of us have on the local level is dealing with the regional office staff. Particularly as new programs are evolving and as decisions are made and regulations formulated, the interpretation of them perhaps is quite different and perhaps more rigid than the interpretation or the explanation that we hear in this room this morning.

I think this is the level frequently of some of the communications and how misunderstanding occurs. I think we have all learned a lesson or two on how perhaps this can be improved.

Dr. KIMMICH. Are you suggesting that Dr. Frechette's information may have come from a regional office?

Dr. PHILP. I don't think he was acting on hearsay.

Dr. WINSTON. The welfare director ought really to ask to come in and go over this with us and see what the problem is.

Dr. PEEPLES. My comment yesterday was in the same vein. I think my comment has pretty well been cleared up now. But we did get the same information from the regional staff, Dr. Winston.

Dr. WINSTON. I believe we say a full-time person who can be a social worker plus a half-time doctor—it is minimal time so that you have somebody to deal with.

Dr. PEEPLES. In our preliminary plan which was written up and discussed with the regional welfare staff we had proposed to do this by assignment of a part time or as much physician time as needed to the State welfare agency. We were informed by the regional staff that they felt that this should be a full-time physician or a part-time physician employed by the welfare department in that department.

Dr. WINSTON. I think this is a philosophical question. My own experience is that when you are held accountable it is a little easier to be held accountable by people who are directly employed by you rather than who are responsible to somebody else. But we have not talked with you either, Dr. Peeples, and we hope to get to see you soon.

Dr. KIMMICH. Dr. Thompson.

Dr. THOMPSON. The impression that everybody else has had, I have had, Dr. Winston, from your own staff—as long ago as November in a Washington meeting—is that, even though there is no policy, we have been told this.

Dr. WINSTON. We do have a policy about a skeletal liaison staff. I want to make that clear but it is so minimal that nobody has to worry about duplication.

Dr. THOMPSON. Coming to Utah, even on your minimal staff, in order to carry out the responsibility of the State health department under the State law and even under the Federal law with regard to title 19 because we do have a role in title 19 as one of the sections provides and we are licensed agency in welfare, and to add to that the function under title 18, we now have a staff, most of the positions which are now filled.

The principal ones that are not filled are the medical ones and this plan is full time. If you require a half-time physician in the welfare department to do some functions and I don't understand what he can do except communicate——

Dr. WINSTON. Which is very important obviously.

Dr. THOMPSON. This can still be provided without wasting duplicated manpower as scarce as it is. I strongly agree there ought to be a strong liaison and a strong responsibility. If we are going to be responsible for quality care through professional channels this is something on which we don't want to be second guessed by administrative persons.

I certainly support there ought to be a person someplace who has this responsibility for liaison. It could be a social worker. I would hate to see it be a physician if there were two physicians involved when actually one physician can do the whole job for both agencies in the State of Utah.

The other thing I would like to comment on, at no time, not even on one occasion, has anybody from the welfare administration sent me any information for guidelines, for background. The only indication I had, Dr. Winston, was as a result of your insistence that the State director of Utah come in for discussion of the title 19 program.

I have enough to do. I am not making myself a nuisance in Utah to get into title 19 which by the course of events is in the welfare department, not by the Governor's decision but this is where the appropriation was made for Kerr-Mills and the rest of the welfare items.

So I went in when I got invited. We are now brought in on this medical advisory committee and we are getting a plan to study.

Dr. WINSTON. It has not been approved.

Dr. THOMPSON. I hope it won't be. It needs a lot more work on it. The point is that we need to participate and it seems to me that you, the welfare administration in Washington, should put the word out to your regional staffs to include us for some of the information, for some of the education, from the beginning, because suddenly we are brought in, after all the plans are written, and then they ask you what do you think about it.

Well, if you start telling them frankly what you think about it you become quite a stinker because you find quite a lot of things that are professionally wrong with it.

Yet if you were to participate in the plan development this kind of human situation would not be created. I think the welfare departments should see this as an opportunity to finance a program which is commendable but I think that you could do something to stimulate this.

Dr. WINSTON. Could I comment on this a minute, Mr. Rogers?

Mr. ROGERS of Florida. Yes, we want to try to conclude at 12:30 if we can.

Dr. WINSTON. Yes, sir; I will. I think this is a very important question and one that has given us great concern.

I often review the different functions of health and welfare around title 19 and they run something like this. Where the welfare department is the resposible agency it might certify eligibility, it has to do that anyhow; it must see that there is matching money; and it will see that the bills are paid.

By and large we look to the health department and their resources in the State in terms of the quality of the services that are rendered.

Now I don't recall exactly what we said when you came in with your State welfare director, because we have had a great many come in. As I say, this was to give us the opportunity to get advice.

Dr. THOMPSON. You made some of the same comments on the Utah plan that I had and I thank you for it because it helped us to get a quality program. You see, we could have presented a better plan if we had participated in it earlier. It would have saved all our time.

Dr. WINSTON. You are perfectly welcome to give suggestions. But I want to say we have put great stress on the medical advisory committees. After all, these are State administered or State supervised programs. We do not administer directly out of Washington.

Now you want State responsibilty. Under title 19 you have State responsibility for the coverage of the program; the scope of service; the quality of the service. So, where your questions have been directed

they have really been in terms of is this medical advisory committee in the State sufficiently representative of the various health interests in the State?

Is it related to the medical centers in the State, are there board people on the advisory committee? Frankly we feel that in the long haul it is the kind of consultation and advise that the medical advisory committee gives and the standards that they hold up to the State that will determine pretty much where this part of the program goes.

I am glad to know you will be giving leadership to that particular committee in your State along with the other ways in which you help us.

Dr. THOMPSON. I hate to put in the record this but we don't have a medical advisory committee. We have one by name not in function. There are 2 doctors, 1 besides myself, on this committee of about 18 or 20 people. This is not a medical committee.

Dr. WINSTON. That committee won't be approved I can assure you when it comes in. It is my experience that the medical personnel are in the majority on these committees.

We have very good medical consultation ourselves and we are looking at the makeup of the committee.

Dr. THOMPSON. Our understanding is that if your staff could come and talk with me in Utah I believe then I could understand and help you on this more.

Incidentally we have a little "Hoover Commission" in Utah. There is a special session being called on May 16 to consider its recommendations. One of the findings and recommendations in there is on the welfare. It says this: With regard to the welfare department, the medical service unit as now in existence shall continue. As now in existence means a one-fifth time doctor and one social worker and a clerk.

It says in the health department portion of the Hoover commission report that the impact of medical care is so great and the information is not yet available for it to foresee the real details of the program in the future and recommends that the Department of Health establish a division of medical care service in order to be ready for the impact.

So I think the thinking is that they don't want to have two medical departments, they want one medical department to work effectively.

Mr. ROGERS of Florida. I think we will pursue this a little later when we have the Under Secretary here with us and counsel. We will now adjourn until 2:30 this afternoon.

(Whereupon, at 12:30 p.m., the subcommitte recessed, to reconvene at 2:30 p.m.)

AFTER RECESS

(The subcommittee reconvened at 2:30 p.m., Hon. Paul G. Rogers (chairman of the subcommittee) presiding.)

Mr. ROGERS of Florida. The committee will come to order, please.

We will interrupt the panel, if we may, to hear the distinguished Under Secretary of the Department of Health, Education, and Welfare and his associates.

Mr. Secretary, we are delighted to see you. We appreciate your kindness in arranging your schedule to come so that we could talk about something that is causing a great deal of concern throughout our

country, particularly those concerned with public health and the administration of programs.

Will you go into that and then we won't keep you any further? We appreciate the Assistant Secretary coming, Assistant Secretary Lee, and Mr. Wilcox, counsel.

In developing the testimony we have heard from some of the State health officers that they are concerned that the way that the law is being applied is as follows:

A State may be given the right to decide which agency shall administer title 19. The governor may make this selection.

But the way the law is written or as it is being interpreted it would appear that if the department of welfare is selected to administer this program, as to the medical functions it then can receive a reimbursement of Federal funds or a grant of Federal funds up to 75 percent, whereas if welfare is selected but it would like to contract with the health department, then the reimbursement can only be 50 percent.

Mr. COHEN. That is correct, Mr. Chairman.

Mr. ROGERS of Florida. If the health department is selected to do the job it could then get 75 percent?

Mr. COHEN. That is right.

Mr. ROGERS of Florida. But there is a requirement in the law that the welfare department shall determine the eligibility but there is no like requirement in the law that the health features should be carried out by the health department.

Now this seems to be an inequity. We are concerned as to whether it can be corrected by administrative procedures or whether some movement will have to be started to amend the law. Now one reason we are concerned particularly is because it would appear that we are requiring duplication, because as a matter of practical application of the law I think we realize that a State is going to try to take that position which will obtain for it 75 percent on the dollar rather than 50 percent on any dollar.

I think we are all reasonable enough to know that this will be the approach made. So, what we wanted to do is to see what was the thinking of the department on this problem, particularly with the great shortage of manpower and the fact that our efforts have been directed to try to increase manpower and that any direction of duplication in the use of critical manpower seems to us to be a step backwards and in contravention of what we and the department, itself, have been trying to do in trying to increase manpower in this area of very short supply.

We wanted to get the feeling of the department on just what could be done to straighten out this matter.

STATEMENT OF HON. WILBUR J. COHEN, UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY PHILIP R. LEE, ASSISTANT SECRETARY (HEALTH AND SCIENTIFIC AFFAIRS); AND ALANSON W. WILLCOX, GENERAL COUNSEL

Mr. COHEN. Could I speak then to what I think is really an important aspect of several questions you raised, Mr. Chairman, namely duplication?

First there is nothing in the Federal law nor in our regulations

or interpretations which either encourages the States to duplicate these services nor would then we pay for them under the terms of proper and efficient administration if they were duplicate.

I would say unequivocably that there need be no duplication of service between the health and welfare department but if there were, under the statute which reads that secretary makes the determination of proper and efficient administration, we would not pay for the service to be done in both departments simultaneously.

I can assure you unequivocably that it is neither the intent of the law or our interpretation nor will we administer it in such a way that it encourages duplication. Rather, we would discourage not only duplication but do everything in our power to see that the administration of the medical care aspects of the program use scarce personnel and facilities at the State and local level in the most rational way.

Now, second, I might say in connection with the discussion that the Federal law as far as the administration of this program, gives the States quite a number of different options as to how it might administer title 19.

It is true that it does not give the State absolutely unlimited, you might say, authority to do anything it wants. The Federal law, since is inception, title I of the act in 1935, has always used the concept of a single state agency which was a concept that the Federal Government wrote into the law in 1935 in order to create a focus of responsibility and accountability in one agency to the Government, to the State legislature and to the Federal department so that when then it came to a question of what actually is the State plan, how is the money being spent, who is the person who is responsible, the Federal Government could look to a particular agency and the head of that agency and he could not say, well, I am sorry I could not do anything about it because Mr. Jones told me that I could or could not do that.

That concept, I think, of the single State agency has been a great and important principle in the law that enables the Federal Government in working with the States to focus responsibility in such a way that the people of the State, the Congress, everyone, know where to look for the State responsibility, know where to look for the Federal responsibility.

Now up until 1965, under the so-called vendor payment medical care provisions which were inserted in the law in 1950 for the public assistance programs and then with the Kerr-Mills program in 1960, the single State agency responsible for administering any medical assistance aspect of the program was the State welfare department.

That was an outgrowth of a historical set of facts which were largely that medical care to needy individuals was a part of the public welfare programs, but it was also part of a historical pattern in which the State health departments had exhibited no interest whatsoever in the administration of the controversial elements of medical assistance. Now what has happened, in my judgment, Mr. Chairman, is that when the big political and ideological battle over medicare was broken by the Congressional decision that we were going to go into a big program of medicare, whether it was through the insurance program or medical assistance, State health departments then felt, and quite properly so, that they could now go into the administration of

these controversial programs without fear of having to have a whole complex of economic issues about physicians fees and standard setting and relationships with the State and local medical societies, impairing the other parts of their traditional public health program.

Now that particular evolution of thinking did not quite come into focus until after the House Ways and Means Committee had reported out medicare in title 18 and medical assistance in title 19.

It was at that point after it passed the House and it was obvious then that Congress was going to pass these bills, that the people who felt that the State health department should have a role in these programs, went to the Senate Finance Committee and obtained an amendment which gave these other alternatives, other than the State welfare department being the administrative agency under title 19.

When that issue came before the Senate there was this House-passed bill which had been interpreted in accordance with the committee's report, on page 65 of the House committee report, language which said that while the State welfare department was to be the single State agency (and I now read from page 65 of the committee report), responsibility can be arranged by a welfare agency for actual provision of medical care by or through a health agency and under suitable contractual relationships as some States have done under the MAA program.

MAA in that context meant the Kerr-Mills program enacted by Congress in 1960.

So when the bill passed the House and you gentlemen voted on it in the House, the bill consisted of using the State welfare department as the single State agency but with a clear recognition to the department which it had been following that you could have a contractual relationship that would use the State health department for the full content of the medical aspects of the program.

At the same time the House committee had placed into the law in order to encourage States to provide a high quality medical care program and for a focus of medical administration, they had written into law that the State agency could get 75 percent Federal matching for the parts of the program that involved skilled professional medical personnel and staff directly supporting such personnel, rather than 50 percent which would be the normal case for general administration, in the attempt to encourage the States to employ high quality personnel.

In the executive session in the committee there had been a lot of discussions that medical personnel salaries are higher than normal salaries. It is difficult to recruit these people. They are scarce employees, and that unless the Federal Government gave some encouragement and higher portion of Federal matching, the States might not be able to carry out the plan effectively without a higher degree of matching.

So the committee wrote into the Federal law the 75-percent requirement on the assumption that the medical care aspects of the plan would be in the State welfare department, but that they could contract medical care element out to the health department but the health department at that point would not get the 75 percent, it would get the 50 percent.

Now I will comment later on the policy, but that is the way the bill was in the House. Then it went to the Senate and the Senate

debated at quite some length whether to give the option to the States to use the health department as a single State agency or the welfare department or other alternatives.

In that discussion came out the general agreement that the element relating to determination of the individual need with respect to individual persons was a welfare department responsibility in the sense that it was a nonmedical element, and that in any case should be retained by the State welfare department.

As a matter of fact, health departments said they not only did not want to determine individual eligibility, they did not feel qualified to do it and it should remain in the welfare department.

At that moment when the Senate made the change which ultimately was adopted by the Congress, by the conference committee, the other elements in this total situation were not reviewed, that is the 75 percent with respect to the medical personnel, and the statute remained the same as the House-passed bill, namely that the 75 percent for the medical personnel would only be available to the single State agency that was administering the plan.

This is then what resulted in the anomaly or inequity, whatever you want to call it, which we now find ourselves with, namely that if the welfare department is selected as the single State agency and makes the contract with the health department, then the 75 percent for medical personnel can only be paid to the welfare department, but if the State selects the health department, then it can get 75 percent for the medical personnel.

So the State still has the options that are open to it.

Mr. ROGERS of Florida. Now let me ask if I may interrupt, does that mean if health is selected that any work that welfare did would only get 50 percent?

Mr. COHEN. Yes.

Let me make this clear. This goes back to your problem of duplication. The assignment of these functions would be such that there is no duplication, the full content of medical care administration would be in the health department and the residual functions of determination of eligibility for which the State welfare department would get 50 percent of matching even if it were the single State agency, would be no different.

In other words, with respect to eligibility determination. Because that is just a 50/50 matching in any case.

Mr. ROGERS of Florida. I see. So that the 75 percent only applies to the health——

Mr. COHEN. It only applies according to the statute and I think I should read the exact words of the statute, section 1903(a)(2). It says:

> An amount equal to 75 per centum of so much of the sums expended during such quarter (as are found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel and staff directly supporting such personnel of the State agency or of the local agency administering the State plan in the political subdivision.

So what I would like to say in conclusion here, Mr. Chairman, is that as I see it a State has at least five options as to how it could operate under this statute.

First, the State could select the State department of social welfare to administer all aspects of the program. That is what we might call the traditional approach that was present in the law under the Kerr-Mills program and up to the 1965 law.

Second, the State department of social welfare could be designated as a single State agency and the welfare department could arrange for the actual provision of medical care by or through the State department of health under suitable contractual relationships. That option is authorized by the House committee report of 1965.

Third, the State department of health could be designated as the single State agency and the determination of eligibility for medical assistance under the plan for each individual could be made by the welfare agency.

That would permit all of the medical functions without duplication to be handled by the State health department.

Four, a new State agency could be established to administer or supervise the administration of the plan and this new agency could be called, for example, the State medical assistance agency.

With appropriate contractual relations with the State department of health to handle the medical aspects and appropriate contractual relations with State department of welfare to handle determination of eligibility.

Dr. HILLEBOE. On a reimbursement basis of 75 or 50 percent?

Mr. COHEN. As a single State agency if they contracted out for the health department to handle the medical care they would only get 50 percent.

Fifth, a new State health and welfare agency could be established which would encompass the total programs of both present agencies.

Now if a combined health and welfare department were established in which these functions were all under them, then obviously both health and welfare, as some States have, then obviously it could be worked out so that the actual full 75 percent matching cost could be obtained.

Now subject only to the fact, as I said, that this anomaly or inequity is the result of this legislative history, the State has the full option of these five plans but there is some inequity with regard to the 50 or 75 percent, depending on where the responsibility is located. But I certainly want to make it absolutely clear as I have said before that under no case should there be, nor I think would there be duplication of medical care functions between the two agencies.

Mr. ROGERS of Florida. Thank you for your explanation. As you say there appears to be very obviously an inequity in regard to the medical care functions to the degree that if these functions are performed under contract with the health department then the State would only receive a reimbursement or funding of 50 percent.

Whereas if performed by the welfare agency it would be 75 percent. So, I think it gets down to the point that the inequity then is within the law, which was obviously overlooked when they made the change to let the State decide——

Mr. COHEN. That is the way I would like to look at it, Mr. Chairman.

Mr. ROGERS of Florida. Would it be the department's position that they would request that this be changed in the legislation to try to make this an equitable situation so that regardless of which agency

provided the medical care services they both get 75 percent or they both get 50 percent.

Why should this not be done?

Mr. COHEN. There is some ground for saying that we should reexamine the situation and see whether the same proportion of Federal matching should not be applicable, no matter where the location of this medical responsibility is placed.

Whether that should then be 50 percent as it was in the old law or 75 percent or 66⅔ percent I would not want to say at this time, but I would concur in the observation you made it probably should be rationalized so that there would not be a financial incentive or disincentive to do what the State felt was proper.

Mr. ROGERS of Florida. Yes, I appreciate that answer because I think this is most important. As I say, whether it should be 75 percent or 50 percent, that would have to be gone into.

But what we are interested in doing is to supply the best health care. Now, if it is taking the 75 percent to get that best health care, I don't know why, if you are going to give 75 percent to welfare, you shouldn't do the same for the health department. Otherwise, it amounts to saying, in effect, if we want to provide better medical care, we handle it through welfare, but we don't provide quite such good care if we handle it through the health department.

This, in effect, is what the law is saying to the States; so I would hope that the department would come forth with a recommendation on this to the Congress to help us correct this inequity.

Now, it seems to me that there is a possibility of duplication. I may be in error, but from my understanding of what we have been told, if there are sufficient people to do the job in the health departments, to have to set up another advisory administrative unit in welfare seems to me could very easily result in duplication.

For instance, one of the witnesses, Mr. Mulder of the Welfare Department, was saying in our hearings yesterday, and I will quote him:

> There is a pending requirement which the Secretary has not yet adopted but which is a staff recommendation that there must be a progressive development of those medical care units starting with the large metropolitan areas until ultimately the entire State and each administrative agency within the State has the necessary professional competence on its own staff.

And I further questioned him—

> Do you mean that every metropolitan area that has been designated through the census would then have to have this setup with a medical adviser?

And he said:

> Yes, this is the recommendation.

Now, that would be a tremendous duplication if we get into that. I can see the possibility of it if we are going to have questions on health standards, and so forth, which might have to be determined and they are directed to some other department rather than letting the health department, which is already set up to do the work, do this. Now, let me ask you this.

This program I believe is administered by the Social Security Agency, is it not?

Mr. COHEN. Yes. The health insurance programs are.

Mr. ROGERS of Florida. Are they using the health department?

Mr. COHEN. Yes, sir. If you want to make the anomaly, more complex, under title 18 when they use the health department they pay a 100 percent of the cost because that is an exclusively federally financed program.

So you have a situation where you are using a State health department in a situation where you can have a 100 percent Federal matching and 75 percent Federal matching and 50 percent Federal matching for different contents of service.

Mr. ROGERS of Florida. And we are finding that this is true in a lot of programs, like the crippled children program. They told us if a child is crippled, if he goes to one program he gets 50 percent, if he goes to another he gets 65 and if he goes to another it is 75.

Mr. COHEN. I would maintain that there need not be any duplication of administrative services in the State or local agency administering this program and to the extent it was brought to our attention under the language of the proper and efficient administration we would have to see that it was modified and we would not pay the State for any kinds of service that are truly duplicatory.

Mr. ROGERS of Florida. This might be a way to hold them in status quo until it is changed. Now you tell us that under title 18 you are using the Public Health Service.

Mr. COHEN. We are using the State health departments; yes, sir.

Mr. ROGERS of Florida. Why can't they be used under the——

Mr. COHEN. They can be.

Mr. ROGERS of Florida. Yet, we have encouraged the use of a separate organization to be set up by giving 75 percent funds?

Mr. COHEN. Let me say here again is an anomaly. For 15 years we have been trying to encourage the State health departments to do it but for about 14 of those years they did not show much interest in doing it.

Now the situation is changed because we have a new law. That is what is changed in this whole situation.

Mr. ROGERS of Florida. And I am not opposed to the welfare department. I think they are doing a magnificent job. I think in this business of setting up standards and advice we have the competence and we want to build that competence.

Mr. COHEN. There is no question about that, Mr. Chairman. I would say this, and I would say for Secretary Gardner that he and our department will want to do everything we can to strengthen the State health departments to take on increasingly this important role in title 18, title 19, title 5, and the vocational rehabilitation program.

Unless we are prepared to vastly strengthen the State health departments to meet this commitment we are not going to carry out all this wonderful legislation you enacted last year and the other proposals that we have pending before you this year. As you know, our proposal pending before the full committee with regard to the comprehensive State planning grants is based entirely on the philosophy that the State health departments should be increased and expanded and strengthened.

Mr. ROGERS of Florida. I know. That is very encouraging.

Mr. COHEN. So I would say there is no difference of opinion in principle on that issue whatsoever.

Mr. ROGERS of Florida. Now let me ask you this.

Under your title 18, where there have been consultations with groups already set up, have your medical standards been set up?

Mr. COHEN. Under title 18?

Mr. ROGERS of Florida. Yes.

Mr. COHEN. The standards for hospital participation have been established.

We also issued them on extended care facilities, laboratories, hospitals, and on home care agencies.

Mr. ROGERS of Florida. How many standards have been agreed upon under 19?

Mr. COHEN. Let me just say on that one point, I believe the four that I have just stated have been issued in the Federal Register as part of the rulemaking power but they have not yet been finally issued by the Secretary.

Mr. ROGERS of Florida. At least they have been proposed and agreed upon?

Mr. COHEN. They have been proposed.

Mr. ROGERS of Florida. Now have you done likewise in title 19?

Mr. COHEN. In title 19 we have not yet finalized the basic policies.

Mr. ROGERS of Florida. You see, this points up the difficulty. Now there is no reason why those standards could not be established with the consultation of people already set up rather than looking to different groups, to set up another administrative body to get this advice.

Mr. COHEN. As far as the Federal level is concerned, Mr. Chairman, they have been developed with the full cooperation of the Public Health Service as far as the Federal standards are going to be concerned.

Mr. ROGERS of Florida. Now what about the health care? From what I understood you have this advisory council under 18.

Mr. COHEN. Yes.

Mr. ROGERS of Florida. You have an advisory council under 19?

Mr. COHEN. Yes, sir.

Mr. ROGERS of Florida. How many times have they met?

Dr. WINSTON. I don't really know how many times they have met, but regularly. I think we have a great deal of help here already because it has been our position that where standards have been worked out under title 18 it is imperative to try to use those same standards under title 19, and that we would be putting ourselves and all of the suppliers in great difficulty if there were one set of standards for 18 and another for 19.

Therefore, as we have worked on these we have assumed that we would utilize the title 18 standards.

Mr. ROGERS of Florida. I think this is encouraging because it seems to me otherwise, as the commissioner says, there is another duplication. But I am encouraged and I hope you will take this to the Secretary and to make plans to pursue it with him since the State legislatures are now meeting. They are anxious to be able to use the personnel that they have trained (and which we have encouraged) to become experts in the health field, and now to have to set up a different organization is not much of an encouragement as far as we have been able to determine from the testimony.

Mr. COHEN. Could I say this, Mr. Chairman?

Mr. ROGERS of Florida. Yes.

Mr. COHEN. I believe that we are in a great transitional period right this minute. For 30 years in this country there has existed a tremendous ideological conflict about medical economics, the role of the Federal Government in medical care and particularly with regard to insurance and medical assistance. I need not tell you gentlemen that.

The issue over the Kerr-Mills legislation of 1960, the elder care, medicare in 1962, 1964, and 1965 was an issue which I think was devisive at the time with respect to not only medical people and nonmedical people but with regard to Federal and State agencies that had some role in the field.

I feel that now that that has been decided by Congress you have seen a great crossing of the Rubicon take place in which now all of these people who before felt they could not fully cooperate or they had some reservations, some limitations, or they did not want to take a certain role in it, that has all changed since the Social Security Act Amendments of 1965 were passed.

We are now in an era of cooperation. We are now in an era of good relationships, working relationships between the medical profession and the nonmedical groups, the insurance people and others, medical relationship between the assistance and nonassistance people, between the Public Health people and others, between the Federal agencies and State agencies, I see that we are now at a point where we can go forward to make progress which it was never possible to do before 1965 simply because you had this overlay or undercurrent of controversy and debate and mixed feelings about what the proper role is. So I think that you are going to see a tremendous degree of cooperation and rationalization of programs which have been backed up and held up for years waiting for this decision to be made.

Mr. ROGERS of Florida. Let me say this, Mr. Secretary, that we have passed out of our committee—I, as you know, and you worked very closely on it—a bill to increase manpower in the medical field.

Mr. COHEN. Yes, sir.

Mr. ROGERS of Florida. And I have supported that legislation.

Mr. COHEN. Yes, sir.

Mr. ROGERS of Florida. We have an international health bill. I voted for that.

Mr. COHEN. It is a good bill, Mr. Chairman.

Mr. YOUNGER. The Rules Committee did not think so.

Mr. ROGERS of Florida. Some don't think so.

Mr. COHEN. When there is a question between the Rules Committee and this committee, I will choose this committee.

Mr. ROGERS of Florida. I am not in support of legislation to increase manpower if we are going to pass laws which duplicate and do not use efficiently the manpower we have trained. I think there is a defect in the law. I would like to get some assurance by you and the Department that you will actively pursue this to try to get this worked out.

Mr. COHEN. I can assure you that the Secretary himself is personally interested in this and will devote his attention to seeing what can be done to eliminate this inequity.

Mr. ROGERS of Florida. Could you give us some assurance—and I think you said that you are not, as some have stated and this is simply down the line and I don't think it was actually put out at this level, but I think some clarification should be made to let people down the line know—that the Department is not insisting or trying to imply that the State welfare department should take over the medical care functions of the health departments in the administration of title 19.

Mr. COHEN. That is correct, Mr. Chairman. I can assure you that the Secretary himself has stated that any of these five options that I have indicated which would utilize, among other things, the State health department fully or in any way that could be worked out is perfectly permissible under the Federal law and the Secretary has instructed the staff that they should give the State the full option in these five areas that I have enumerated.

Mr. YOUNGER. Will you instruct your regional people in the same vein?

Mr. COHEN. We will instruct everybody, Mr. Younger.

Mr. YOUNGER. Sometimes we find some very peculiar reaction down the line. I ran across one in my district the other day. A lady went in to pay her income tax. She had cash. They refused to take the cash and the man in charge of the office, said it was the law, they could not accept cash, and made her go out to get a cashier's check in order to pay the income tax, when it was written on every bill that it is legal tender for all debts, public and private. So you get some peculiar interpretations down the line.

We want you to be sure that you instruct your regional office, especially down in Atlanta—is that where we want it?

Dr. SOWDER. Yes, sir.

Mr. COHEN. I will see that the people, especially those in Atlanta, are duly instructed, Mr. Younger.

Mr. ROGERS of Florida. Mr. Secretary, could you place some urgency upon the handling of this 75–50 percent matter to see if you can't get something before the Congress if there has to be a change in the law or even some administrative action?

Mr. COHEN. As you are aware, Mr. Chairman, an amendment to that will come before the House Ways and Means Committee. I will certainly, as we would do in this committee, before we make a recommendation we will consult with the chairman of the Ways and Means Committee about that matter.

Mr. ROGERS of Florida. Yes. And I will speak to the chairman, too, myself. I am sure this committee can be helpful in helping to bring this here and in the Senate too. I think this has been most helpful. You have been very kind to come.

Dr. HILLEBOE. Mr. Chairman, I think three things should be said. First of all, I think it is very significant that Mr. Cohen has publicly stated and made it clear to all that he wants to build up the Health Department's participation in this program for the very obvious reason that no one can do it alone. It is going to be too big a job for everybody. If we come out together we will be very fortunate. I hope this is given publicity. I think it should be said in every corner of the country. I think this will be most useful.

The second point is that on the advisory committee on title 19—for our information are there any health officers on this committee?

Dr. WINSTON. Yes; you were not here today when I spoke to that point. Dr. Teague has been a member of that committee for a long time, and of course he comes from a State in which there has been a contract with the Health Department.

Dr. HILLEBOE. How many members are there on the committee?

Dr. WINSTON. There are a majority of doctors. He is the only health officer.

Dr. HILLEBOE. I think this is an important point, Mr. Chairman, is that regulations are now being drawn up for title 19. In view of discussions that have been held in the last 2 days which have been very helpful to the health officers and have given us an opportunity to air these views, I wonder if these regulations could be held up until some of these matters are settled within the reasonable purview of when you have to get these regulations out. I think some things have come out that do have application and if it would be possible for the Department to consider this within reasonable limit it would be most useful.

Dr. WINSTON. No problem about that.

Mr. COHEN. Let me say first to make it clear, in connection with title 19 we don't have what we call regulations. I think there is a big difference between title 18, which is a Federal program, that is, an insurance program, and title 19, which is a Federal-State program. What we tried to do in title 19 and this accounts for the difference, since you have so many options, what Dr. Winston does is send out material which is more in the nature of guidelines and then the State in every case, so far as I know up to now the State health officer and State welfare officer come in to discuss the particular proposal that they have. In other words, this is a very important distinction. In title 18, which is an insurance program, it is a program in which certain medical services are available and they are available to everybody that is in the group. There are no options particularly with regard to whether a service is included or not once the standards are set. But in title 19 within a certain orbit the State has a great many options as to what kind of medical service it wants to provide and how it wants to provide it and with whom and how much it wants to pay for it.

There is something stated in the statute but there is a lot of leeway. On many of those factors the State has a wide range of authority. So you have to keep in mind that in dealing with 18 and 19 you are dealing with two quite different animals as far as relationships are concerned with providers of service.

Dr. HILLEBOE. Mr. Chairman, I think this is quite clear, Mr. Cohen has made it clear. But I wonder if these guidelines are sent not only to the welfare departments but also to the health departments? It is my understanding from some of the health officers that they do not get these guidelines; these go only to welfare.

I think it would be highly desirable to have these guidelines go to the health departments, Mr. Cohen, as well as to the welfare departments. Would you concur?

Mr. COHEN. Well, they can go to anybody. I don't think they have to be restricted to health departments. The material that we have can go to schools of public health and can go to anybody who wants to have them available. But I think where we are sensitive

about this problem is that the decision as to who is the single State agency is up to the Governor and the legislature. We are very conscious that this is a political decision in every State. We do not try to predetermine nor do I think we should, what the Governors and the legislatures want to do about selecting the State agencies.

Mr. ROGERS of Florida. I would agree with you except for the 75–50, which you have agreed to.

Mr. COHEN. Yes, but what I am trying to indicate is simply that we do not want to, in publishing anything or to make anything available in a given State, indicate that we are in any way trying to prejudice the Governor or the legislature's decision.

As I said earlier, our position should be that while we want to promote the quality of medical care we hope that the State Health departments will be fully utilized. The ultimate decision as to the administrative agency and relationship is a matter of State determination.

Mr. ROGERS of Florida. I think that is good, that is fine. But the main thing that I see which we both agree is an inequity, is the 75–50 percent.

Mr. COHEN. On the other hand, if the State health department administers it they get the 75 percent. You see from that standpoint——

Mr. ROGERS of Florida. Then you require the welfare to carry out its duty of qualifying the people, that is in the law.

Mr. COHEN. Yes, sir; but that is not a medical determination.

Mr. ROGERS of Florida. I am not saying this except that you require one agency to function and you don't require the other to function by law and you prejudice the functioning of one by only giving them 50 percent, if you let the one agency that you require do it all.

Mr. COHEN. I disagree with you on that, Mr. Chairman. If the State of "X" wants to pick the State health department to be the single State agency they are going to get 75 percent Federal matching for the health component that they administer, and the welfare department making the individual eligibility determination will get 50 percent for that function, which is all that the welfare department would get if it were the single State agency itself.

Mr. ROGERS of Florida. All right. But by law you require in any instance the welfare department to be a part of the program. You do not require it by law to include the Health Department.

Mr. COHEN. That was a Congressional decision, Mr. Chairman.

Mr. ROGERS of Florida. I am not saying that. What I am saying is that this is so. So this should be corrected on the 50–75 to allow the Governor a true independence of decision, which is what you want and what we want.

Dr. HILLEBOE. Mr. Chairman, while Mr. Cohen and his colleagues are here I think it would be very interesting to hear from one or two of the States. Mr. Breslow is from California. It would be very nice if we could take a minute to hear some of their problems.

Mr. ROGERS of Florida. If we could quickly have a comment.

Dr. HILLEBOE. We would like to hear from Dr. Lee, also.

Dr. BRESLOW. Thank you very much, Mr. Chairman. It was certainly encouraging to hear Secretary Cohen indicate the changed

position with respect to these matters. It appears that the passage of the social security amendments of 1965 has been the big factor in it.

Mr. COHEN. Could I just say, Mr. Chairman, I take exception to what Dr. Breslow said. I don't think there is any change in position, Dr. Breslow. I did not express any change in position. I have expressed the same position right along.

Dr. BRESLOW. I was speaking of the changed position with respect to the relationships between health and welfare departments and the relationships between the Government and the professional groups that are concerned. I thought that was the change of which you were speaking.

I hope that this constructive and optimistic frame of mind will prevail. It was also encouraging here today to hear that there will not be statements which prejudge the assignment of functions within States. During the past several months in the development of this program some things did happen indicating, to some of us at least, a certain prejudgment. Let me just mention two of these. In doing so let me remark, as I did yesterday, that in California we have adopted one of these five options which is very satisfactory from our standpoint, and we hope it will be from the Federal standpoint as well, namely, the designation of the combined State health and welfare agency as the single State agency for administration of title 19.

But before this was done the guidelines first established for the new program, for title 19, were distributed by the Welfare Administration to the State welfare departments throughout the country. The Welfare Administration did not bring to the attention of the Governors or others in the States, however, the several options to which the Secretary has referred. It would be very desirable even now to bring these options directly to the attention of the Governors and the legislative bodies.

Secondly, in the discussions of the implementation in California of the title 19 program a representative of the Welfare Administration when asked a direct question as to whether title 19 did not provide for options other than the election of the welfare department he responded that there were other options but they would create great difficulties.

We have a bit of history here and I am very glad to learn that this history is now being passed over and we are getting a new situation.

Further, it is encouraging to hear the indication that those responsible for title 19 are going to adopt the standards that have already been worked out for title 18. We in the States who have been working on this problem have been satisfied with what has been done in this regard for title 18 and we are pleased to know that the same requirements are going to be established for title 19.

Dr. HILLEBOE. Mr. Chairman, could we hear from Dr. Lee, too, because he has been working in some of the States.

Dr. LEE. I would only add a few words, Mr. Chairman. One with respect to the role of the State health departments in setting standards and this goes back many years in the medical care area particularly relating to maternal and child health.

From the mid-30s when the maternal and child health legislation was first passed, in every State, the administration of this medical care program has been in the State health department so there has been long experience with this. The crippled children's programs have sometimes been with the welfare department, sometimes with the health departments. These two programs have been characterized, more than any other medical care programs receiving Federal support I think, by high standards, particularly the crippled children's programs. But both have had standards built into the programs and this is I think a very important element in considering the title 19 programs and it is one that has been of concern to the Welfare Administration and they have made I think a considerable effort to encourage the States to funnel the same standards that are used under the crippled children's programs under the title 19 program. So I think we are very mindful of this long tradition of the State health departments with respect to standards and quality of care and encouraging the States to adopt the same standards under the title 19 program.

Mr. ROGERS of Florida. I think that is excellent. As I say, the only thing that is not encouraging is the 75–50 percent inequity as I stated.

Mr. COHEN. Although I would like to say this, Mr. Chairman, that while I agree with you the Congress in title 19 made so much new Federal money available to the States for medical care that was not available before, I would hope that until this is worked out no State would make its decision on what to do on the basis of this rather small amount of money that I think is involved because I think that when you consider the millions of dollars that are involved in the medical care itself, which is really the basic element, I cannot believe that a State legislature or Governor, all other things being equal, is going to change a basic policy decision because of the difference between 50 and 75 percent. At least I hope they would not do so while this matter is being worked out because I think you are dealing with a very, very basic and fundamental problem, of use of scarce resources, facilities, standard setting, quality care, that should be the decisive element in the decision.

Mr. ROGERS of Florida. I would agree with you, but I am afraid some will be affected, as has already been indicated to us from some experience that the States are now having.

Dr. HILLEBOE. Mr. Chairman, Dr. Peeples from Maryland would like to comment.

Dr. PEEPLES. I would like to say that we in Maryland believe that this legislation on title 19 is really a godsend to the State. I only bring up two problems while Secretary Cohen is here. One of these deals with reviewing preliminary plans for title 19 as opposed to preliminary plans or planning for title 18. When we did this for title 18, both the Public Health Service and the social security representative from region 3 were present. However, when we reviewed plans for title 19 the Public Health Service regional people were not involved at all. This was preliminary review, of course.

I wonder if it would not be a good idea to extend this consultative facility to title 19 as well as to title 18.

The other question I have concerns adopting standards which are established for title 18 or title 19. This is good and we expect to do so. But there is one area in title 18 as regards extended care which relates to only those facilities which have essentially the same nursing capabilities as hospitals. If we extend this very finitely to all people in the 65 and over category who are immediately indigent and who need care, we cannot find that type of care for them. We have to have two different categories of extended care. One for the chronic patient who needs care for a long period of time, who is not going to get any better, who has no home, who has a chronic illness which one cannot expect hospital treatment or anything else to rehabilitate. Yet they need nursing care, not of the acute nature that one would need coming out of a hospital expecting to be rehabilitated, going back home to be his own or going back to a job.

So this is a complication. This is a benefit that everybody 65 and over believes they have but they don't actually have.

Mr. COHEN. Could I comment on those points, Mr. Chairman?

Mr. ROGERS of Florida. Yes.

Mr. COHEN. On the first point we are now of course examining, we have had several meetings in the Department about the more effective coordination between the Public Health Service and the Welfare Administration, Children's Bureau and the Bureau of Family Services in these matters of joint interest. We will certainly examine the point that Dr. Peeples made with regard to other States and their consultation.

On the second point, Dr. Peeples is correct that under the insurance program under title 18 the only type of facilities for which we can provide payment for are extended care facilities that meet a very, very high standard of quality of care.

Congress was very specific about this in 18, that the extended care facilities were not just all nursing homes, all skilled nursing homes but a very limited type of convalescent care that provided a very, very high standard and which most of the nursing homes in the country today could not possibly meet.

But in title 19 it not only uses the term "skilled nursing home service" which is somewhat different, but it also provides for paying for other medical services. So there may have to be gradations of types of care in facilities for the chronically ill which will establish a different kind of relationship or standard in 19 and in 18.

Dr. PEEPLES. Yes. Very much so.

Mr. YOUNGER. If most of the nursing homes will not qualify where in the world are you going to get the care?

Mr. COHEN. That is a very good question. Let me discuss it in this way: Congress in the laws passed intended that the nursing home care, which is called extended care facility, in title 18, should really be directed toward convalescent care after a period of hospitalization. That was the fundamental direction. Not nursing home care unlimited for all chronic illness but rather for a person who had an acute period of hospitalization—they defined that as at least 3 days, and who needed a limited amount of nursing home care on the presumption that they would either be returned home or some other longer range arrangement should be made for them.

So that actually what you are doing in title 18 is looking at a very narrow problem.

Now the general problem of nursing home care for a person with a terminal illness or an aged person with chronic disability, that is not contemplated, generally speaking, in title 18 except maybe for the initial period after they came out of a period of hospitalization. Whereas in title 19 you might be actually providing nursing home services to a needy person for 2, 4, 5 years, with multiple chronic disabilities.

Dr. HILLEBOE. Mr. Chairman, Mr. Cohen's colleague, Dr. Winston, would like to comment.

Dr. WINSTON. I would like to go back to a couple of points that Dr. Peeples made.

I am sure you are getting consultation, Dr. Peeples. It happens that you have the same medical consultants that we do in the Welfare Administration. So I am sure that the lines of communication are very direct. Actually, it is true that you and the State welfare director came in very early about title 19 but as far as coming in as other States have been doing for some consultation on their plan, Maryland has not yet done so. When you come in you will find a high level staff member from the Public Health Service is right there raising questions and making the necessary points from the point of view of their interest. So, I want to assure you that they are directly involved. Perhaps you were out of the room this morning when I was explaining our very great debt to them.

Now with regard to this other point, the nursing home situation, is a very, very difficult one of course because we want good standards. We all recognize the fact that it is in substantial disarray in many places. I think you will be interested to know that there was a very long conference quite recently with quite a number of representatives from Dr. Stewart's staff with the medical consultants who have been working with the Welfare Administration from the outside and members of our staff around how we could hold to the highest possible standards and yet recognize the realities of the situation, how we could take a firm position on quality of care. We know that one of the reasons we have not had higher quality generally is because payments have so often been inadequate. Yet we must give lead time to those facilities that need some time in order to move up in terms of standards.

This group—and I understand there was quite some reluctance on the part of some of them to take a position for really good standards—recognized too that there might be a differentiation between people newly going into group care and this large group who have been in the facilities over a period of time, and that we can make a differentiation there. So, there is a lot of work going on in which the people in the Public Health Service who take the leadership in the nursing home field have been given direct consultation. I thought that was important to get into the record.

Dr. HILLEBOE. Dr. Thompson.

Dr. THOMPSON. I would like to make a couple of comments and ask a question.

First, every time I hear Secretary Cohen speak I am always pleased because I believe through the exchange of ideas we come to a great deal more understanding, we of him and I think he of us.

In light of this, though, I am concerned, and I have been before, when you keep relating to the dark days, 14 of the 15 years, so to speak. I think the same days are still present for title 19, but not for 18. The reason I speak about this is because I can remember when I tried to get State appropriations to support the so-called standard health program which the Congress has made special categorical grants for and was in competition with the welfare department who were also seeking appropriations to carry out some of the medical care programs for which they had the responsibility by State decision but also by dictate of the congressional act.

We were actually in competition in the legislature for the same dollar. At such a time I am hardly in a position to say to the legislature, "Let the welfare department get their million dollars for the medical care program but don't give us our million dollars for cancer, heart, crippled children."

I make the best pitch I can for the latter programs and let welfare do the best they can. I think we have to understand that the health department's problem in the past is trying to fulfill legal obligation. Medical care in most cases was not one of them. I think this will continue to be a problem for a while under title 19. At least in Utah it is because in order to meet the objective under title 19 in Utah there has to be an increased State appropriation.

At the same time to meet the objectives of the Federal act for cancer, heart, stroke, and whatnot, I am going to go and try to get some increased appropriation for these activities and I believe that we are going to be constantly faced with this in order to achieve the objective of the Federal act, until it is reached in 1975. I think we have to remember that the future will be no different than in the past in terms of competition for the State dollar. Whether it will be arrived at by one agency going for all of the appropriation or two agencies each going for a piece of it is the question. But in any event the legislature has to make up its mind on the relative merits of each.

My request is partly in answer to an observation you made Mr. Chairman. You said there is still one inequity. That is the 75–50 percent. I submit there are two inequities, the one you mentioned and an inequity I am going to mention. I wonder if Mr. Cohen won't correct the second inequity by seeing to it that the prejudiced positions already established by sending these documents and standards only to welfare be changed and that the documents also be sent to the health departments or any other departments of State government that could have a role and do it right away.

Mr. COHEN. I see no reason, Mr. Chairman, why we cannot send them to any State agency that has an interest in them. I see no problem on that at all.

Mr. ROGERS of Florida. Here again I think these sorts of complaints could be channeled through your State Public Health Association to the Department, and where they can comply, like here for instance, by letting them know of your concern, I think this could be corrected very easily and the Department would be delighted to

do so. There are so many things I think that can be corrected if they also know your concern. I think it is a lack of communication more than any other thing.

Thank you very much, Mr. Secretary, Mr. Lee, and counsel. You are very kind to come here on such short notice.

Mr. COHEN. It is always a pleasure to appear before your committee.

Mr. ROGERS of Florida. Would you let us know after the conference with the Secretary what can be accomplished on the 50–75?

Mr. COHEN. Yes, sir; we will be glad to do so.

Dr. HILLEBOE. Mr. Chairman, I would like to add the thanks of the health officers, former and present, for the excellent presentation by Mr. Cohen.

Mr. COHEN. Thank you, Doctor.

Dr. HILLEBOE. If it is all right with you, we will go on with our program. Do you want to take a break for 10 minutes?

Mr. YOUNGER. Before you break, it seems to me that out of this conference we ought to establish probably a small committee, maybe three or four, to funnel your complaints and to meet with the Department in regard to their various problems, then we would know that you have such an organization of the State health officers to function through.

Dr. HILLEBOE. Very good. Mr. Younger, this is an excellent suggestion. We look forward to the executive committee of the State health officers, directors, and mental directors. We will also ask them to inform your subcommittee so that you know it has been done.

So I think, Mr. Chairman, if we could take a 10-minute break we will try to finish up by 5 o'clock.

Mr. ROGERS of Florida. We will recess for 10 minutes.

(Brief recess.)

Mr. ROGERS of Florida. The committee will come to order, please. We will continue now until the conclusion. We are going to try to conclude at 5 o'clock.

Dr. HILLEBOE. Mr. Chairman, before we start with our summary reports, I did want to tell you that this noon I had the pleasure of being present when Mr. Folsom presented the report of the National Commission on Community Health Services, "Health Is a Community Affair," to the President.

This group has been working about 4 years developing this program, and many of the recommendations fall into the areas that you have been discussing. It was very pertinent.

The President was very nice, and talked to us about 20 minutes ad lib on the importance of health. We were impressed with his knowledge of what was going on, and his desire to be of help.

I asked Mr. Folsom if I could have a copy of this report for you. This is not to be released until May 9 or 11. He said if you would not release it until then, he would like to present you with a personal copy, because he felt you might find it of some use and benefit. Many of the things we have been talking about the last 2 days are in this report.

So this is with the compliments of Mr. Folsom.

Mr. ROGERS of Florida. Thank you very much. The committee

appreciates it. We will certainly go over it, and it will be of help to us in the work of the hearings.

Dr. HILLEBOE. Before we get into our final reports, we have not heard very much from a distinguished member of the Department of HEW, who is genuinely interested in an important part of our program. I refer to Miss Mary Switzer, an old friend of many of us for many years.

I wonder if you would let me ask Miss Switzer to make a few comments about the role of rehabilitation, the place of rehabilitation in the developing programs.

Miss Switzer.

Miss SWITZER. Thank you very much.

I would like to say that it has been quite educational for me to have been here and listen to the discussion, and it has been a temptation to break in in areas which may be none of my business.

But I would like to underline a number of things that have been said, particularly in the importance of health related agencies concerning themselves more intimately with the mental aspects of vocational rehabilitation.

Over the years one of the great problems that our program has had has been in getting adequate medical consultation, both in quality and quantity—this is in all areas of the work—partly because the program started first as an educational program, and so the medical aspects did not really come into it until 1943. But it has always been a struggle.

The State health departments now, with some of the shadows and prejudices of the past about the service behind us, perhaps in their involvement in the largely expanded medical care programs in the future, much could be done to utilize their skill and standards.

Traditionally the vocational program has had excellent relationship with the medical profession. We buy and procure medical services in the conventional way, so we have not been really involved in many of the arguments and disputes that have characterized others.

Since 1954 we have had a relationship with the social security program in the determination of disability under the old-age disability insurance plan, and the State rehabilitation agencies are very deeply involved in that, and rehabilitation costs for beneficiaries will be paid for from the trust fund as a result of one of the amendments to the law last year.

Just one or two other points. I think that we are contributing through our training program very substantially, although it still is far from enough, due to the personnel shortage situation.

We have the major support in the field for physical and occupational therapy, and for speech and hearing therapy, for rehabilitation counselors.

Our ability is growing. It is only the limitation of facilities and people to our giving increased support. We feel very strongly that this is going to be one of the great bottlenecks for the standard of service and amount of service in the future, if we are not all together on the economical use of personnel.

So I want to thank you, Mr. Chairman, and the committee, for the privilege of being here, and Dr. Hilleboe for his giving me a chance to say so, and to hope that among his recommendations will be an

earnest support to health officers to be a little more aggressive in their approach to the rehabilitation program.

We have a great deal more money to spend on medical care and services than we have had before, and we would like the cooperation of your group in achieving the objective of the best service.

Dr. HILLEBOE. Thank you very much, Mary.

We accept your challenge, and I am sure you will hear from the health officers.

Mr. Chairman, I would like to now begin the conclusion of our conference, which we will end at 5 o'clock. So I have asked three of the representatives from the three meetings to give a summary, very briefly and informally. We will ask each one to speak less than 10 minutes, if possible, and then we will have a short time for discussion before we close the meeting.

The person who will start the discussion will be Dr. Dennis, whom you recall reported at the first meeting.

Dr. Dennis.

Dr. DENNIS. Thank you, Mr. Chairman.

I, too, would like to express my appreciation for the privilege of being here.

I think rather than read a 10-minute summary of 5 hours of discussion, I will quickly present what I felt were clear-cut conclusions of what I heard, from the standpoint of my particular orientation, and I might comment on a few of these things.

Conclusion 1. It is agreed that health programs can have only one objective, that is, to serve people.

I think it is important to remind ourselves that even the country doctor, if you press him, will come up with exactly that same objective. We are not really as far apart as we might appear to be sometimes.

2. There is abundant evidence that fragmentation, duplication, and multiplicity of sponsored health programs do exist at Federal, regional, State, and local levels.

Some have expressed the opinion that this might even be good, that we did occasionally have dry rot in some of our agencies, and that perhaps a new look, a new approach, would be stimulating.

I think the validity of this philosophy is sound. However, I would object, for a more pragmatic reason, and that is that any kind of duplication of manpower requirements at this critical phase of transition in medical development in this country simply does not permit this kind of waste of manpower.

3. Component fragments of health programs are at present subject to no organized administrative mechanisms to coordinate participating interagency cooperation.

4. Agencies that are not primarily health oriented frequently require health programs as a means to accomplish their ends.

No one questions this but medical programs require medical judgments and a medical accounting of results.

A number of agencies, with health programs being used as a means to "their" ends, do not now appear to have appropriate medical consultation and supervision.

6. The Surgeon General's Office has the competency and the co-

operative spirit required to develop a participating coordination of interagency health programs.

7. Title XIX requires clarification.

With all that has been said, I will not discuss the matter further.

8. In the final analysis, health programs are skilled people at work. Skilled people are produced by education and training. The health manpower resources required for new programs do not exist and we will soon face the force of this truth.

There is evidence of a belated thrust to beef up health manpower programs, but again this is apparently being approached by an uncoordinated, fragmentation, duplication, and multiplicity of health manpower, educational, and training programs involving many different agencies.

I hope we do not have to meet here again next year singing the same theme song pertaining to the duplication and fragmentation of health educational programs, Mr. Chairman.

I am going to take the editorial privilege, if I may, of stating that it has occurred to me during this discussion that perhaps we should borrow a page from some of the very successful aspects of the Public Health Service program operations, and I refer to their excellent utilization of "blue ribbon," "gold plated" advisory councils, in which they have mobilized some of the best brains in this country and on a broad basis. Certainly many of the new programs require such an advisory council at State levels.

I would suggest that the thought be entertained of such a top level council for the health and health manpower educational programs, and include repersentatives from organizations such as the Association of American Medical Colleges, the American Health Association, and, yes, even the American Medical Association.

It struck me that we are here as a rather small group talking as if we control all of the health activities in this country, and we cannot and should not do so. I think the Surgeon General touched on this yesterday. We cannot ignore the mechanics of delivering health services, and the fact that there are 200,000 physicians in this country, and we must rely on their assistance, and we must enlist their support. Support cannot be imposed.

I would include others who are vitally interested, such as medical educators, other educators, businessmen, labor, and a broad spectrum citizen representation.

In addition, I would suggest that, perhaps, from the national level it might be possible to encourage the top personnel at the State levels who are ultimately responsible for the delivery and direction of health services, such as, the commissioner of health, director of the department of welfare, director of mental hygiene, director of State university medical centers, and the director of rehabilitation should sit down together, break bread together, and commune, and do it frequently, because it is they who will ultimately make health programs look good or bad.

Dr. HILLEBOE. Thank you very much.

The next person who is going to summarize our discussion is Dr. Kimmich.

Dr. KIMMICH. The second section was primarily devoted to the question of so-called bypassing State officials.

In summary, it seemed that some of the recommendations, and the kind of agreements that came out of this session had to do with the hope that we would all adopt a philosophy of operations which take place through responsibility and facilities at the State and local level, but which are supported in part by Federal funds and guidelines, rather than the other way around.

Another point was that we made a plea—we have done this all through the session, it seems to me—for full required, formalized participation in the formulation of policy and regulations by official representatives of both the mental health directors and the public health officers to the Department of Health, Education, and Welfare, rather than as a matter of information or as a catch-as-catch-can basis.

Along with this was the basic point of view that the State people, and their local counterparts, must do the implementation. They have the authority, they have the responsibility, they have the skills necessary to carry out these programs which are stimulated or supported financially at the Federal level.

Therefore, they should be full participants, rather than people to be informed and brought in whenever somebody happens to think of it.

Another point was an expression of feeling that all program grants at the State and local level should be approved at the State authority level before Federal approval.

Another was that State-by-State negotiations and alternative approaches allowing for differences in State circumstances should be a part of the Federal approach to Federal-State programs.

The hope was expressed that we not employ at the Federal level, ritualistic and symbolic representation by someone who is supposed to have represented, let us say, the State thinking in public health or mental health.

There has been a tendency to say, "well, such-and-such was on an advisory committee, and he represented State or local community thinking," when in actual fact no official representation was requested from a major national group, such as, for example, the State and territorial health officers.

Another point was the hope that short-term matching grants, the short-term matching grant philosophy and technique, be discontinued as a major approach to program and demonstration—to program grants primarily, hoping for the use of block grants, with a more indefinite period of grant survival, and with the full awareness that State accountability is proper, should be required, and should be quite specific.

At no time did anyone in the group express any feeling, as I recall, that there should be no strings at all to Federal grants, that there ought to be somehow a bag of money delivered to the State and a pat on the back, with no further comment.

It is quite the reverse. Accountability is well supported at the State level. But the hope is that a broader approach, a block approach, without quite so much of what we called "fine print" at one point, with considerable amount of accountability from the standpoint of fiscal program and program success evaluation, should replace the system of building in the strictures at the beginning. It

should be studied periodically to see if the program is doing what it was hoped to do. This approach would allow for State and local differences, and an easy State and local fit of the Federal program to their circumstances.

We hoped for a simplification of the Federal multiagency grant approach, and coordination at the Federal level of the various kinds of program grants, so that joint programing at the State level would be more easily carried out.

We have all run into this problem of having two or three or four departments trying to meet a common aim, each doing a part of the job, and find ourselves tripped up and unable to carry out smoothly such a program in concert, because of the multiplicity of regulations and categorizations which get in our way.

We would hope this would not be so in the future.

These were basically, as I saw it, some of the major points, and suggestions, and hopes expressed by the panel.

Mr. Chairman, I had some material which I simply wanted to refer to for inclusion in the record, but not to read.

Is this the time?

Mr. ROGERS of Florida. Yes, that would be proper.

Dr. KIMMICH. Shall I just present it, without reading the titles?

Mr. ROGERS of Florida. Yes. We will keep it on file as part of the permanent committee records.

Dr. KIMMICH. I will give it to the secretary.

Dr. HILLEBOE. Thank you very much, Dr. Kimmich.

The last report is by Dr. Sowder.

Dr. SOWDER. My topic is on flexibility and I found it very difficult to summarize these many very fine things that were said, but I attempted to do it.

I have a little four-page summary in written form for the record. I will give you the highlights of my summary.

Mr. ROGERS of Florida. We will accept it for the record.

(Statement referred to follows:)

SUMMATION—THE DESIRABILITY OF ALLOWING THE STATES GREATER FLEXIBILITY IN SPENDING FEDERAL GRANT MONEY

(By Dr. Wilson T. Sowder)

Discussion has traced the Federal support of State and local health services from the early programs of the Sheppard-Towner Act for MCH, the sections of the Social Security Act of 1935 dealing with health services, and the various amendments and later health legislation providing funds for grants to States.

These grants have increasingly had important and beneficial effect on programs. They have provided services, improved the quality of service, and States and local health departments have been stimulated to develop enlarged spectrum of services for which greater State and local funds have been made available. There has been successful accomplishments.

There seems to be unanimous agreement by State health authorities that there is increasing rigidity in the use of Federal funds to the extent that they are not being used as efficiently as everyone would like. Federal grantors may not feel the administrative requirements are unreasonable.

Three main measons for increasing rigidity:

(1) Multiplicity of Federal agencies and units involved,

(2) Tendency to minimize flexible general purpose health grants and favor categorical and project grants,

(3) Categorical and project grants administered by various units of the Department of HEW with different regulations and guidelines for use.

The impact of the rigid requirements has been felt within the last three to five years—and seems to stem from the rapidly developing shift toward the project type fund mechanism as a means of providing Federal support to today's health problems.

Discussion of the topic illicited some examples of cases where the State had little to do with the planning and responsibility but acted more as an agent of the Federal government rather than a partner. These also require rather inflexible administration. These include:

(a) VD Project Grants.
(b) TB Project Grants.
(c) Migrant Health Projects.
(d) Maternity and Infant Care Projects.
(e) Nursing Visits—Categorical Funds.
(f) State Contract For Certification of Provider of Service Under Medicare.

Project grant funds do have limited need, but to be used for disease programs and problems common to all or most States is not best. These needs could better be met with formula grant-in-aid funds. Apart from areas where project funds are suited, they have limited effectiveness. States find it difficult to really plan programs of the project type. As a rule the planning is at Federal level and handed down to States. This discourages the development of real State and local plans based on their needs.

Discussion pointed out some of the impediments such as variety of reporting forms, periods, project years; extreme detailed reporting requirements; difficult and costly methods of proving effort/or time devoted; validation procedures; and overlapping and inter-related purposes of many categories and projects. Lack of budget flexibility is one of the greatest promoters of wastefulness. Not only has the administrator little incentive to save, but as the end of the fiscal period approaches there is often an attempt to deplete the account so as not to leave an unexpended balance—which is always an invitation to cut back on that particular item in a succeeding year.

Need was pointed out for a new philosophy of long-range continuing support of health programs with Federal funds, rather than to limit funds to the initiation of new programs which are turned over to the States or local communities for continuation. Our present medical technology permits us to aspire to new goals of disease prevention, health maintenance, and longevity. These new goals will not be reached without a strong continuing partnership between Federal and State resources.

The States want to be partners with the Federal government—real partners. In order to have this partnership most fruitful it is desirable that we have a national health policy. We need to establish goals and objectives to achieve that policy and periodically determine progress being made toward the objectives. Such a policy would determine the general shape, direction, and character of our health programs. Within tihs framework the States then should have the responsibility to develop their own objectives and methods of implementing them.

Greater flexibility for the States is necessary in order that a proper foundation of basic health services may be developed. A series of unrelated specialized health programs further accentuates the fragmentation which is the bane of our health services.

State and local health departments are responsible and material branches of their levels of government. Understanding and cooperation between them and their governing bodies and the public are generally excellent. State and local legislative bodies constantly review their total health program and their total resources. There is effective State and local control and stewardship of health department activities. Federal health agencies have no monopoly on trained experienced personnel. Congressman Rogers during yesterday's discussion expressed confidence in State and local abilities to do a good job.

It was pointed out that performance and results are the goals really, and can be obtained more efficiently as real partners without the over-use of the "earmarked dollar" control applied to each program decisions.

The actual program development and implementation within the broad guidelines of the national policy should be a responsibility of the State agencies. Good administrative practice calls for maximum flexibility in the use of Federal funds at the State level. Federal funds should permit for alternative methods of accomplishing policy objectives. And only in this manner can we identify and accept better ways of accomplishing our goals.

Finally, we are not asking for a blank check, but reasonable flexibility with objectives well planned and accomplishments evaluated.

Dr. SOWDER. No. 1—and this is just some of the highlights—these grants have increasingly, the Federal grants, had important and beneficial effect on the programs in the States. They have provided services, they have improved the quality of service in the State and local health departments, and State and local health departments have been stimulated to develop an enlarged spectrum of services.

But there seems to be unanimous agreement by State health authorities that there is increasing rigidity in the use of Federal funds, to such an extent that they are not being used as efficiently as any of us would like.

The main reasons for this, we think, are the multiplicity of Federal agencies and units involved, the tendency to minimize the flexible general purpose health grants, and to favor categorical and project grants, and the fact that categorical and project grants are administered by various units of the Department of HEW, with different regulations and guidelines.

No. 3. The impact of the rigid requirements has been felt most within the last 3 to 5 years, and seems to stem from the rapidly developing shift towards the project type fund mechanism.

No. 4. The group seemed to say—well, there were some examples, let us say, of some of these problems where it seemed that the States are expected to act more as agents of the Federal Government, rather than as partners, as we would like them to be.

Examples were given in venereal disease control, TB project grants, migrant health projects, maternity and infant care projects from the Children's Bureau, then the project money from the Social Security Administration under medicare.

We agree that project funds do have a limited need to be used in certain areas, but many needs could be better met by formula, rather than by project grants.

The States find it difficult to really plan programs to be financed under the project type of funds. As a rule, the planning for project is really done at the Federal level, and handed down to States, and we think this discourages the development of real State and local plans based upon their needs.

No. 6. Some details were given as to impediments to efficiency, the variety of reporting forms, variety of periods, different project years, extremely detailed reporting requirements, difficult and costly methods of proving effort or time devoted, validation procedures, overlapping, interrelated purposes of many categories of projects, and so forth.

No. 7. It was pointed out there was a need for a new philosophy at the Federal level, and for long-range, continuing support with Federal funds of our programs in the States and in the local communities.

The States want to be partners with the Federal Government. But they do want the privilege, within broad outlines, of working out their own objectives, and the method of implementing them.

The actual program of development and implementation within the broad guidelines of the national policy should be, we think, a responsibility of the State agencies. Good administrative practice, we

think, calls for maximum flexibility in the use of Federal funds at the State level.

The Federal funds should permit alternative methods of accomplishing policy objectives, and only in this manner, we think, can we identify and develop better ways of accomplishing our goals.

Finally, we are not asking for any blank checks, but for reasonable flexibility, with objectives well planned, and accomplishment evaluated.

I have enjoyed this meeting very much. I think it is one of the finest I have ever attended. I think you have done a real service, Mr. Rogers, you and your colleagues, to the country, in holding this meeting.

Thank you.

Dr. HILLEBOE. Do any other than the members of the panel wish to make any additional comment?

Dr. Richmond, do you have anything you would like to add?

Dr. RICHMOND. Mr. Chairman, I, too, would like to express my appreciation for what has transpired here during the course of these 2 days. I know that the agency I represent has gained a great deal from the discussions that have gone on here, and the very thoughtful presentations that have been made.

I would just like to invoke my role as medical school dean, and representative of an agency, to make some comments on some of the issues we were struggling with yesterday afternoon, related to fragmentation.

Fragmentation, it seems to me, occurs in various directions through categorization of programs by disease, by region, and in terms of service areas. We spent a considerable period of time discussing that.

Then as in the case of my agency, there is categorization in terms of income group, as another approach to the delivery of services.

I would just like to say, Mr. Chairman, that I don't view these developments in any negative sense. I view them as a charge which Congress has given us to translate the knowledge which we have developed, particularly in the research laboratories of our medical centers in the country, into programs from which people will benefit.

I think that we are in a transitional period. Secretary Cohen talked about the transitional period we are in in terms of accommodating to the new social security amendments. I think we are also in a transitional period in accommodating to the various regional programs which are upon us.

It seems important to note that the disease categorical programs have largely benefitted those people who are already identified as being ill, and tend, therefore, to place a premium on the central resource, that is, the medical center, as a resource for the care of patients with complex and very critical kinds of illness.

It seems to me that the great unresolved problem which my agency faces, and which many of us are struggling with, is the needed increase in services, both quantitatively and qualitatively, in communities at the preventive level.

The kinds of programs that certainly the Children's Bureau and in the area of child health has dealt with so extensively in the years

past, the Public Health Service, and other agencies in HEW have dealt with.

I would just add one additional note in relationship to the regional programs which are emerging. We noted yesterday afternoon those in heart disease, cancer, and stroke, those in mental retardation, those in mental health, and the Children's Bureau in effect have programs which may be regional in scope—our agency has programs which could be regional in scope, and it seems to me that some of the issues your committee has been struggling with are extremely important in connection with the planning process.

Dr. Frechette emphasized this very cogently, and I would just like to add to this emphasis. It seems to me as the programs are proliferating, we stand on the verge of killing the geese that lay the golden eggs, in terms of the health planners in our communities.

That is, if we throw too many loads upon them, as separate discrete loads, it seems to me that we do run this danger of overtaxing the health planning resources in our communities.

It would be my hope that out of the deliberations of your committee we could indeed have some development which would lead us toward more effective planning structures, health planning structures, in communities across the Nation.

Dr. HILLEBOE. Thank you very much, Dr. Richmond.

We have two or three health officers who would like to comment.

Dr. Breslow indicated he would like to say a few words.

Dr. BRESLOW. Just a word, like the others, to express great appreciation for the opportunity of appearing before you these two days.

In thanking you, I would like to call attention to a couple of items. One is that the airing of feelings, as well as of viewpoints, and of history, in which we have engaged with you the past couple of days I think augers well for the future in this period of tremendous change.

In the assumption of new responsibilities and rearrangements and realinement of functions and relationships, tensions are bound to arise. I think all of us are conscious of this, even though some of us expose ourselves as victims, if you will, of the particular situation.

But we certainly must go through this process. I believe that this opportunity of appearing before your committee has been extremely helpful to all of us.

Dr. HILLEBOE. Thank you very much, Dr. Breslow.

We have a couple of other people.

Dr. Peeples.

Dr. PEEPLES. I would just like to make two brief comments.

I have been very much appreciative of the opportunity to be here.

One further is that any criticisms I may have made here of some of the various agencies; I think they are all doing such a good job basically that they can stand a little criticism.

Secondly, criticism of our own task. Here, if we are to get into basic support grants, and I recommend that we all refer to these grants, if the legislation, H.R. 13197 is passed, as basic support grants, rather than block grants.

In order to properly account for the expenditure of the funds, I think we have to develop goals which are more measurable than we

have in the past. This is going to take considerable planning in itself, to determine what these goals are, so that we measure them in as objective terms as possible, rather than the subjective terms that we have had to in the past.

I have very much appreciated being here at this conference. I think all of us would want to congratulate Dr. Hilleboe for making this conference run as smoothly as it has.

Dr. HILLEBOE. Dr. Stewart.

Dr. STEWART. Mr. Chairman, I want to thank you for the opportunity to participate in this panel discussion. I think you are to be congratulated for providing a forum for the airing of some problems which have been around for a long time, getting worse, and neglected, really, over a period of time.

I don't see how anything other than constructive suggestions and action can come out of this.

Thank you very much.

Dr. HILLEBOE. Dr. Philp. I want to thank you, too, Mr. Chairman, and also in thanking you, perhaps to voice something which has been concerning me this afternoon, because it appears that we have discussed and I think agreed on the problems of fragmentation, and multiplicity of grant activities.

I think we are now leaning definitely in the direction of comprehensive planning for public health programs, followed by some kind of substantial Federal support of State and community programs, which I would agree might better be titled basic support grants.

This means we will be in for a period of phasing in the comprehensive approach, and phasing out the categorical approach, and it means somehow we are going to have to glamorize the comprehensive approach, and deglamorize the categorical approach, and this may not be easy, and how do you handle this transition?

I think we are all aware that you and many others are under constant pressure from various groups to do something about disease "X" or condition "Y", and you have propositions before you in this present session of the Congress on new diseases which propose against a categorical approach.

So I just mention this, because I think we all have a job to do to move this transition, if this is the direction that we are going to take, and I certainly hope it is.

Dr. HILLEBOE. Thank you very much.

Dr. Winston, we would like to hear from you.

Dr. WINSTON. Thank you, sir.

I, too, would like to express my appreciation for being here.

I don't normally have the privilege of appearing before this committee, as do my colleagues from the Public Health Service, so this has been an added privilege for me.

I have said on many occasions, and I think it is appropriate to reiterate, that along with a strong welfare department providing services to people wherever they live, it is our hope that there will be strong health departments, also providing services to people in every locality.

We have deliberately, as has been acknowledged here, consulted the State health directors as we have moved into the legal intricacies

of title XIX, and we look forward to the increased relationships that we shall have in that connection.

I think we can only view the future insofar as it relates particularly to the new legislation with great hope because I see it offering not only the opportunity to provide certain medical resources for people that we have been unable to provide up to this point, but also that, of necessity, State health and welfare departments and the Federal agencies will have to work more closely together.

I want to assure you the full cooperation of the Welfare Administration as we go forward.

Dr. HILLEBOE. Thank you very much.

Mr. Chairman, I have only one regret in our meeting the last 2 days. That is, we were going to take the first hour this afternoon to discuss with you the question of evaluation of results and measuring cost-benefits.

May I just say in passing, because the hour is late, and I do not want to get into it, because it would take at least a full hour, that the Public Health Service and the Children's Bureau and the State and local health departments have been very conscious of the deficits in arriving at cost-benefit relationships.

We recognize, as you said yesterday, we really have to discontinue our efforts to measure effort, and get into measuring effects. This is going to require the most skillful kind of managerial ability.

We are not talking here about research, and trying to find why the cell works the way it does, or biological research. We are concerned about what we call epidemiological research, which is the research on the disease and its effects.

We are concerned with research on social science. Why do people act the way they do about health? Why can't we get people in Harlem, where health services are available and accessible, to use the services?

These are human motivations. These are human feelings and cultural patterns.

The third area of administration research, operational research, is trying to make better use of the moneys we have.

Those of us who have been in this business for 35 years, as I have, know that you very seldom save money of the kind you can hand over to the Budget Director or hand over to the Congress. You can sometimes make better use of the money that you have.

I believe that this is perfectly sound. It is in this area that health departments and mental hygiene departments and welfare departments must concern themselves, with cost benefits. In other words, we have to consider input in relation to output.

I think I can assure you that many of the States—Dr. Breslow's is one—have been doing some outstanding studies over the past years. There are other States that I could mention.

The Public Health Service, under Dr. Stewart's capable leadership, when he was in the Division of Public Health Methods, began to study the question of how do we evaluate the results of what we are doing.

This means we are going to have to cut out some of the things that are obsolete or that are no longer productive, get out of this busi-

ness of counting noses—how many visits do we make—to how many children do we give tuberculin tests.

We have to start thinking of results. How many active cases of tuberculosis do we get under medical care, and get their sputum to be negative?

I want you to know that we are very conscious of this problem, and know it is a very important one.

If you will give me the privilege of just taking a few minutes, because we are not yet at 5 o'clock, I would like to summarize a few things, as the elder statesman in the group. After all, I did start working in public health in 1932, which is 34 years ago. I think some of my colleagues here whom I have had the privilege of working with over the last 20 years will let me do this.

First of all, I would like to say that perhaps you have a better idea, because of these 2 days, you and Mr. Younger and Mr. Van Deerlin, of the complexity of supplying health services to the people.

It is a fantastically complex operation. As health officers we have to be generalists. We have to know something about TB, syphilis, schistosomiasis, any disease or disability—you name it—we have to learn something about it.

If we just brought across to you the idea that this is a tremondously complex thing, this is important.

The second point, and I am summarizing the summaries, is that we need to pull together these things from a general viewpoint—because I was not a participant, perhaps I can do this, and it will take a very short compass of time.

It is obvious there is need for a principal health agency in government. Unless someone can come up with a better agency, it should be built around the Public Health Service.

Whether we turn it into a Health Administration, whether we call it something else, we really need to have a principal health agency in the Federal Government, preferably in Health, Education, and Welfare, because this is the area of human resources.

Dr. Stewart spoke about this, and it is necessary to have it, because we have to have one group responsible for policy and for planning, not for HEW, but policy and planning for the United States of America.

I make no distinction whatsoever of the groups involved.

This immediately brings up the point that as soon as such an agency is designated, this agency must come up with a national health plan.

Mr. Chairman, we do not have a national health plan. We have disease plans, and we have had other plans, and we have maternal and child health plans. Even such a thing as welfare is split up into half a dozen categories.

Some way, somehow, we need to have a national health plan, reconstructed at intervals, and this should be for the use of the President, for the Members of Congress, and for all of the Federal agencies.

I am sure if you gentlemen had the opportunity of referring to a national health plan, to see whether or not new legislation should be set up on a categorical basis or as part of an existing program, if

you found where you could attach something to an existing program, this is always a better thing to do.

It is always unwise to set up a completely new organization, such as was indicated in Welfare—this idea of setting up a commission in State government of several units, where you already have existing departments that can be utilized.

Anyone who knows anything about organizational theory in making profit in business knows that you do not set up additional units if you already have one that will produce a profit.

So, this is the sort of thing that this group could do.

In general support grants that were particularly emphasized by Mr. Younger, I think really that is the key to the whole thing, this idea of general support grants.

I think, too, in the meantime, there are some things we can do to join forces. Certainly Dr. Yolles should be concerned with, and should concern himself with the idea of pulling together physical health center resources with mental health resources, because here we are dealing with both the head and the body.

It reminds me of a meeting of a farm group up in Ithaca a few years ago. One of the farmers went to this meeting, and the man talked about psychosomatic medicine. When the farmer went home to his wife after the meeting, his wife asked, "What did they talk about?"

"Well, there was an expert there, an expert on psychosomatic medicine."

"What in the world is that?"

He said, "Well, it seems some of these bright doctors have just discovered that the head is fastened onto the body."

It is this kind of thing that we need to recognize.

I am sure that without interfering with either one geographically in our large cities especially we can bring our facilities together, so that our experts in mental health and our experts in physical health will contact each other. We will save money, as we do in our hospital survey and planning groups.

Likewise, in health and welfare, we have to join forces.

There are many paths. I don't think we have to interfere with any State, and there are a half dozen ways of doing it.

Mr. Cohen presented five methods of going forward with title XIX. I think there should be "X" number of methods. I don't think it should be limited to five. There could be 16 methods. The methods should be limited to those which will help.

We need in addition to health and welfare to look at public health and mental health. We need to look at the great area of school health and school health education.

The future of our country depends upon a population of young adults who form the core of our married families, of our married men and women, who know what health is, and who practice it.

The only way we can do that is to get them when they are young. We are greatly deficient here. I think here Dr. Stewart and his colleagues in education need to face this problem.

One thing that was not mentioned was the Food and Drug Administration and other health activities. Food and Drug is for the purpose of preserving health. It has no other purpose. It is

not mainly to regulate industry. Its ultimate purpose is to protect the health of the people.

I am simply mentioning some of the things that might be of use.

Another point that has come out is that obviously the Health, Education, and Welfare group must put its own house in order to set a pattern for the States.

In a similar manner, the States must put their houses in order, because they are not in order. They are badly fragmented.

I would think that neither the Federal Government nor the State government should be the first one to cast stones. I cannot see any reason why this clarification cannot go forward.

If this were done, it seems to me whenever the President or Congress comes up with a new program, one can very simply refer to these groups to get the kind of information that is necessary.

We specifically talked about bypassing. I think this morning some things were said about the business of monitoring, the business of a clearinghouse.

This is something that can be done, because this is what we do in business, to carry on a good business.

The question of flexibility: I had a little impression this morning that we were nitpicking, but maybe this is not so. To the men who are fighting this each day, this becomes terribly important. Nevertheless, these problems were brought up.

I would say finally that out of this whole thing the key issue is the health manpower shortage.

You emphasized this time and again, Mr. Chairman, in our discussions on the 75–50 percent thing. You emphasized it on the duplication of people.

We don't have enough manpower to go around. I would think that we have to take some urgent action. This is an emergency situation. I think what is being done at the present time is not enough.

I know that the Public Health Service, I know HEW, is concerned about it, but I would think this is an emergency situation of the kind that Vietnam is in the Defense Department. The manpower situation is that kind of an emergency in the health field.

It is not just a question of getting enough of certain people. In business we don't use a $15,000-a-year man if we can use an $8,000-a-year man to do the same thing. We don't use an $8,000-a-year man if we can use a $4,000 clerk.

So we can't use expensive nurses if we can get some clerks to do the bookkeeping. We don't use a dentist if we can get a dental assistant to fill teeth.

This perhaps is radical, but we need some radical changes.

I am mentioning these things because it seems to me your committee in just 2 short days has crystalized some of the things that need to be done.

I can assure you that through the executive committees of the State and territorial health officers, and State mental health directors, we will pass on these bits of information and see if they can follow through on them.

As your moderator, I want to thank you for the opportunity of appearing before you and Mr. Younger and Mr. Van Deerlin.

You have been very sympathetic. It has been an honor and privilege to work with you.

I return the meeting to you.

Mr. ROGERS of Florida. Thank you very much.

Mr. YOUNGER. I want to express my thanks. We have had other panels since I have been serving on this committee. I think this has been one of the most productive panels we have had.

Part of the difficulties arise from our own legislation. One of the difficulties that we have here in the committee, and I recognize it, for it has been brought up several times, is that the health bills come up here, and we pass it without any relation at all to what the next bill may be, or what has come before this.

That is a difficulty which I saw with this international health bill that came up the other day. We have three other bills. To me, we ought to consider legislation not by piecemeal, but to find out how these bills are going to be dovetailed together.

As I say, part of this fault we have created ourselves, the fact that we do not ourselves have a good legislative plan on health, or a program.

I think part of the fault comes from the administration sending up these bills. It was brought out the other day, we legislate, appropriate, authorize money for medical schools, for colleges, for nursing homes, and so forth, and then the administration sends a letter to all the Governors that they can't use it, you are not supposed to expand, you are supposed to cut down your construction.

We get this all the time.

I always revert back to my philosophy that it would be a wonderful world if it were not for people.

I have enjoyed this panel very, very much. I think you have all contributed a lot to our organization.

Mr. ROGERS of Florida. Mr. Van Deerlin.

Mr. VAN DEERLIN. One of the continuing problems in government is communicating between the field of expertise and the field of laymen. Congress is made up mainly of laymen. We are all laymen in most fields, of course. I think there are only three physicians in the entire Congress.

So this demonstrates how important is the job that you undertook to do in this panel. I think you have all done a very adequate job of communicating.

I recall once when Jim Farley was asked about how he found it possible to contribute to Government with his very slight educational background, he made the point, "Well, you can't sit in this Cabinet for 4 years or 8 years with the kind of minds that are represented here without learning something."

In 11 hours of yesterday and today, I have been bound to learn quite a bit.

I appreciate your part in that, and I would not want to miss the opportunity, because I think I can do it without appearing to be fawning—I want to say I am quite impressed by the full year of preparation that Paul Rogers has put into the work of this subcommittee, and the very faithful response that he gave the committee chairman, the preceding committee chairman, and the manner in

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which he has prepared himself, and the staff, for a very exacting task.

The proof, of course, is going to be what comes out of it. We will know in the months ahead what we have there.

I think you have done an absolutely exemplary job, Mr. Chairman, in bringing the committee to this point. Let's hope we get the results that all of these panelists are hoping for.

Thank you.

Mr. ROGERS of Florida. It is always good to have friends, you see, as your colleagues sitting on the committee. I could not have had two finer friends with me during this meeting, and who have been faithful throughout.

Particularly I want to express the committee's thanks to each of you for taking your time to come, the representatives of the Departments who have taken time from their very busy lives, and I know how busy they are, for you to come to be with us. It has been most helpful.

Of course, to each of you on the panel, who have left your individual States and traveled here to make a contribution, I think it has been a real contribution. I have been very pleased with the entire hearing, but particularly with the panel.

I think we have had brought out in the open many problems that needed to be discussed, and we have had discussions with the right people. So I think we have a better understanding of what can be done, and the role that each is to play.

I hope our committee, and I am sure it will have as its purpose, will try to follow up now, to see that some of these suggestions are carried out.

I would hope that in the field of manpower, which I do think is most important, that our State health officers will be brought in on this problem more than they have. There is no reason why State health officers should not be brought in to help train manpower, encouraging junior colleges in the business of training nurses.

There are so many problems to be met in the health field that I think a periodic getting together will be very helpful, particularly our State health people and our top administrators of the Federal programs. I hope this can be done, because there were many misconceptions that existed that have already been straightened out, just by talking with the people who are really responsible for the program. So this is most helpful to us.

We are grateful to each of you.

If we may leave it on this basis, we may call you again for further advice, and whenever you have information that you believe will be helpful to the committee, we hope you will communicate with us.

Thank you all.

The committee is adjourned until further call of the Chair.

(Whereupon, at 5:05 p.m., the committee adjourned, to reconvene at the call of the Chair.)

INVESTIGATION OF HEW

FRIDAY, MAY 27, 1966

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON HEW INVESTIGATION
OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. ROGERS of Florida. The subcommittee will come to order, please.

Mr. Secretary, we are very pleased to welcome you to the committee again, and your associates. The committee, as you know, has been making a study of the Department now a little over a year and we want you to know that we have had excellent cooperation from all of the Department's agencies and we are very grateful for that. It has been most helpful. We hope that when we finish our hearings we can write a report that can be helpful to you and to the Department as well as to the Congress.

We are very anxious to go into the details of the reorganization that has been proposd by the President, and I think we are fairly knowledgeable on many items since we have been studying this for approximately 1 year now. But we are particularly anxious to have your comments, and those of your associates if you so desire, and then a few questions afterward.

We are delighted to welcome you here and would appreciate receiving any testimony you may desire to present.

STATEMENT OF HON. JOHN W. GARDNER, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. WILLIAM H. STEWART, SURGEON GENERAL; DR. PHILIP R. LEE, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS; AND DONALD SIMPSON, ASSISTANT SECRETARY FOR ADMINISTRATION

Secretary GARDNER. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to appear before your committee. I would like to tell you something about our plans to strengthen and revitalize the health functions of the Department of Health, Education, and Welfare.

In particular, I want to talk about the President's Reorganization Plan No. 3 of 1966, which was transmitted to the Congress on April 25. The plan, as you know, provides for the reorganization of the

health activities of the Department, with specific attention to the programs of the Public Health Service.

I know that you are as concerned as we in the executive branch that the vital, and expanding, health activities of the Federal Government be conducted in as efficient and up-to-date manner as possible. And I believe the members of this committee, above all others, appreciate the need for organizational reform.

You have devoted a great deal of time and attention to the study of health activities. You are fully informed on the current organization of these activities in the Federal Government and you are aware of the problems that this organization presents. You have heard testimony from outstanding health leaders and have weighed a number of alternatives.

I cannot tell you how gratified we are by your interest and concern. I believe we need this kind of searching inquiry and dialog to help us reach our common goal, which is better health for all of our people.

I am convinced that Reorganization Plan No. 3 will enable us to move toward that goal. It is a step in the direction that this committee has so clearly identified.

In his health and education message to the Congress, the President said that "our first concern must be the efficient and effective administration of the Federal health programs." He announced that he would submit a reorganization plan to modernize the administration of these functions.

Reorganization Plan No. 3 is the result.

The plan provides for the transfer to the Secretary of all functions of the Public Health Service, of the Surgeon General, and of all other officers and employees of the Service, and all functions of all agencies of or in the Public Health Service, except the statutory councils, boards and committees. It abolishes the four statutory bureaus of the Service and the statutory offices of the heads of these bureaus. And it authorizes the Secretary to provide for the functions so transferred, along with records, property, personnel, and funds.

As you will recognize, this is a standard reorganization plan of the sort recommended by the Hoover Commission and since put into effect in almost every major department of the Federal Government. Its sole purpose in the present instance (as in all earlier instances) is to place in the hands of the Secretary the power to reorganize (now and at any future time) as the requirements of the times demand. In these times of rapid change—and the necessity for swift adjustment to change—such flexibility is crucial.

Unlike most other governmental units, the Public Health Service organization is fixed by statute. The four present bureaus of the Service were created by law in 1943, and that organization was carried over intact in the Public Health Service Act of 1944, which codified all PHS functions.

In the 23 years which have elapsed since this structure was created, the Congress has assigned 50 major new responsibilities to the Public Health Service. The budget has increased more than 4,000 percent—from $52 million in fiscal year 1943 to $2.4 billion in fiscal year 1966. The staff has doubled, increasing from 17,000 to 34,000 employees.

In short, the Service has undergone enormous growth in the past two decades. Yet an outdated statutory restriction prevents us from making the basic structural changes necessary to accommodate this growth.

The result is organization rigidity and incongruity. The existing bureau structure, with the exception of the National Institutes of Health, is simply too inflexible to meet today's needs. Many of the new responsibilities of the Service cannot be narrowly compartmentalized in the old organizational categories. They call for a combination of activities—research, service, training, and cooperative enterprise with State and local agencies.

But there is something of even greater importance. The Public Health Service should be the agency to which organizations and individuals throughout the Government turn for advice on all matters related to human health. It should provide professional guidance for the health-related activities of other agencies of HEW and the Federal Government generally. In short, it should exercise national leadership in health.

As presently constituted, however, the Service is hard put to administer its own greatly enlarged responsibilities efficiently, let alone discharge its guidance and leadership functions.

To prevent stagnation, organizations must continually renew themselves. This is compelling when we consider the complexity and dynamics of administering the affairs of this Nation. The very size and nature of the Federal Government make it particularly susceptible to stagnation. We should, therefore, make special efforts to build in arrangements for renewal.

It is difficult enough to sustain an environment of creativity and renewal for most large and complex organizations even under the best of circumstances. When our hands are tied by archaic restrictions, it is almost impossible.

To be sure, no large-scale organization can exist today without being divided into bureaus, divisions, and branches. But no organization should have to exist with organizational arrangements made 20 years ago to serve vastly different problems.

This is what has happened to the structure of the Public Health Service. It gives neither the Surgeon General nor the Secretary the flexibility we need to administer our present health programs effectively, nor does it permit us to take full advantage of the explosion of medical knowledge to plan for the health programs of the future.

I invite you to compare, for example, the relative ease with which we were able to reorganize the Social Security Administration in order to provide for the medicare programs, with the rigidity which prohibits an effective reorganization of the Public Health Service. Similarly, in other recent reorganizations in the Department—the Office of Education and the Food and Drug Administration—we were not hampered by the restrictive barriers which apply to the Public Health Service.

If we are to move our health programs forward, it is essential that the Secretary have authority to adjust the organizational structure and distribution of functions within the Department in ways best calculated to reach the goals set for us by you in the Congress.

Through the improvements envisioned by Reorganization Plan No. 3, the President said, "we can achieve the full promise of the landmark health legislation enacted by the 89th Congress."

Reorganization Plan No. 3 simply provides the Secretary wth authority to reorganize. It does not specify what form the reorganization is to take. But I made the decision some time ago that when the plan went up I would tell Congress quite explicitly what I intended to do if I were given the authority.

Briefly, I propose to put into effect a plan developed by the Surgeon General with the advice of a committee of distinguished citizens chaired by Dr. John J. Corson of Princeton University.

The plan calls for organizing the Public Health Service into eight major components: The Bureaus of Health Services, Health Manpower, and Disease and Injury Prevention and Control, National Institute of Mental Health, the National Institutes of Health, National Library of Medicine, National Center for Health Statistics, and the Office of the Surgeon General.

I will describe each of these in turn.

The Bureau of Health Services will serve as a central resource for improving the quality and accessibility of health care for the American people. It will include all PHS activities concerned with quality standards for health service. It will combine direct medical care programs with those which support new and improved personal health services.

The Bureau of Health Manpower will have the primary concern for building an adequate supply of health manpower for the Nation. It will be responsible for projecting manpower needs and developing programs to meet them. It will serve as a central point of information for educators, administrators, and others involved in the training of professional and subprofessional health workers.

The Bureau of Disease and Injury Prevention and Control will consolidate all PHS activities in preventing and controlling disease, disability, and accidents. It will monitor contaminants in the environment which may be harmful to health and work to prevent illness and death from environmental factors.

The National Institute of Mental Health, as a bureau, will be responsible for the rapidly expanding national program for dealing with mental illness. It will incorporate the present functions of the existing Mental Health Institute, plus the Fort Worth and Lexington psychiatric hospitals. It will administer a unified program of research, manpower training, demonstrations, and mental health services. It will also serve as the principal focus for research and control programs in alcoholism and drug addiction. The National Institutes of Health will continue to have a supervisory relationship to its intramural research program.

The National Institutes of Health will remain a bureau of the Public Health Service, in parallel with the other bureaus, and will continue to serve as the principal medical research arm of the Department. It will be strengthened by the addition of an environmental health sciences institute.

The National Library of Medicine will retain its existing functions, including the programs initiated under the Medical Libraries Assistance Act of 1965. We are considering measures to further strengthen

and consolidate the scientific and professional communications functions in the National Library of Medicine.

The National Center for Health Statistics will continue to serve as the principal national source of reliable statistical data on health. I also expect to make further studies of the relationships between the National Center for Health Statistics and other data-gathering units of the Service.

To assure efficient administration for the numerous programs of the Service, we plan to strengthen—and, to some extent, reorganization—the Office of the Surgeon General. The proposed changes will be designed to achieve better coordination among the grants programs of the Service, to establish uniform management policies and practices, and to create a central point of contact within the Service for all programs involving other agencies and institutions.

In addition to these organizational measures, I see a great need for improving our capability for planning and coordinating the Department's health programs and for continually reviewing their effectiveness.

The members of this committee are well aware of the interrelated nature of the health programs of our Department.

For example, the Public Health Service shares responsibility for administering the medicare program with the Social Security Administration and the Welfare Administration. Of the eight agencies of the Department, at least four—the Public Health Service, the Welfare Administration, the Vocational Rehabilitation Administration, and the Office of Education—have responsibilities in the field of mental retardation. Other programs which cut across agency lines are aging, alcoholism, juvenile delinquency, drug abuse, environmental contamination, and training for the health professions.

Portions of these programs fall in different organizational boxes, but they must be dealt with as a unit. They are, in fact, serving to pull the Department together, to coordinate its health activities. New management techniques are very helpful. We are confident, for example, that effective application of the planning-programing-budgeting system, now being emphasized throughout the executive branch, coupled with advanced systems analysis techniques, should pay great dividends. Essentially, however, it is the unifying nature of our mission and the flexibility of our organization that will enable us to move forward in all of these programs.

In summary, the rapid growth of Federal involvement in health has made the present Public Health Service organizational structure obsolete and dictates a need for improvement. The structure must be adaptable to change. Flexibility is essential—flexibility to make changes now and continuing authority to make further adjustments as our functions, responsibilities, and workload change.

Reorganization Plan No. 3 of 1966 is designed to give us that flexibility in order to meet the great and growing needs of the future.

Mr. Chairman, I am therefore strongly urging the Congress to permit this plan to take effect without delay. It has a high priority on the President's agenda for a more effective Federal Government.

Mr. ROGERS of Florida. Thank you very much, Mr. Secretary, for your statement and for setting forth the reorganization that you

plan to effectuate as soon as the reorganization plan is approved by Congress.

It is my understanding that if Congress does not adversely act on this plan, it will go into effect June 25.

Secretary GARDNER. Yes, sir.

Mr. VAN DEERLIN. Mr. Gardner, is it your expectation that the Office of the Surgeon General under this reorganization plan will exercise a little more direct authority in the field of the National Institutes of Health than appears to have been exercised in the past?

Secretary GARDNER. It is my belief that the Office of the Surgeon General in the past has been considerably handicapped in its capacity to have command of the forward planning and the data and the kinds of information about the whole Public Health Service that it needs in order to do an effective job.

I would not single out the National Institutes of Health as a particular problem, but I believe that it shares with all of the other parts of the Public Health Service the need for some kind of forward planning with respect to health activities generally. Not only in the Public Health Service, but in the Government.

Mr. VAN DEERLIN. The NIH, of course, has been the fastest growing of all. I think that the impression left with the committee was that we have been pretty lucky in the past the way this has worked but that this luck was something that perhaps we could not bank on forever, and that one desirable objective was to bring the program more directly within the purview of the top.

Secretary GARDNER. Let me say two things about that.

First, I do not think I would have chosen the word "lucky." I believe that some very good and far-sighted efforts produced the good results in the National Institutes of Health.

Mr. VAN DEERLIN. I would agree with that.

Secretary GARDNER. And all of us at this table have a very, very high regard for Jim Shannon and his capacity for leadership.

My concern about strengthening the Office of the Surgeon General applies not only to the National Institutes of Health but all of the Public Health Service and all of the health activities in Government. I feel that the Office of the Surgeon General ought to be the focus of health activity in this Government, and I choose the word "focus" because I do not mean point of control, I do not mean an organization category, I mean it should be sufficiently staffed and sufficiently on top of the movement in the future of health activities so that the Surgeon General can exercise the kind of leadership which his title would suggest.

Mr. VAN DEERLIN. I know some other members are going to explore the environmental health field a little more fully, but you know the feeling has been that perhaps environmental health is being downgraded a little in the reorganization plan. Those of us who come from areas where water pollution is a problem, or, as in my case, air pollution in southern California, have some concern about the continuing watchfulness and research activity in this area.

I wonder if you feel our fears in this direction are groundless.

Secretary GARDNER. As a native of southern California, I share your concern about air pollution. I am personally very strongly

interested in environmental health. I am determined that our Department will take an aggressive and imaginative approach to this field. It is pretty clear that we have a special mandate in the field of environmental health. It is a big field. To the extent that it can be dealt with adequately, it will have to be dealt with by a number of departments. But we are clear as to what our mandate is and we are going to press it aggressively.

I would like to have the Surgeon General comment a bit further on this because I know he shares my interest and he will have one or two comments on the question.

Dr. STEWART. I can assure you in proposing the reorganization I have no intention of downgrading the environmental aspects of our health programs. In fact, I was trying to do just the opposite.

Our function in approaching this problem of what we call "the quality of our environment" has to be firmly based on health considerations. Our job is to make sure that the hazards that are in our environment do not hurt you, cause illness, cause injury, and to do what we can to prevent these things from occurring. This is where we take off from. We must have a solid foundation. In our programs in the environmental area we are trying to prevent disease or injury, or control disease or injury, by detecting what contaminates the environment, whatever piece of the environment we are talking about—the air, the water or anything else.

The reorganization plan does not propose any change in the present Division of Air Pollution. It will remain the same. It will report to the same bureau chief it now reports to.

Dr. Prindle spent 6 years in the air pollution program. He is terribly interested in it. We have talked about how we might increase our activities.

I believe, on careful examination of what we are trying to do, that we come out with a stronger approach to detecting the hazards in our environment and to doing something about them than we have had in the past.

One additional thing. Particularly in air pollution, but in all of the areas of pollution, one of the unknowns in many of these fields is what do low amounts of these contaminants in the environments do to a human being. It does not make any difference how they get to a human being, whether it is through the air or water or soil or food. The question is the total amount that this person is getting at any one time. Generally, this amount is below any level which creates any visible disease or injury in most instances.

We need to be much better equipped to find out what low doses of various contaminants in the air or water or anything else, particularly the amount that is getting to the person, actually do to a living organism, human beings. This is why the new toxicology which has emerged from the new field of molecular biology is so important in trying to examine what these low doses do. The major developmental centers of molecular biology are spread around the country, but really developed in the intramural programs of NIH. This is where our strength in this environmental area is. This is why I thought it was wise to transfer the Environmental Health Sciences Center, which is proposed for the North Carolina Research Triangle, to the jurisdiction of NIH, because they would be able to have an input of scientists

into this which would be more difficult to get in some other organization.

I think this will strengthen our efforts in that part of the environmental health programs. I think it adds up to a strengthening of our approach to environmental health.

Quality in environment involves many things. We have had great talk about them, beautification, highway billboards, signs, litter on the streets, contaminants in our air, contaminants in our water, noise in our cities, and you can go on and on.

It really involves almost the entire structure of the Federal Government; and society, I might say. But our primary role relates to the health aspects—that we make sure that whatever is in the environment is not causing disease, is not causing injury; and if it is, that we do something to get rid of it.

Beyond that we should have our role to cooperate with other agencies who have the primary responsibility in that area, such as, for example, the Department of Agriculture. This was the thinking behind this.

I was trying to put together the functions which I thought had common purposes, and the functions I put together in the Bureau of Disease and Injury Prevention and Control have as their purpose disease and injury prevention and control. They use common methodology of surveillance and epidemiology and monitoring and measurement.

In addition to the common methodologies utilized, the various programs within this Bureau utilize different means of doing something about whatever the thing is that is causing disease. If it is measles, we will use a vaccine. If it is lead poisoning, we may do something else to take it out of the environment. The methodology is different. One may be immunization and one may be engineering the ventilation in a factory. But the common purpose is to prevent injury, prevent disease or control it as best we can. This gives us then the primary responsibility for setting those standards of the environment which we think will avoid disease or injury, or which we can prove will not cause disease or injury. This is the thinking behind it.

Mr. VAN DEERLIN. Thank you.

Mr. ROGERS of Florida. Congressman Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

Mr. Secretary, normally a reorganization plan is proposed for the purpose of efficiency and economy in Government. You have stressed the efficiencies that you expect to get but you have said nothing about any economies.

Is this going to decrease the number of employees or increase it, or cost more money or what?

Secretary GARDNER. I think the three gravest wastes of money in organizations are: first, the pursuit of outworn objectives; second, the fractional use of personnel because their talents are not being used fully or because they are in a rut; and third, outworn organizational structures that do not permit you to do the job effectively. This addresses itself to the third of those sources of waste. I consider it a very serious one.

I believe that by doing our job more effectively, by organizing ourselves so that we can attack the job effectively, we will in effect

save money. We will make the dollars go further. We will get more out of the dollars.

Mr. YOUNGER. How about the number of personnel?

Secretary GARDNER. I do not see any likelihood we are going to be able to reduce the number of personnel.

Mr. YOUNGER. Do you see any likelihood of it increasing?

Secretary GARDNER. I would say that a certain amount of increase is built into the programs which were passed by the 89th Congress, and I suspect that further increases will come from additional programs. But we are not planning increases to do the same job that we are now doing.

Dr. LEE. I would like to add an additional thing on that, two things actually.

I think with the new organization in the Surgeon General's Office and the planning-programming-budgeting system we are clearly going to be able to identify overlapping areas, or areas of duplications. I think in this effort we may effect significant savings. In the reorganization that the Surgeon General has proposed the Bureau of Health Services will examine new approaches to the delivery of health services in the community, working with organizations in the community, which could result in considerable savings for individuals, communities, and the Government.

We know that the costs of medical care are among the most rapidly rising of any in our economy. I think that through some of these new approaches that will come from this reorganization that we may have some profound effects that will save far more money than we imagine at the present time. I think the potential is great for significant savings to the taxpayers in a very direct fashion in terms of what he pays for his medical care. I think this is an important but indirect benefit that can flow from this reorganization.

Mr. YOUNGER. One of the reasons we authorized the Reorganization Act of 1949 was "to reduce expenditures, to promote economy to the fullest extent consistent with the efficient operation of Government." That was the reason for this reorganization plan. Then it says also "to reduce the number of agencies by consolidating those having similar functions under a single head."

I do not see anything in your plan where you are reducing the number of agencies.

Dr. STEWART. No, sir, there is not any reduction, Mr. Younger.

As far as your question about the budget, the total amount of funds and number of positions to be available are those we now have in the 1967 budget should the Congress permit the establishment of what we have proposed as the bureau structure in this reoganization.

Secondly, as far as economy goes, this is one agency which has a common purpose—the health of the people. It is principally to make it more efficient. That agency is now in the same organizational structure it was 23 years ago and yet it has many more programs aimed at the primary function than it every had before, and they all must be, by law, put into one of three operating bureaus. The structure has been fixed for 23 years. We are going to carry out the same programs with the same people but we should be able

to do it much more efficiently than we are doing it at the present time.

Dr. LEE. I think also, Mr. Younger, without the reorganization it will be necessary, for example, to develop a large medical unit in the Welfare Administration to provide the medical leadership that is needed there. With this new reorganization the Public Health Service can much more effectively provide that leadership to and with the Welfare Administration in the title 19 program. It already provides health personnel and medical leadership to a number of other organizations, the Coast Guard, the Bureau of Prisons, and the Peace Corps, for example. There are a number of other areas where it relates with outside organizations. I think that with the proposed reorganization the Public Health Service can much more effectively carry out their responsibilities.

Every year there is an enlarging area of responsibility for the Public Health Service. Without the reorganization it will become increasingly difficult for the PHS to provide this additional, and a very important role, of leadership throughout the Federal Government.

Mr. YOUNGER. But you think this reorganization will not only provide for more efficiencies in the administration of the HEW, but also you think it has the potential of saving some money?

Dr. LEE. I think it has the potential for saving money and I think it also has the potential for reducing the need to develop medical or health units in other departments and other agencies, some within the Department, some in other organizations.

Mr. YOUNGER. So that if that potential is not reached, then it is the responsibility of the Secretary; is that right?

Dr. LEE. I think it is the responsibility of the Office of the Secretary, and certainly he will give every attention to this.

Mr. YOUNGER. Do you accept that responsibility?

Secretary GARDNER. Yes, sir.

Mr. YOUNGER. What is going to happen to the Corps?

Dr. STEWART. The reorganization plan does not affect the Commissioned Corps other than to vest the present authority of the Surgeon General in the Secretary. This has nothing to do with the personnel system itself.

Secretary GARDNER. We have some plans.

Mr. YOUNGER. That is what I wanted to know. I wanted to know what your plans are.

Secretary GARDNER. We have not finished working them out and that is why we did not make any reference to them. Developing changes in a personnel structure is a long and arduous business, I find, and we are still debating it with everyone in town.

Mr. YOUNGER. I think that may be an understatement.

Dr. STEWART. Our personnel proposal is now in the Bureau of the Budget. We are negotiating back and forth on the details of it. And eventually it will come before the Congress, and this committee will have an opportunity to look at it then.

Mr. YOUNGER. It has been rumored, been talked about right along, it is the purpose to abolish the Commissioned Corps.

Dr. STEWART. I do not think the intention is to abolish it so that nobody has any job.

Mr. YOUNGER. I do not mean that. I mean the rank and considerations. We have had that up before in our committee many times, and we have recommended laws which treat the Commissioned Corps very much like the Army insofar as fringe benefits are concerned. Those bills have been reported by our committee.

I am anxious to know whether or not you are going to abolish them, or reorganize them, so that they are just ordinary Government employees with the ordinary fringe benefits. Or are they going to be comparable to the Army?

Dr. STEWART. Mr. Younger, we have under consideration extensive modifications of the personnel system which is now being discussed with the Bureau of the Budget. We are not prepared at this time to say what will be the final product of these discussions. Eventually there will be a bill in the Congress on this. At that time we will be prepared.

Mr. YOUNGER. It is true that so far as the Commissioned Corps is concerned, you have the authority to send them any place in the world?

Dr. STEWART. I cannot require a man to go anywhere. We have a sort of quasi-military system in which there is somewhat of the military authority but I cannot force a man to do anything. He can always quit. This happens.

Mr. YOUNGER. That is the difference between your organization and the Army—the Army officer cannot quit?

Dr. STEWART. In peacetime, I guess he can. I do not know what the rules are at the present time.

We also know that we have positions, places where we must have positions which are not highly desirable places and we know very well if a person goes there and really does not want to, we are only going to get a half job instead of a full job. But we try very hard and actually we have a very loyal bunch of people in the Public Health Service who take on some of the most arduous isolated tasks and do them well.

Mr. YOUNGER. I was interested in that because of this international health bill that came up and was recommended by you because you needed a group you could send anywhere in the world. I understand you already have that.

Dr. SREWART. Within the system we have a flexibility of movement that is peculiar to this particular system. But when you put the question: Can I force a person to go somewhere? The answer in the long run is, "I cannot." It is highly udesirable to do that anyway.

Mr. YOUNGER. You cannot assign a commissioned officer to a specific task?

Dr. STEWART. I can assign a commissioned officer to a specific task, yes.

Mr. YOUNGER. And he either performs that or he can resign?

Dr. STEWART. Or he can resign, that is right.

Mr. YOUNGER. That is what I say. If you wanted to send one of the Commissioned Corps to India to help out in the health program, then you could assign him to that area and he would have to go or quit?

Dr. STEWART. It has that flexibility.

On the other hand, if he really did not want to go we would only get half a job even if he went. So we try very hard to engage people that are interested in this type of work.

Mr. YOUNGER. That often happens in Government service.

Dr. STEWART. Yes, sir.

Mr. YOUNGER. You mentioned here the Bureau of Disease and Injury Prevention and Control. Do you expect to have assigned to you, instead of the Commerce Department, highway accidents?

Dr. STEWART. No sir. But we will have a role in conjunction with the Department of Commerce in the traffic safety program. We have a Division of Accident Prevention now. We are now talking with the Department of Commerce on how we relate these two programs together.

Mr. YOUNGER. It is rather strange because in all of the hearings—we conducted 3 weeks of hearings on accident prevention and so forth and the HEW Surgeon General was not represented in those hearings. Do you recall?

Dr. LEE. I testified before both the Senate and House on this.

Mr. YOUNGER. You did.

Dr. LEE. The surgeon General was at the World Health Assembly at that time and could not be here to testify.

Secretary GARDNER. I think we recognize there are very large aspects of this that go far beyond our Department and its capabilities. But as long as the present very large number of Americans are dying on the highways, the principal health organization of the Government will continue to have a hand in it.

Mr. YOUNGER. You mentioned that you will combine direct medical care programs. What are those?

Dr. STEWART. In the present existing Bureau of Medical Services in the Public Health Service, we operate two direct medical care programs. One is our hospital system for the care of the merchant seamen, the Coast Guard and a few other legally designated beneficiaries. We also provide medical care for Federal prisoners. We operate two narcotic and psychiatric hospitals and we operate the leprosarium in Carville, La. That is the Division of Hospitals. There is also a system of clinics for the same beneficiaries.

We also operate all of the hospitals and clinics and really the total health program for American Indians and Alaska natives. This is a system of hospitals ranging from 10 beds to 400 or 500 beds scattered for the most part around the western part of the United States and in Alaska. These are our principal direct medical care operations.

Mr. YOUNGER. They are in connection with Government agencies primarily?

Dr. STEWART. These are legally designated Federal beneficiaries. The larger groups are the American Indian, native Alaskan, the merchant seamen, the Coast Guard, and Federal prisoners.

Mr. YOUNGER. It has nothing to do with the general public?

Dr. STEWART. No, sir.

Mr. YOUNGER. In regard to the environmental health, I noticed the other day a grant was made to Stanford Research in connection with environmental health service. What was the nature of that?

Dr. STEWART. I am sorry I cannot tell you, Mr. Younger. I will be glad to get it for you. I just do not know the details.

Mr. YOUNGER. There is an establishment or center in North Carolina, is there not?

Dr. STEWART. It is just emerging from its birth at the moment. We have temporary facilities, about a hundred people now. We have a request for the apportionment of the planning funds from the Bureau of the Budget almost ready right now, and we will begin to plan the ultimate structure fairly soon.

Mr. YOUNGER. Is there not quite a center in Cincinnati?

Dr. STEWART. Yes, sir; there is. There are to be two. There is the Taft Engineering Center; and then there are other activities scattered in a variety of buildings in the Cincinnati area. We are planning now a new building in the Cincinnati area to house some of these who are now scattered in temporary and rented quarters.

Mr. YOUNGER. When you get through, will there be regional offices, or is your plan to have the center in North Carolina as the main governmental environmental health center?

Dr. STEWART. No, sir. Our regional operation is with the regional offices of the Department. We do have a health director in each of the regional offices of the Department. As far as our environmental health activities go, the Environmental Health Science Center that will be developed in the Research Triangle of North Carolina will be part of the National Institutes of Health. This will be our basic environmental science research facility, mainly aimed at the definition of the biological effects of these substances that are found in the environment on human beings.

The Taft Engineering Center in Cincinnati is now part of the Federal Water Pollution Administration, and no longer belongs to us.

The new building in Cincinnati, which is being planned at the present time, will house part of our air pollution research, part of the solid waste research, and occupational health research, that we carry on now in various rented quarters.

There also are regional radiological laboratories for monitoring, surveillance, and epidemiological work—one in Las Vegas, Nev., one in Montgomery, Ala., and one in Winchester, Mass., for the northeastern part of the United States. Then there are a series of shellfish laboratories which are working on the problems of contamination of shellfish. We have one in the Northwest, one down in Mobile, and one in Narragansett, R.I. These will all be part of the Disease Prevention and Control Bureau, which will also include the Communicable Disease Center at Atlanta.

Then there is a CDC field station in Phoenix, Ariz., which is working on salmonella and shigella infections.

I may have left out one or two.

Mr. YOUNGER. I know, Mr. Secretary, you make a statement that "I am therefore strongly urging the Congress to permit this plan to take effect without delay."

Secretary GARDNER. Without any more delay that is implicit in the 60 days arrangement.

Mr. YOUNGER. Sixty days, requirement.

Secretary GARDNER. Yes, sir.

Mr. YOUNGER. That is all, Mr. Chairman.

Mr. ROGERS of Florida. Mr. Gilligan.

Mr. GILLIGAN. Thank you, Mr. Chairman.

Mr. Secretary, as Mr. Van Deerlin said a moment ago, some of us do have some interest in the problems of environmental health. I happen to have a special interest, perhaps because I do represent a district in Cincinnati which has long been associated with the Public Health Service efforts in the field of environmental health.

Moreover, I spent more than 10 years in a city council and therefore I perhaps have a clear viewpoint about the problems of the environment in our major urban centers—how to make our cities livable.

I thought at one time that I had some understanding of the structural and functional approach of the Public Health Service to the problems of environmental health. It seems rational and reasonable to me as it was set up. I must confess that I am not so clear any more in terms of the proposed organization of the Public Health Service as to what exactly the Federal Government, and more specifically the Department of Health, Education, and Welfare and the Public Health Service, regards is the mission of the Federal Government in the field of environmental health.

If I may offer in the way of a long-winded question this for your comment:

Under the old organization under the Bureau of State Services, there were two divisions: there was the Community Health Division, and the Environmental Health Division.

Under Community Health Division, we had accident prevention, Communicable Disease Center, Community Health Services, dental, public health resources, hospitals and medical facilities, and nursing.

And then under the Environmental Health Division we had air pollution, environmental engineering, and food protection, occupational health, radiological health, water supply and pollution control.

Now some of the community health divisions have been moved into the newly proposed Bureau of Health Manpower—Dental Public Health and resources, hospital and medical facilities and nursing. Community health services have been moved into the Bureau of Health Services. And most everything else has been lumped together into a Bureau of Disease and Injury Prevention and Control.

The term "Environmental Health Service" seems to have disappeared from the organizational lexicon of the Public Health Service.

Also, the concept of attacking the various elements of the environment, of studying them first and deciding what might be done to improve the environment, especially in our cities, as it appears to me has disappeared. And we have a melange of various functions. It may be clear to Dr. Stewart and to you how these various activities will relate one to the other and how they will achieve their objective, but it is less clear to me now under the newly proposed structure than it was under the old.

One further comment: It seems to me as a layman that there was a distinction to be reasonably made between personal health, which is a basically medical problem, and the cleaning up of the environment which, while it has some medical basis and scientific basis, is fundamentally an engineering problem.

Again, that differentiation, if it is a valid one, seems to have disappeared in this organizational setup.

I wonder, having unburdened myself of all of that, if you or Dr. Stewart would care to comment on the mission and objective of the Federal Government in the field of environmental health and how you think it can be better achieved under this setup than under the old.

Secretary GARDNER. I would like to ask the Surgeon General to comment.

Dr. STEWART. Mr. Gilligan, when I looked at the Bureau of State Services, the community health side, there were three purposes being carried out by the programs within that part of the Bureau of State Services. One was manpower. We had the Health Professions Educational Assistance Act being administered in the Division of Hospital and Medical Facilities in Community Health Services. We had the Nurse Training Act being administered by the Division of Nursing, and we had the Dental portion of the Health Profession Educational Assistance Act in the Dental Division.

These three areas were mainly our manpower activities which emanated from these two pieces of legislation which developed in the last 3 or 4 years, and they seemed to be a logical grouping in recognition of the problems in health manpower. They will form the Bureau of Health Manpower.

There was another set of functions which were related to the quality of medical services. The standards, the development of new methods of delivery, the building of hospitals and nursing homes and outpatient departments and all of these activities which seemed to lend themselves to being grouped together for a purpose—the Division of Medical Care Administration, the Division of Hospital and Medical Facilities minus the medical school construction program, some portions of the Division of Community Heatlh Services, and some activities of the Chronic Disease Division which relate to screening examinations, development of standards in nursing homes and this type of activity.

Then the third were some of the chronic disease activities and the Communicable Disease Center which had as their purpose the development of methods and carrying out of those functions which are assigned to us to prevent or control disease.

Likewise we have our Division of Accident Prevention which has as its primary purpose the prevention of accidents and injuries, and if they are not prevented, to control the effects of accidents as much as possible.

I then looked at the environmental health activities under the environmental health part of the Bureau of State Services. At this time, the Water Pollution Control Division is no longer there. The air pollution program is. The question I had in this area is what is our primary, the Public Health Service's primary role?

It seemed to me that our primary role here is to prevent disease and injury from occurring as a result of pollutants in the environment. It can go beyond this. But this is our solid base. It is true that it is an engineering job to get the pollutants out of the environment, but it is a biomedical job to know how much lead in the environment will not cause harm to human beings. It is really the difference, the approach which you go through the environment, and say any contaminant in the environment is bad and should be taken

out by engineering, and the other one is what harm is it causing? Does the environmental health program have any concern with the rising rate of mortality from chronic respiratory diseases in this country? There is some epidemiological evidence there is some association between contaminants in the air and the rising rate of chronic respiratory illnesses in this country.

Then it seems to me it is a biological problem to find out what these substances are that cause these effects. It is an engineering problem to prevent or do something about the substances getting into the air.

It is not an either/or. It is a double approach. The basic primary thing that we stand on in our job is to protect and to promote the health of the people. We start with people.

Mr. GILLIGAN. I agree with that. I do not quarrel with it. As I said before, for instance, in the last couple of years when we talked about the development of the Environmental Health Research Center, which was to be located in North Carolina, the concept was advanced that taking place at this center would be the basic research of the medical facts of life, how the human might be affected by contaminants in the air, or water, or radiology or whatever.

The applied research problem would be conducted in probably the older facilities, and in the Cincinnati area, or new facilities to be designed somewhere else.

Thus, it seemed to me, when the Congress in the last couple of years with the development of an Air Pollution Control Act, with the introduction significantly of title II of that act in the 89th Congress of solid waste disposal, there were questions raised within this committee as to what possible connection there could be between garbage collection and air pollution. The link is obviously the incinerator.

Our thrust has seemed to me, and certainly the interest of city officials, local health officials, has been in relating these various fields of control of pollution of water, air, and other elements, and suddenly, it would seem to me, that that direction has been obscured or lost by the Public Health Serivce's proposed reorganizational plan. For instance, I do not understand why the old division between community health and environmental health could not be more clearly maintained here. Why, even the very term "environmental health" seems to drop out of sight.

Dr. STEWART. Mr. Gilligan, I think I said earlier that the quality of the environment is such a vast problem that it really involves almost the total structure of the Federal Government and society. This involves things that are far beyond the part of this——

Mr. GILLIGAN. You mentioned billboards.

Dr. STEWART. Billboards, urban renewal, all of these things are part of the quality of our environment. There is one agency that has the primary responsibility to make sure that what is in the environment is not causing disease or injury. That is the Public Health Service. This is our primary role. We must tackle this through determining what are the things that are reaching people, through whatever sort of environment we are talking about, water, air, and there are several of these contaminants which reach the person through multiple channels.

Mr. GILLIGAN. I agree.

Dr. STEWART. If we can find what they do for people, we can set standards on these bases. There will be other reasons to set a standard, too, beyond the health reason. Health becomes the primary reason.

Mr. GILLIGAN. Let us assume that the research is done and certain standards are set. What in your view is the function of the Public Health Service and the Department of HEW or the Federal Government in taking the next step of applying these standards in a related and coordinated program?

Dr. STEWART. I look on the Division of Air Pollution, as it now is doing in promoting the programs under the Clean Air Act, to emphasize the removal of these contaminants from the environment, the air.

Mr. GILLIGAN. Because water pollution control has been now transferred into the Department of the Interior, is it the view of the Public Health Service that you no longer have any concern with water pollution?

Dr. STEWART. No, sir. We still have the same primary function on the contaminants in water that affect the health of man. We are working now with the Department of Interior on the agreement as to how we will play this role with them. If we have another outbreak of problems traced to water, such as the Riverside, Calif., outbreak of last year, we will investigate this. We will be the ones who decide what disease is being caused and that it is coming from the water. We will work with the Department of the Interior on what needs to be done in order to stop that contamination, whatever it is.

Mr. GILLIGAN. Mr. Chairman, I do not want to transgress on my time limitations here but I must say that I remain unsatisfied with the programs advanced to this point. I am painfully aware on my frequent trips back to my district of the great concern and almost total demoralization of the people in the Public Health Service who have worked for many, many years in that area in the field of what they regard as environmental health as to their future. What is their mission? Where are they going to work? Are they going to work at all, or is the Public Health Service going forward in this field?

Dr. STEWART. It is very difficult for me to understand this. Everything I am trying to do is to make it so they have more support and better programs. The Division of Occupational Health will not change. The Division of Air Pollution will not change except as we augment their programs with personnel, budget, and others. The solid waste program will continue but they will have an orientation toward preventing disease, injury. This is a purposeful type of operation.

Mr. GILLIGAN. Do you find a relationship between air pollution, water pollution, radiological pollution and occupational health which does not embrace at least in the same way communicable disease or health?

Dr. STEWART. No, sir. The thing that draws these together into a common purpose is disease prevention and injury prevention and control. This is the common thing that draws these together. Our occupational health program is trying to keep the worker from being injured by toxic substances in the environment. The radiological

health program is trying to keep people from being injured by radioactive materials in the environment, and the Communicable Disease Center is also concerned with the environment.

They also are involved in other ways of controlling diseases but most of the control of communicable disease has been through the control of the environment, mostly in the water area. They serve as a source of intelligence in which you point out the problems of the contamination of the water. Infectious hepatitis epidemics are being monitored and studied by the Communicable Disease Center, the ways of doing so about infectious hepatitis in the water, how do you get it out of the water supply, will be a clear function of our water supply activities.

Mr. GILLIGAN. We recently heard of awards that were given to the university in Cincinnati for the development of a university-based institute for environmental health training, to train people at the doctoral level in the field of environmental health.

Again, as I say, I thought when that award was given that I understood what the program was all about. Are we to understand that a program attempting to develop what might be known as environment health officers would involve training in all of the disciplines which you have now listed under the Bureau of Disease and Injury Prevention and Control?

Dr. STEWART. No, sir. But I think there are people who need to be trained on the techniques of removing things from the air, like sulfur dioxide, or for the other missions. They need to know how to remove substances from the water which might be harmful to people, or need to know how to provide a safe environment in a working situation. This is the environmental health specialist. He is a man who knows how to manipulate the environment through ventilation, through control devices on emissions, or anything else.

Mr. GILLIGAN. Engineering problems?

Dr. STEWART. It is mainly an engineering approach, yes, sir.

Mr. GILLIGAN. Have not up to this point at least the majority of the people working in these fields as Public Health officers had an engineering as opposed to a medical background?

Dr. STEWART. I do not think this is entirely true across the entire range that we are talking about. Most of the work in toxicology of substances, chemicals and working environment, has been done by toxicologists who may have either a chemical or medical background. The same thing is true in radiology and radiological health. They may have a medical background. It is a combination of skills which cuts way across the line.

You have to relate, I think, the effects of these substances on human beings and their disease-causing and injury-causing capabilities to the application of control methods.

Mr. GILLIGAN. I do not object to that relationship.

Dr. STEWART. The purpose is to prevent disease and injury.

Mr. GILLIGAN. I would certainly grant that that is the objective in the program. It amounts to carrying forward a program which has certain logical cohesion and coordination which may very well be present within your plans and schemes but which are not completely evident to me from the organizational structure which you submitted.

Dr. STEWART. Mr. Gilligan, the concern that you are raising has

been brought to my attention by letters and also by the National Advisory Environmental Health Council with which I met about a week ago. It was my feeling at the meeting of the Environmental Health Council that they agreed with me on the fact that our primary purpose in this was disease prevention and control and that they were not really concerned too much about the organizational arrangements that have been suggested, as they were with the fact that the words "environmental health" had been dropped.

Mr. GILLIGAN. Mine, too.

Dr. STEWART. If this is so, I am not going to have a reorganization plan rise and fall on some words I chose for a new title of a bureau. I was merely trying to develop a bureau name which described what I thought was that bureau's primary function or purpose. But I think we are open to suggestion on bureau names.

Mr. GILLIGAN. I have the feeling, sir, that you put your finger on one of the problems. The very disappearance of the term suggests maybe more than was intended to a lot of people who have had a very deep interest in the problems of the environmental health. I do not suggest that all these people are related directly or indirectly to the Public Health Service. A lot of them are city councilmen and public health officers and so forth.

Dr. STEWART. That is right. I have searched for a name. My only desire would be to hope to get a name which does not dissemble environmental health as something different than disease prevention and control.

Mr. GILLIGAN. Mr. Chairman, I thank you.

Mr. ROGERS of Florida. I want to continue a little bit. There is great concern in that area, as you can see from the questioning. Also, we are getting a lot of telegrams and so forth, as you probably received yourself. There is some concern that there has been a fragmentation of the environmental health structure rather than a tying together. For instance, setting up the organization under NIH and yet setting up other functions in another bureau rather than keeping the two together.

Take mental health under the organization. We put it all in by itself in one bureau. We do research there. We do the community function, but here the concern has been that instead of pulling together the environmental health and emphasizing it, the name disappeared and the Assistant Secretary, I guess it was, for environmental health matters has now been transferred to another department.

There is no one that comes in with that term to fill his place. There is no term in any of the bureaus of "environmental health" and we see the division in two bureaus rather than a coming together in one.

Dr. STEWART. Mr. Chairman, I think one can look at this another way, that the present structured environmental health part of the Bureau of State Services remains the same and reports to the same bureau chief. To it will be added the Communicable Disease Center as an entity. The Environmental Health Science Center will be transferred to NIH, as I explained earlier. This is our basic research element which requires the type of scientist which has been involved in the NIH program before.

The carcinogenesis program in the Cancer Institute is closely related to this approach. We have other splits. You cannot put everything in the bureaus. I tried in using this reorganization to put functions with like purposes together. I admit that one gets a different access of logic when you get to the Mental Health Institute or a different set of reasons. It seemed to me that it would lend itself much more in an organization if we could organize by purpose. This was my attempt. We have other situations.

The basic virology work in this country in the Public Health Service is done in the National Institute of Allergy and Infectious Diseases and some in the Cancer Institute.

Developmental work on the application of vaccines, including field studies, against virus diseases, is carried on by the Communicable Disease Center. So we do have these two bureau arrangements.

Dr. LEE. Mr. Chairman, I would like to make an additional comment. I can assure you that the Surgeon General and all of us have examined this area with great care and with a great many people. I think that you are underestimating the importance of the creation of the Environmental Health Science Center in the National Institutes of Health. I think we have seen other areas, Cancer Institute, for example, the Heart Institute, and these others which have proved to be the wellspring of knowledge from which significant programs developed.

I think that one of our difficulties today has been the weakness of the research base in environmental health. One of the reasons we are faced with the enormous problems we are faced with is the lack of a strong scientific base. I think this is an important organizational move on the part of the Surgeon General.

Mr. ROGERS of Florida. Yes, this is the thrust of what the Congress has wanted for some time, increasing our activity in environmental health.

Dr. LEE. I should say——

Mr. ROGERS of Florida. You should know because we passed specific legislation on air pollution and water pollution in recent years trying to add some emphasis to this program. I think that the concern may be not that you have not emphasized environmental health but the fact it does not look so when you drop the word "environmental" from the name of the Bureau. Can you not call it the "Bureau of Environmental Disease and Injury Prevention and Control" or something like that? Is there any reason why you could not at least consider tying in "environmental" some way in your bureau?

Secretary GARDNER. Let me suggest that we go back and think very hard about names.

Mr. ROGERS of Florida. I think it could be helpful for the satisfaction of these people in the field. If this is the intention of what you are trying to do, and I think it is, let us recognize it. I think this could be helpful to these people and give them some assurance that you are emphasizing this program as Congress intended, and as you stated you wanted it.

If you could take that tack and consider it, let us know. I think it would be helpful.

Secretary GARDNER. I think this is perfectly feasible. If I may, I would like to make a few comments on some of the related points. It seems to me that the symbolizing of our interest in a name is an acceptable thing and a perfectly natural thing for people deeply interested in this to hope for, even though a very superficial thing. The idea of putting all of these activities together I find most unattractive. It seems to me that every problem of any significance spills across organizational lines and gets into everything. Health gets into everything today. Education is into everything. The hope that we can go back to getting things in neat organizational categories is not going to work, least of all for environmental health which in its nature cuts across lines. The way to get a first-class research operation out of this is the way that we are taking, which is to put this in the NIH.

What the proponents of environmental health must do is watch the vigor with which we pursue it, all of these activities. The extent to which the Secretary backs the air pollution unit and gives it strength, the extent to which we really put our backs into trying to do something about this, I promise that I will make that effort.

Mr. ROGERS of Florida. Good. In fact, you might want to comment on some rumors that have been going around, which I think it would be good to put to rest, that air pollution and solid waste programs may be transferred out of the Department of HEW. What would be your comment on that?

Secretary GARDNER. I do not know the source of the rumors, Mr. Chairman. Certainly those rumors do not arise in my vicinity and I would not welcome the departure of either of these programs.

As I said, I am personally interested in environmental health.

Mr. ROGERS of Florida. You would not, as far as you are concerned, give your approval to that kind of transfer?

Secretary GARDNER. Most certainly not.

Mr. GILLIGAN. Mr. Chairman.

Mr. ROGERS of Florida. Yes.

Mr. GILLIGAN. Along these same lines, I think it might be of very great interest to this committee, certainly to one member of this committee, to have your proposals, Mr. Secretary, and those of the Surgeon General concerning what plans you may have in mind for developing again within the precincts of the Public Health Service some research and training in the field of water pollution control.

I recognize the meaning of the transfer to the Interior Department but it does seem to me utterly impossible to talk in any meaningful way about the control of our environment, especially within our cities, without talking about the problem of water supply—of pure drinking water.

Further, it seems to me that we have had, for instance, in my district in the Taft Center, a very extensive training program which the Public Health Service, public health officials from not only every State in the Union but all over the world, have been brought in for training in means and methodology of providing clear water and pure water.

Is this in your view to be carried on within the Public Health

Service? It is a health problem. Is it to be carried on within the Department of the Interior or how is it to be handled?

Secretary Gardner. In my testimony in relation to the transfer of water pollution I emphasized very strongly the continuing functions of our Department in this field and I would like the Surgeon General to comment further on that.

Dr. Stewart. As I said earlier, Mr. Gilligan, we have an important role to play in the safety of the water that human beings come in contact with. We are at the present time working out the agreement with the Department of the Interior as to who will do what and how it will relate to one another as provided for under Reorganization Plan No. 2.

We see ourselves having a major role in this particular portion. Just who will be responsible for the training that is carried on within the Taft Center, I do not know at the present time. The Taft Center will become part of the Federal Water Pollution Control Administration. The water pollution training will involve many, many kinds of people other than those who might be involved in water supply. I assume that they will have training programs but I just do not know what the details are, what they are planning for the Taft Center.

Mr. Gilligan. I am not so concerned about the physical location of the training, as that it be within the Public Health Service in some fashion or other so that it can be related to, for instance, air pollution and the other problems of environmental health.

Dr. Stewart. There is no question about that, Mr. Gilligan.

Secretary Gardner. Mr. Gilligan, I see no possibility that we could relinquish basic functions with respect to water pollution that affect health. This was clear on the part of all concerned in the transfer.

Mr. Gilligan. With your permission I would like to introduce for the record a letter from the director of the Albuquerque Department of Environmental Health which says perhaps more clearly than I have been able to say some of the things about which people are concerned in this proposed reorganizational plan and comments about the disappearance of the concept of environmental health as this gentleman at least views it.

With your permission I would like to introduce this as part of the record.

Mr. Rogers of Florida. Without objection it will be made a part of the record.

Mr. Gilligan. Thank you.

(The letter referred to follows:)

Albuquerque Department of Environmental Health,
April 11, 1966.

Mr. Wesley E. Gilbertson,
Chairman, Engineering and Sanitation Section,
Care of Bureau of State Services,
Public Health Service,
Washington, D.C.

Dear Wes: I enjoyed reading your "message" in the E & S Section Newsletter which arrived today. In commenting on the present and future status of environmental health activities in the country, I have reference to your message and to the contents of the minutes of the Technical Development

Board which were recently distributed, as well as reports concerning the recommendation of the Corsan Committee.

I believe that E & S Section should do everything possible to see that environmental health activities are not cloaked and stifled within a "Bureau of Disease Control". The concept of such a bureau may seem fine but it does not really take cognizance of the existing patterns and changing patterns of organization and delivery of environmental health services. To state that "the methods of improving the individual's chances for a long and healthy life should not be divided into two systems for delivery of those services" sounds wonderful in theory. But my feelings are that following such a pattern will only lead to further fragmentation and de-emphasis of environmental health services to the end that we will not only have two systems but are more likely to have ten or fifteen such systems. Experience in all parts of the country has proven that such a single system has caused fragmentation of environmental health interests into numerous other agencies, departments, and special districts. Therefore, if Public Health Service leadership is to retain whatever is left of environmental health, it is my feeling that environmental health must be given the necessary visibility, emphasis, prestige and status. Further, environmental health should not be submerged and delimited within a "Bureau of Disease Control" which by its very title will force further fragmentation of environmental health inasmuch as the Bureau title in itself would be misleading and too narrow in concept to retain any type of environmental health activity. I think this was well pointed out in the second paragraph of your "message" which indicates that environmental health programs cannot be based on health factors alone and cannot be limited to disease cause-and-effect relationships. Many large and important environmental health activities have already been splintered out of health agencies at all levels of government throughout the nation. Increased emphasis on environmental health factors and strong leadership will be required to retain those which are left as well as to plan and administer new environmental health programs which are necessary.

As I attempted to stress in my January 26 letter to you, the emphasis on environmental health programs is more necessary than ever but the chances of this emphasis are increasingly limited within traditionally structured health agencies due to the numerous huge, new personal health and medical care programs.

I am sure many of us still feel that APHA and PHS are not exerting the necessary forceful leadership to see that we have the proper structure for environmental health services. If we continue studying the matter much longer, perhaps we will not have too much environmental health left to worry about within APHA and PHS. Other agencies have shown the ability and willingness to give proper status and budgets to environmental health factors and they are clamoring for greater control. Many foresaw that the structure for water pollution control activities within PHS should be upgraded, but this was not accomplished in time to attempt to save the program.

I would have addressed this direct to Dr. Ingraham but I feel that action and recommendations along these lines will be more effective if directed through the Section Council.

Best personal regards.

Very sincerely,

LARRY J. GORDON, *Director.*

Mr. ROGERS of Florida. Mr. Secretary, if I may question you just a little bit.

In your reorganization of the Public Health Service, have you given any thought to the proposal for a separate Department of Health, taking it out of the Department associated with Education or perhaps combining Health and Welfare?

Secretary GARDNER. Yes, sir. We have given a good deal of thought to the future structure of the Department as a whole. I spent a good deal of time on that. I think the ruling consideration as we have looked at it is that the trend of events, and particularly the legislation of the 89th Congress, has tended to produce an inter-

weaving of the programs in my department such that it is increasingly difficult to see a breakout of these functions.

When you see the Social Security Administration administering medicare, and therefore in health activities to the limit, when you see the Welfare Administration administering title 19 and therefore in health activities very heavily, when you see the extent to which the health activities penetrate vocational rehabilitation, relating to the Food and Drug Adminisration, affect education in such programs as school health, you find it very difficult to see how just at this time when these functions are becoming closely related to one another to pull them apart in separate departments.

If that were done, it is my conviction that the kind of coordination which the Department is now accomplishing would have to be carried on somewhere else.

There would have to be then a coordinator somewhere above the Departments who carried that on.

Mr. ROGERS of Florida. Like the Defense Department is now set up?

Secretary GARDNER. That would be one pattern or it might be done in the White House.

Mr. ROGERS of Florida. Have you given any thought to perhaps having, say, a Secretary of Health, a Secretary of Education, and a Secretary of Welfare?

Secretary GARDNER. Yes, sir. This has been studied in our Department. It has been widely discussed. Marion Folsom, one of my predecessors, advocates the creation of three Under Secretaries, as you know.

Mr. ROGERS of Florida. Yes.

Secretary GARDNER. I would say that if we want to such a tripartite arrangement it would be preferable to have three Secretaries. But these things are simply matters that we have discussed and——

Mr. ROGERS of Florida. But you have felt now is not the time to act on these proposals?

Secretary GARDNER. That is correct.

Mr. ROGERS of Florida. I presume there is a continuing review of organizational structures in your Department, that it does not stop with just this organizational plan?

Secretary GARDNER. Very much so. We will continue examining one after another the Department's functions.

Mr. ROGERS of Florida. Let me ask you this: How much of your time would you say that you can actually devote as a Secretary to the running of the Department itself? In other words, you have to come up here on the Hill, spend a great deal of time here. We realize that. You have to meet with your people. You are called on to make speeches and public presentations of what you are trying to do, to sell the public on acceptance of many things that need to be done. What do you say is your estimate of your time that you can actually devote to the internal affairs of the Department? Could you give us a percentage, or is that too difficult to do?

Secretary GARDNER. No, I think I devote about at least 80 percent of my time to management of the Department. That is perhaps a commentary on how little I do in the way of ceremonial duties. I

do not really regard my time spent up here as wasted with respect to managing the Department.

Mr. ROGERS of Florida. We are complimented.

Secretary GARDNER. I sometimes feel I should pay tuition for what I learn in these hearings.

Mr. ROGERS of Florida. This is an interesting comment, because in our studies we have talked with other Secretaries, one of whom (who was a fairly recent one) estimated he could spend only 25 percent of his time in actually administering the Department, which we can understand.

I did want to get your comment on that. I think this is interesting to see the difference in approach between the various Secretaries.

Secretary GARDNER. I do not make very many speeches.

Mr. ROGERS of Florida. That probably would be good advice for all of us, Mr. Secretary.

Let me ask a few specific questions.

It seems to me in the past we have emphasized research in our activities in the health field from the Federal standpoint through NIH particularly, a bricks and mortar program where we help build under the Hill-Burton programs. Then, of course, some community activity. From the legislation that has been passed and from the programs we see emerging, and evidently in the planning, it looks to me like we are now getting into the area of services, delivery of services. What would be your comment on this?

Secretary GARDNER. May I ask the Surgeon General to comment?

Mr. ROGERS of Florida. Yes.

Dr. STEWART. I certainly think that in the present era there is great public interest and concern about the delivery of health services. This is apparent in the actions of the Congress in the last few years. It has been mainly in the service area that there has been consideration. I think this is what might be called the developing area at the present time within our functions. It relates to research in the sense that I think that medical research has begun to give results in which the public is interested. It has raised the expectations of the public. They want these latest treatment devices and techniques and things like that. I think there is an interest in it.

As to the manpower problem: Are there enough doctors? Are there enough nurses? All of these needs have become preeminent at the present time. This does not mean that research is no longer of interest. It is just as important, just as solid as it always has been.

Mr. ROGERS of Florida. You are now planning to create, in effect, five bureaus although I am not counting the Library of Medicine, the National Center for Health Statistics, and so on. The Bureau of Health Manpower—if I am concerned about wanting to be a doctor is that the Bureau I contact?

Dr. STEWART. Yes, sir.

Mr. ROGERS of Florida. If I am a university president or dean and I want to know about getting money for a program for training doctors or nurses, do I go to this Bureau?

Dr. STEWART. Yes, sir.

Mr. ROGERS of Florida. In other words, you are trying to set up your bureaus so that through their name and function people through-

out the country will know exactly where to go, rather than have it so fractionalized. Is that correct?

Dr. STEWART. Yes, sir.

Mr. ROGERS of Florida. I think that is a good move that is badly needed.

On health services, if a community wants to build a hospital where do they go?

Dr. STEWART. Health Services.

Mr. ROGERS of Florida. Health Services?

Dr. STEWART. That is right.

Mr. ROGERS of Florida. The Division of Chronic Disease—if we have a problem with a disease in a community they go to this Bureau, is that right, or where?

Dr. STEWART. No, the Chronic Disease——

Mr. ROGERS of Florida. Or to the Disease and Injury Bureau?

Dr. STEWART. Actually the existing Division of Chronic Diseases has two types of programs in it. It has the disease targeted programs, like heart disease control, cancer control, prevention of rheumatic fever. These would be in the Bureau of Disease Prevention and Control.

The programs we have which are trying to develop new ways of screening diseases, new developments in outpatient departments, new standards in nursing homes—programs that are generalized in relationship to services—would be in the Bureau of Health Services.

Mr. ROGERS of Florida. In the Bureau of what I hope will become Environmental Disease and Injury Prevention Control or whatever it may be, how are you going to carry on your activities in conjunction with the other departments of Government concerned with the environmental functions? That is, like HUD, Interior, Commerce? Have you got the personnel? Have you given status to that program so that the person in charge can talk to the head of the water control program in Interior, or what?

Dr. STEWART. At the present time there are a lot of working relationships between people because they have common interests in a field. This works very well. We will have, in the agreement that we are developing with the Department of Interior, guidelines as to how we work out the more specific relationships between our Department and the water program in Interior. We are also working the same one out on traffic safety. These are fairly recent. We have to work out the formal arrangements.

Mr. ROGERS of Florida. You say "we." How is that done, by the staff head, or is it through your office, or the Secretary level, or where?

Dr. STEWART. At the present time there is a committee that is working on the relationships with Interior on which we have two representatives. There are two from Interior. I do not know whether the Secretary's Office has a member on it or not. I assume he does. When one is talking about policy development, these would more likely be between the offices of the Cabinet members.

If it is in the program implementation this should get as close to the program people as possible.

Secretary GARDNER. Mr. Chairman, I believe that the Federal Government has not yet found the means of pulling together all

the pieces of the environmental health picture. That is one of the tasks we are going to have to address ourselves to in terms of some kind of interdepartmental committee structure more effective than the arrangements now available.

Mr. ROGERS of Florida. Do you plan to do that out of your Office or out of the Surgeon General's Office?

Secretary GARDNER. This would involve consultation with the Office of Science and Technology and the Budget Bureau and others interested in this kind of coordination.

Mr. ROGERS of Florida. You are giving active consideration to this?

Secretary GARDNER. Yes, sir.

Mr. ROGERS of Florida. In trying to tie together the environmental programs?

Secretary GARDNER. Yes, sir.

Mr. ROGERS of Florida. That needs to be done?

Secretary GARDNER. Yes, sir.

Dr. STEWART. I may give an example. We are beginning to work out relationships with HUD at the present time. We have a man detailed to HUD who is working with the Under Secretary in developing this. There is going to be a conference this summer jointly between the two in which we will have quite a participation and they will, too. This is the way we are developing these types of relationships.

Mr. ROGERS of Florida. As you may be aware, we had a week's hearing earlier this year with State public health officers, also the Surgeon General participated, the Commissioner of Welfare, and who else?

Dr. LEE. The Under Secretary was there, Mr. Chairman.

Mr. ROGERS of Florida. Yes. Also the Commissioner of the Vocational Rehabilitation Administration.

We got into quite a discussion as to the area of trying to build up, as I understand you want to do in some of the proposed legislation, the State health programs, in trying to give them more flexibility rather than making grants in categorical fashion where they have no flexibility. It is my understanding that it is now your feeling and the feeling of the Department that this should be relaxed some. The States should have more determination, and you would let it be their determination, as to whether they need to fight cancer more in their State—because this may be more of a problem in one particular State than another—or heart disease, or venereal disease, or whatever it may be; is that correct?

Secretary GARDNER. Right.

Mr. ROGERS of Florida. We are also concerned with manpower. We are seeing more and more what we think is a shortage develop as demands increase. We were concerned with one problem there in title 19 which I think the Department is now aware of. It is my understanding that the Department will present to the appropriate committees suggested legislation to correct what we feel is an inequity, and I think the Under Secretary did, too, in the administration of title 19 in that the law requires that the Welfare Department qualify people. This must be done, so you must tie in welfare. It then says that one agency is selected by the Governor—

and the right to select whichever agency is given—but if the State selects Welfare, which would be placing all the title 19 functions in one department, then the medical care activities can be reimbursed 75 percent by the Federal Government. But if Welfare contracts for the medical care functions to be carried on by the health departments already established in the States, the States only get 50 percent Federal reimbursement. This is, in effect, telling the States to use Welfare. That is what the Governors are going to do.

We felt this was an inequity and would cause a duplication of manpower. Could you comment on this? It is my understanding that this corrective legislation wordage is being sent up by the Department?

Secretary GARDNER. We are now working on that. We have faced precisely the problem you have described in the terms you have described it. We are now trying to develop some better approach.

Mr. ROGERS of Florida. Is this to be anticipated fairly soon?

Secretary GARDNER. I am sorry that I cannot tell the exact time.

Mr. ROGERS of Florida. Could you let us know?

Secretary GARDNER. Fine.

Mr. ROGERS of Florida. We feel it is very important because the legislatures are meeting. To many of us it is of vital concern. It seems to me to be a duplication and a waste of manpower to let this develop. We ought to correct it quickly. If you could help with that, I think this would be a real service.

Secretary GARDNER. Would you care to comment?

Dr. LEE. I would only add to what the Secretary said. Since your hearing this was immediately taken up by the Under Secretary with the Office of the General Counsel and then with people at the White House and the Bureau of the Budget. This is now pending and should be forthcoming fairly soon.

Mr. ROGERS of Florida. That is very encouraging.

Dr. LEE. We will let you know as soon as that is ready.

Mr. ROGERS of Florida. Let me go on for just a minute or so to the National Institutes of Health.

I am somewhat concerned, Mr. Secretary, about setting up the National Institute of Mental Health as a separate bureau, separate and apart from the National Institutes of Health organization overall. What do you feel? Is this a necessary move?

Secretary GARDNER. I would like to ask the Surgeon General to comment. Let me first say that the National Institute of Mental Health is now organized, as you know, in most of its activities quite differently from the rest of the National Institutes of Health. Its action programs are really of a different nature.

The second thing I would say is that the intramural research program of the National Institute will remain on the campus and in a relationship to the rest of the National Institutes of Health.

Dr. STEWART. Mr. Chairman, when one looks at the National Institute of Mental Health, as it now exists, he sees that about 70 percent of its budget is related to functions and purposes which are outside of the function and purpose of the National Institutes of Health. They are in the community service area—in the improvement of services, training of service manpower, and bettering ways of delivering service, building comprehensive mental health centers.

We, in effect, have had a division or institute, within a bureau structure, which has 70 percent of its budget outside the purpose of that overall bureau, the National Institutes of Health. In looking at this problem we looked at it two ways: One was to split the National Institute of Mental Health into two parts, the 70 percent function I am talking about—and that which is related to the research and research training mission of the National Institutes of Health. This would result in two focuses in the mental health field at a time when the mental health field is in an almost revolutionary change. The movement from treating people through institutional care, as the sole care, in effect, for the mentally ill, to community care, is one of the major changes that has occurred. This movement needs a focus and needs strength. I think, if we created two focuses, we would not really give the program the type of focus that it needs in regard to the problem we are talking about. We are talking about 50 percent of the hospital beds in the United States. We are talking about a great many people with these problems and the difficulties in taking care of them.

Effective action in the field of mental health also requires a cadre of people who are somewhat different.

The other thing is that it is our hope that the mental health movement will move closer to the mainstream of public health programs, and become closer to that provided for physical illnesses. The comprehensive mental health center is certainly a movement in this direction. As the point of delivery of service the centers being developed, mainly around general hospitals, are moving it into the place where people normally get treated for whatever their health needs may be.

Mr. ROGERS of Florida. You do not feel this could be done through the Bureau of Health Services?

Dr. STEWART. No, sir. At the present time, I think the mental health movement needs its own identity, its own focus, its own push, to accomplish these major things that they are trying to do. I think at the community hospital level this is where it is going to come together.

Mr. ROGERS of Florida. What about heart, cancer, stroke?

Dr. STEWART. Heart, cancer, stroke will have a relationship to the Bureau of Health Services—there is no question about that. It will also have a relationship to the Bureau of Disease Prevention and Control.

Mr. ROGERS of Florida. Where will that be located?

Dr. STEWART. It will continue to be located at the National Institutes of Health. It is located there for a couple of reasons: One is that the major thrust of this was to attempt to get out into the community those new diagnostic and treatment techniques which it developed in the big medical and university centers and get them into a relationship to the community hospital. NIH at that time had the greatest relationship with the university and research centers. Secondly, at the moment when that law came into effect the administrative skills seemed to be more likely to carry out a difficult program in the National Institutes of Health than in other bureaus and services. Both Dr. Shannon and I recognized that there are some

anomalies in our logic in this thing. We both agreed that we will see it develop.

We do have to report to the Congress in July of 1967 and at that time I think the organizational setting can be taken up.

Mr. ROGERS of Florida. This will be constantly reviewed?

Secretary GARDNER. Yes, sir.

Mr. ROGERS of Florida. We have gone into quite thoroughly the operation of the National Institutes of Health by interviews, by checking people with whom they deal. There has been, at least it is my feeling after some of this review, that we have had a tremendous program, in effect, subsidizing and developing a scientific community in the country. This is what we have developed through the National Institutes of Health. We have not emphasized enough some directional approaches, planned programs, in fact, in the categorical fields that the Institutes were established for. In other words, I do not think we have had enough directional effort made or planning done by the individual Institutes to say, now we want applications for grants to do research in this particular field, trying to accomplish this objective.

I think for too long we have said that they don't want to do any of that. Really the basic research must be carried on in the field. We have just let everybody put in an application for whatever he particularly wanted. It may not be associated with what we want to do. I realize we come on many things that way, too. I think we need to give more attention now, and more effort, to help bring about more planning.

This was a criticism, too, I think of the Woolridge report, a lack of planning. I hope, and I would like your comment on that, you will see if we cannot have better planning, give a little more direction and control in some of our work, particularly in the categorical diseases which we think we have been doing but really we have not. We primarily have subsidized basic research, which I am not criticizing. But I think we need to bring a greater emphasis on our planning.

What would your comment be on that?

Secretary GARDNER. I think you have stated the problem very well. I think that the basic research is immensely important. The undirected research—undirected enables scientists to follow their curiosity. I think many of us have felt that at various points greater introduction of directive effort would be useful.

Mr. ROGERS of Florida. Are any steps being taken to effectuate this?

Dr. STEWART. Yes, sir. Your description is quite right. During the growth phase of NIH, in the 1950's, the essential element was to build this strong basic research in biomedical sciences.

We have seen this grow. We have seen this mature. We now have an outstanding, strong basic science, biomedical science in this country. This is absolutely essential. You have to build these directive programs on top of this. You cannot do it the other way around. We have seen emerge now the need both because of this strong basic science and because of the science that we are going to produce that we now have leads and we now have directions. We have seen programs that have developed in this way recently. The Woolridge committee pointed out some of the managerial problems involved in

this type of research. Dr. Shannon has had studies made of how he might better manage the contract portion of developmental research that we are now getting into. I think we are taking steps in response to the emerging program and response to the Woolridge committee report.

Mr. ROGERS of Florida. Are you going to see that these Institutes have planning groups to do this? We have found that there is not too much correlation as far as planning between your study groups and your councils for extramural programs and whatever is done intramurally. It seems to me that there ought to be more coordination and working together.

Dr. STEWART. I think the organizational structure of the Cancer Institute has been moving and, to a certain extent, our National Institutes of Mental Health, toward relating these together and this has been in the direction you are talking about. I think this is going to depend more on the state of the art in a field than it is on whether some Institutes may not be as far along as others would be. It certainly is moving in that direction that you are mentioning.

Mr. ROGERS of Florida. What about budgetary support for these positions that might be required; is that any problem?

Dr. STEWART. The budgetary support has been increasing. I think our problem is more in attracting the kind of people that we need.

Mr. ROGERS of Florida. I think until we get some positions set up to fill, this is our concern now. I do not think we have made enough effort to get positions to fill.

Dr. STEWART. We have added positions in these top levels. I think there is going to be need for more.

Mr. ROGERS of Florida. I would hope that you could follow through on this because this is one of the great areas we see that needs action. This is planning in our National Institutes of Health.

Secretary GARDNER. You are speaking specifically of top positions in the planning area?

Mr. ROGERS of Florida. Yes; to coordinate this planning and do something about it.

Dr. STEWART. Last year I think the Congress added a fair number of positions in Dr. Shannon's planning office and now he is developing these at each Institute. There may be other managerial changes he will have to make in order to manage the type of program that is emerging, which is different from the individual grants to the individual investigator.

Mr. ROGERS of Florida. I understand. The reorganization plan in effect will abolish the National Institutes of Health and the position of Director?

Secretary GARDNER. Yes, sir.

Mr. ROGERS of Florida. Are any of the Institutes abolished?

Secretary GARDNER. No.

Mr. ROGERS of Florida. Why not?

Secretary GARDNER. I am sorry to tell you that I do not know the details, the technicalities of it; the reorganization planning as stated is simply designed to give me whatever authority I need to reshape this. I am going to redelegate any authority back to the Surgeon General.

Dr. STEWART. May I delegate it to the man who knows something about it?

Secretary GARDNER. This is the Assistant Secretary for Administration.

Mr. SIMPSON. Mr. Chairman, the several laws that organize the programs in heart, cancer, mental health, and so forth, provide that these programs shall be carried out by the Surgeon General through the respective Institutes. The Congress made a conscious decision in enacting these laws that they wanted them carried out through the machinery represented by the Cancer Institute, Heart Institute, Mental Health Institute, including their advisory councils, and the other Institutes.

We saw no need to change that fundamental concept. It has worked very successfully, and there is no intention in this reorganization plan to change it. We saw some advantage, since the Institutes had achieved a national stature in their own name here, of maintaining them. What the plan does is take the functions of the Surgeon General to carry on the heart, cancer, and other programs, through these Institutes and says the Secretary shall carry out these functions through the Institutes.

Mr. ROGERS of Florida. Of course the Congress set up the Surgeon General, too, and we are abolishing him, are we not?

Dr. STEWART. No.

Mr. ROGERS of Florida. We are not?

Dr. STEWART. No.

Mr. SIMPSON. I am sure the Surgeon General wants to answer that.

Secretary GARDNER. Are you making a suggestion?

Mr. ROGERS of Florida. No, particularly not with this Surgeon General.

Dr. STEWART. I am happy to report the reorganization plan does not abolish the Surgeon General. It does abolish the Deputy Surgeon General.

Mr. ROGERS of Florida. I thought we had information it also abolished you.

Dr. STEWART. No, it does not.

Mr. ROGERS of Florida. And allows the duties to be assumed by the Secretary?

Dr. STEWART. It transfers the authority.

Mr. ROGERS of Florida. It does not abolish the legislative position of Surgeon General?

Dr. STEWART. That is correct.

Mr. ROGERS of Florida. But all of the duties are transferred and can be redelegated by the Secretary?

Dr. STEWART. That is right.

Mr. ROGERS of Florida. When you have those, could we have what the duties are that he has delegated to the Surgeon General?

Secretary GARDNER. Yes.

Mr. ROGERS of Florida. In view of this reorganization, do you think there should be a comprehensive review and subsequent codification of the Public Health Service Act?

Dr. STEWART. Mr. Chairman, we have had some discussions of this about a year ago, of the need for bringing the act up to date since there has been so many additions. I am told this is a terribly hard

job and takes considerable length of time. Beyond that, we would have to consult with, I guess, the General Counsel's Office as to whether it is desirable and how much time it would take.

Mr. ROGERS of Florida. I think we almost have to do something like that in view of this reorganization.

Let me ask you this: What about the Food and Drug? Have you reorganized Food and Drug, Mr. Secretary?

Secretary GARDNER. We are in the process. Dr. Goddard, as you know, has taken very active steps to reshape that agency, to bring in new people, and his goal is to reorganize it rather considerably.

Mr. ROGERS of Florida. You need no authorization of a plan to effect the reorganization within the Food and Drug; is that correct?

Secretary GARDNER. Not in that case, no.

Dr. LEE. I should say that the Secretary is not aware at the moment, but Dr. Goddard's recommendations have gone to Mr. Simpson and now are on my desk. After I review them they will go to the Under Secretary and then to the Secretary. So he has not had the chance to examine them.

Mr. ROGERS of Florida. The committee will be interested in hearing Dr. Goddard, perhaps along with Dr. Lee, come up and tell us about these plans, if we could arrange that. Let us know when you would be ready to come.

I think the committee would be interested in that because we are very interested particularly in some of the FDA procedures, how he is going to set up the reorganization to handle the new drug applications, the testing, such as the pills, and all of these drugs that are going to be tested.

Also, we are concerned about the foreign drug question.

I understand the law requires each batch to be tested when it comes into the United States. Whether this is being done, I do not know.

There are many questions we want to go into. When you are ready give us some idea, and we would like to hear about it.

Mr. Secretary, I think we should have some report on the overall planning council of the NIH that is being set up by Dr. Shannon, and also the various planning groups in each instance.

Dr. STEWART. Dr. Shannon is setting up an "overall committee," which is actually what we call it. He also has his own internal planning staff. The individual institutes will be setting up their own internal planning committees.

Mr. ROGERS of Florida. Let us know what they are doing, their function, and with regard to extramural and intramural activities. This would be helpful.

(The information requested will be found in the subcommittee report.)

Mr. ROGERS of Florida. Also on health manpower, I want to ask a question on the nursing problem that is being accentuated. I know we have discussed the possibility of getting junior colleges in on this. I am personally not satisfied with the way it has yet been handled.

If the Secretary could go into this, I think this would be helpful. I think we are overlooking a great reservoir of people in the junior colleges by not yet really qualifying them for full aid under the Nurses Training Act. I know we were concerned about the Technical Services Act that we passed, which the Department of Commerce is

administering, although it is being coordinated with the Commissioner of Education, and they have now qualified junior colleges to participate in that program, which they should.

I would hope we could go as far in the nurse program, when we have such a shortage, with the junior colleges. If you could go into that and let us have some reaction.

Secretary GARDNER. We will be very glad to do that.

Mr. ROGERS of Florida. Mr. Secretary, we appreciate your being here with your associates to give us your ideas. We probably will keep in close contact before writing our report, and we would like to hear from the Food and Drug.

Thank you so much.

Secretary GARDNER. Very good. Thank you, sir.

Mr. ROGERS of Florida. The committee stands adjourned.

(Whereupon, at 12:07 p.m., the committee adjourned, subject to call of the Chair.)

INVESTIGATION OF HEW

MONDAY, JUNE 20, 1966

HOUSE OF REPRESENTATIVES,
SPECIAL SUBCOMMITTEE ON HEW INVESTIGATION
OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m. in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman of the subcommittee) presiding.

Mr. ROGERS of Florida. The committee will come to order, please.

We have today representatives of the Department of HEW. We are pleased to have the Assistant Secretary for Health and Scientific Affairs and the Commissioner of Food and Drugs.

We are particularly pleased to have Dr. Lee here who has joined the Department, specializing in the field in which we are particularly interested, and also the Commissioner, to present testimony to the committee.

As you know, the thrust of our investigation is with the reorganization and any problems that the committee feels are attendant thereon. So, we are particularly pleased to have you gentlemen here with your associates.

Dr. Lee, if you would present your statement now, we would be pleased.

STATEMENT OF HON. PHILIP R. LEE, M.D., ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. LEE. Mr. Chairman, in addition to Commissioner Goddard, we are accompanied by Edwin R. Lannon, Assistant Commissioner for Administration, Food and Drugs Administration.

We welcome this opportunity to continue our discussion of current reorganization plans within the Department of Health, Education, and Welfare.

As you are aware the Department is faced with a major task in gearing the organizational structure of the component agencies to effectively meet our increasing responsibilities in the health field. This is exemplified by the need for reorganization of the Public Health Service which Secretary Gardner, the Surgeon General and others recently discussed with this special subcommittee. This same situation exists in the food and drug programs. The Drug Amendments of 1962 to the Federal Food, Drug, and Cosmetic Act imposed greatly increased responsibilities on the FDA. Experience gained since the passage of those amendments has shown us that a modifica-

tion of FDA's organizational pattern for handling the review and surveillance of new drugs should be made.

Just last year, Mr. Chairman, you and other members of this committee had an important part in the enactment of the Drug Abuse Control Amendments. The abusive, nonmedical use of important therapeutic agents demonstrated the need for more positive steps by the Government to deal with the problem. The Congress met this challenge with a strong yet equitable law to restrict these medicines to medical channels. But this too increased materially the responsibilities of the Food and Drug Administration.

In the food field, while there has been no recent legislation, there have been increasing responsibilities created by technological advances in this industry. More pesticides are used to produce higher crop yields and better quality agricultural products. An increasing variety of food additives are incorporated in foods to make them more attractive, better tasting, and more economical. These and other advances in the food industry increase the responsibilities of the agency charged with assuring that our food is pure, wholesome, and safe.

It is imperative that we strengthen our scientific capabilities so we are adequately equipped to meet the challenge of these new developments. As new drugs are developed we must be able to make timely decisions as to a drug's safety and effectiveness. In this way we can discharge our responsibility to protect the consumer without delaying scientific progress and the availability to the people of this country of new drugs that can save lives or minimize the disabling consequences of disease.

The need for organization changes to meet these new and rapidly expanding responsibilities of the FDA was stressed by a special advisory committee, appointed last fall by Secretary Gardner to study the FDA. Commissioner Goddard will discuss with you some of the recommendations of this advisory committee and the details of the changes in FDA's organization which have been approved by the Secretary to permit the agency to meet its growing responsibilities.

With your permission, Mr. Chairman, Commissioner Goddard will give his statement.

Mr. ROGERS of Florida. Fine. Thank you.

Go ahead, Mr. Commissioner.

STATEMENT OF HON. JAMES L. GODDARD, M.D., COMMISSIONER OF FOOD AND DRUGS; ACCOMPANIED BY EDWIN R. LANNON, ASSISTANT COMMISSIONER OF FOOD AND DRUGS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. GODDARD. Mr. Chairman, it is a pleasure to appear before you today to discuss the progress we are making in the reorganization of the Food and Drug Administration. This has been, as you can imagine, a most challenging assignment for every member of the agency and I am happy to report that the personnel of the Food and Drug Administration—at every level and at every location—have provided initiative, imagination, and thoughtful reasoning to the total process of this reorganization. Without their assistance, the

work of my office could not have gone forward as well as it has. As I say, Mr. Chairman, I am most happy for the opportunity to enter into the record the progress we have made thus far and to give credit to the agency's staff, who have made that progress possible.

Dr. Lee outlined for you the increasing responsibilities which we face within the Department of Health, Education, and Welfare and the need for modernizing our organization to meet these responsibilities. Neither Dr. Lee nor I need remind this committee of the record set by the 89th Congress in providing for the people of America a broad and responsive health program. Under the leadership of President Johnson and Secretary Gardner, we are prepared to assume our new responsibilities in carrying out that program, as we, at the same time, maintain our watchfulness in all other areas assigned to us by laws passed by former and equally concerned Congresses.

We must, then, work more effectively and more confidently with health agencies within our Department, and I think this is being accomplished. And we must also work more closely with other agencies of the Federal Government such as the Department of Agriculture and the Department of the Interior, to tender the kind of service the people of this Nation need and, through this Congress, have asked for.

The reorganization of the Food and Drug Administration was recommended in a report to Secretary Gardner, who released it on January 17, 1966. The report was prepared by a special committee headed by Mr. Rufus Miles, former Assistant Secretary for Administration in the Department of Health, Education, and Welfare. I would like to offer a copy of that report to you, Mr. Chairman, and request that it be placed in the record.

Mr. ROGERS of Florida. Without objection, so ordered.

(The document referred to follows:)

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., January 17, 1966.

MEMORANDUM FOR THE STAFF OF THE FOOD AND DRUG ADMINISTRATION

On November 14, 1965, I appointed a committee under the chairmanship of Rufus Miles to advise me on current and emerging problems of the Food and Drug Administration and to make recommendations as to the qualifications and requirements desirable for a new Commissioner.

The other members of the committee were: John Corson, Boisfeuillet Jones, Edward Dempsey, Bruce Cardwell, and Dwight Ink. Dean Coston, Deputy Undersecretary of HEW, was assigned to direct the staff work of the committee.

The committee studied earlier reports on FDA, reviewed congressional hearings and reports, examined current writings, talked with a great many informed observers inside and outside the agency, and received and considered extensive correspondence from interested persons.

At the end of the committee study, the chairman and the staff director gave me an extensive oral report on the committee's findings. In addition, the committee submitted the attached written report. (See attachment A.)

JOHN W. GARDNER, *Secretary.*

[Attachment A]

REPORT TO THE SECRETARY ON THE FOOD AND DRUG ADMINISTRATION

Committee procedures and activities

We recognize the great contribution to consumer protection which the present staff of the Food and Drug Administration has made. We believe that the FDA staff has been dedicated to the public interest. It is not the intention of

this report to criticize the performance of the men and women in the FDA who have performed well, but to identify important problems which have arisen and which must be dealt with by the Secretary and the new Commissioner.

The Committee focused attention first upon the major problems of FDA and then upon the qualifications of a new Commissioner. Interviews were held with FDA, PHS, and Office of the Secretary officials, as well as with persons from other agencies of Government and the Congress, and informal discussions were held with persons outside the Government. Letters were sent to Government officials and members of the Advisory Committee on Food and Drug requesting their views. Replies have been received from most of the addressees.

Conclusions

The key problems of the Food and Drug Administration stem largely from its explosive growth and the number and complexity of the problems with which it must deal. The Committee has concluded that the following three major problems face the next Food and Drug Commissioner:

1. *There is urgent need for a clear set of policies.*—Confusion exists within the FDA concerning its basic policies and emphases. There is need to weigh complicated and often conflicting considerations and establish as clear guidelines as circumstances permit. Examples of the difficult issues which require clarification of policy include the following:

(a) What should be the relative emphasis of enforcement as compared to education and voluntary compliance, and how can these two approaches be combined most effectively?

(b) Where should the balance be struck between benefits and hazards in the approval of new drugs?

(c) What principles should be used in deciding difficult cases where the issue is between quick action to protect the public against suspected but unproven health risks and more deliberate action to continue known health benefits? (This problem is made especially difficult when large economic losses hang on a close question.)

Developing such a policy framework is admittedly a difficult and never-ending task, since new policy questions constantly arise and present policies will not remain static but will evolve. The reduction to written form of the agency's guiding principles is nevertheless essential to understandable, consistent, and effective administration.

2. *There is need for a strengthening and re-orientation of management.*—In growing from a small family-type organization in which decisions were made on a case-by-case basis by the top officials, to a large organization dealing with numerous and complex issues, the Food and Drug Administration has failed to make the necessary basic shift in management philosophy and techniques which are required for effective and efficient administration. The Second Citizens' Advisory Committee recommended decentralization of decision-making, but was not sufficiently explicit in pointing out that decisions cannot be decentralized without adequate criteria and guidelines to the decision makers. Without such criteria, delegations result in disagreements between the officials who make the decisions and the officials who have made the delegations; lengthy delays occur in decision-making; and decisions are inconsistent. Without delegations, delays would become intolerable. Delays in some governmental services are merely annoying or inconvenient; delays in decision-making in the FDA may have extensive effect upon the health of significant segments of the American public. They may also have major economic impact upon the industries affected. In short, laxity in management cannot be tolerated.

3. *There is need to elevate the level of scientific competence of the FDA.*—Much of the recent criticism of the Food and Drug Administration has centered upon the need for strengthening the scientific resources and competence of those who have made, or have avoided, decisions which subsequently have come under scrutiny and criticism by congressional committees, journalists, the scientific community, and others. One of the most often repeated recommendations from people outside the Food and Drug Administration is that the new Commissioner of Food and Drugs should be a person who can and will be equipped to elevate the general level of scientific competence of the Food and Drug Administration.

Each of the three problems is made more acute by the intense pressures surrounding the operations of the Food and Drug Administration. Because of these pressures, the agency *must* achieve a high standard of excellence, *must* be skillfully managed, *must* be clear as to policies, *must* function with spotless integrity.

Recommendations

The Committee has agreed upon the following desirable qualifications for the new Commissioner of Food and Drugs:

1. Strong interest in, and commitment to, the promotion of the public good through the effective administration of food and drug laws equitably throughout the United States.

2. Capacity to conceptualize the problems of the Food and Drug Administration and establish principles, criteria and guidelines for delegations to lower level officials so they can make decisions promptly, consistently, and with confidence.

3. Courage to pursue the course of action he believes to be in the public interest even in the face of strong opposition from special interests.

4. Understanding of how to attract, use and hold top-flight professional personnel, especially medical and scientific personnel.

5. Knowledge of the subject matter with which FDA must deal, including an understanding of the scientific background of the difficult issues concerning drugs, pesticides, etc.

6. Experience in large-scale administration.

7. Broad knowledge of and preferably experience in the Federal Government, its processes and relationships among the agencies and with the Congress.

8. Capacity to deal effectively with the information media, clientele groups, and others.

9. A recognized reputation for high competence, either within the Federal Government, or in the biomedical science community, or both.

The Committee recognizes that not all of these desirable qualifications will be found in any one individual, but the list is useful as a yardstick against which to measure candidates.

In addition, the members agree that:

1. The Commissioner, Deputy Commissioner, and Associate Commissioner for Science should be viewed as a team to achieve maximum strength in both management and scientific competence. This whole top team must be sufficiently outstanding to win the immediate confidence of the public, industry, Congress, and the scientific-professional community. It is essential that one of these officials should be a competent scientist, preferably from the life sciences. If the Commissioner himself does not have a scientific background, he should be able to designate as the top scientific post in the organization either the Deputy Commissioner position or the Associate Commissioner for Science Resources. If the Deputy Commissioner position were to become the top scientific post, the position of Associate Commissioner for Science Resources might then be renamed and changed to an administrative position. In any event, the relationships, responsibilities, and authorities of the Deputy and Associate Commissioner positions should be made clear. The Secretary should work closely with the new Commissioner in selecting the rest of the top management team.

2. The challenges before the Food and Drug Administration in coping with the explosive growth in its responsibilities and in upgrading its scientific competence are of such major national importance that it is essential to select the most competent available person for the position of Commissioner, using the entire Nation as a source of recruitment. The best features of the career system can be retained and strengthened in the long run by bringing into the top level of the FDA a Commissioner who will give it greater national standing and strength than could be achieved by any career official within the present staff of FDA.

3. It is essential to build a strong bridge between the scientific activities of FDA and the outside community of science. Essential to this is a strengthening of the internal scientific resource. Additional scientific talent should be brought in. FDA scientists should have more opportunities for research, more opportunities to refresh and upgrade their knowledge and skills. The Food and Drug Administration should further strengthen its relationships with the university community.

Greater use should be made of the scientific resources and capabilities of the Public Health Service (NIH in particular). This will require substantially greater cooperation by both NIH and the FDA. Food and Drug Administration should also have more fruitful relations with the Department of Agriculture and the Veterans Administration.

A scientific advisory committee should be established at the level of the Commissioner's office to advise the Commissioner on the most difficult policy

issues he faces. This committee should advise on scientific principles and criteria, and not review individual cases.

The National Advisory Council (already a strong group) should be further strengthened, and should become a body of the highest possible distinction.

Dr. GODDARD. As I do, however, let me quote a few sentences which, I believe, may help provide a setting for remarks to you today. The Committee drew three basic conclusions about the needs of the FDA:

"(1) There is urgent need for a clear set of policies.

"(2) There is need for a strengthening and reorientation of management.

"(3) There is need to elevate the level of scientific competence of the FDA.

" 'Each of the three problems is made more acute,' the committee said, 'by the intense pressure surrounding the operations of the Food and Drug Administration. Because of these pressures, the agency must achieve a high standard of excellence, must be skillfully managed, must be clear as to policies, must function with spotless integrity.' "

As I noted, Mr. Chairman, Secretary Gardner released the report of the Miles committee on January 17, 1966, the day I was sworn in as the new Commissioner of Food and Drugs. On January 27, 1966, 10 days later, I sent a memorandum to all employees of the agency announcing that there would be a "strengthening and reorganization of the agency," and I would like to introduce that memorandum into the record also with your permission.

Mr. ROGERS of Florida. Without objection, it will be included in the record at this point.

(The document referred to follows:)

JANUARY 27, 1966.

MEMORANDUM ALL FDA EMPLOYEES

From: James L. Goddard, M.D., Commissioner of Food and Drugs.
Subject: Strengthening and Reorganizing the Agency.

President Johnson and Secretary Gardner have given ample evidence of their interest in the continued growth and importance of the Food and Drug Administration. I know I share with all of you the sense of new purpose and new mission that have been assigned to us and which we can expect may be expanded. This means, in the words of the recent Miles Committee Report, that the FDA *"must* maintain a high standard of excellence, *must* be skillfully managed, *must* be clear as to policies, *must* function with spotless integrity."

This is our time to move ahead with devotion and intelligence. I feel confident this agency can do it. Therefore, I am asking all Bureau Directors and other supervisory personnel to give thought to adjusting and modernizing the organizational structure of FDA. Through them, I expect to get the best thinking of all FDA employees.

We intend to move ahead diligently but without needless haste. The rights of every employee will be respected in any reorganization I approve. This is a matter of special interest to me and I have conveyed this interest to the agency's top personnel. The job satisfaction of every employee, the effectiveness of the agency, and the protection of the public interest itself are all at stake. It is in this spirit that I am asking Bureau Directors and supervisors to work with me on strengthening and reorganizing the FDA.

JAMES L. GODDARD.

Dr. GODDARD. I asked all Bureau directors and other supervisory personnel to begin immediately to work with me on this problem. The mandate was clear. It had been provided by the Secretary at the ceremonies marking my appointment.

Beginning in January and continuing to this present day, the Bureau Directors and Assistant Commissioners of the Food and Drug Administration have met with me on a regular basis. These staff meetings were marked by a candor and a sense of high purpose which gave me the assurance to press ahead with all dispatch on the organizational problem. The agency was clearly ready and willing to move forward; the new personnel coming in—and I would count myself among them in this discussion—perceived this readiness right way.

A number of problems were placed squarely on the table during our early meetings in January and February. We tackled two of them in depth right away, laying the groundwork for working out the others as soon as we could thereafter. The first was the role of the scientist in the Food and Drug Administration, the kinds of responsibilities he should have, and his position within the overall organization. The second was the immediate Office of the Commissioner itself.

It is essential in carrying out our responsibilities under the Federal Food, Drug, and Cosmetic Act that our decisions be based on sound scientific judgment. Therefore the scientist must have a very significant and very visible position within the agency. In addition, the scientific staffs should have the kind of balance within the agency overall so that their resources can effectively be tapped by any other units within the agency and also have the strength to carry out its own vital mission of on-going research and analysis.

I therefore have placed highest priority on recruiting to fill the long vacant position of Associate Commissioner for Science. This person will be responsible for providing the Commissioner of Food and Drugs with advice and counsel on matters involving scientific judgments to be made by the Commissioner. This person will also coordinate the scientific activity within the FDA as much as possible. I have qualified that, Mr. Chairman, because the Associate Commissioner for Science must not retard the work of our scientists, must not discourage or be oppressively critical of the work of our scientists. It is his function, rather, to see how the work of FDA scientists—their basic and applied research, their explorations into new methodology, their new and very fruitful relationships with scientists in other governmental agencies and in the scientific community in general—to see how all these things can go forward with a minimum of overlap, of friction, and of waste to produce a maximum return to both the agency and to the public.

The Associate Commissioner for Science will also coordinate the science information program within the agency. There is, for our agency as for all agencies in Government, a serious problem of the explosion of new knowledge in the scientific fields and of the organizing and harnessing of this knowledge to make it work for the public good. This coordinating function within the Associate Commissioner's office will keep "live" the information generated by our agency and make it more readily available not only to our own personnel but also to the scientific community at large.

We recognize that it is a responsibility of any professional—in and out of Government—to make his discoveries, his ideas, his judgments, and his basic data available to all other professional persons. Our establishment of the Office of Associate Commissioner and its func-

tion of coordinating all science activity and science information is, we feel, a way of helping to insure that the Food and Drug Administration produces the maximum results with its personnel, facilities, and budget and that these results in the scientific field are available to all who need the information.

I mentioned, Mr. Chairman, the need to give our scientific staff a balance of strength within our agency, in order for science to form a strong base for regulation. Therefore, after much discussion with our staff, I have combined the former Bureau of Scientific Research and Bureau of Scientific Standards and Evaluation into a single Bureau of Science. The result is an increase in the flow of data among the several scientific disciplines within this new Bureau. There is a growing need for interdisciplinary approaches to solving many of the problems within the areas of food, drugs, cosmetics, and hazardous substances. Therefore, our toxicologists, food chemists, and pharmacologists can, within the organizational context of a single Bureau, more easily exchange data and more effectively join forces to ferret out the answer to a particular problem.

I have indicated that our agency needs a great deal of new information in the cosmetics field. And I am pleased to report that the new Bureau, as it has been organized, is making it possible for our scientific personnel—many of whom are among the best within their own disciplines—to share data in this field and to help other units within the Food and Drug Administration carry out their missions more effectively on the basis of this new data supply. This is but one of the advantages accruing to the Food and Drug Administration from the organization of a single Bureau of Science and by the Office of the Commissioner having a single Associate Commissioner of Science coordinating and advising in this important area.

The immediate Office of the Commissioner, Mr. Chairman, posed somewhat different problems. The Food and Drug Administration regulates industries which produce and distribute products essential to the national well-being. These industries, because of their leadership in manufacturing, distribution, research and development, and competitive business practices, also sell their products around the world. They are diverse and vital industries and need the support of the Food and Drug Administration, as well as our watchfulness.

In addition, the enactment of certain landmark pieces of legislation—medicare, the Drug Abuse Control Amendments of 1965, the Older Americans Act, and other laws—by the Congress have placed

upon the Office of the Commissioner two expanded responsibilities:

First, the Commissioner of Food and Drugs must have access personally or through members of his immediate staff, to the leadership of the industries under regulation in order to help them move ahead competitively without an inadvertent or calculated violation of law.

Second, the Commissioner of Food and Drugs must have access personally or through members of his immediate staff, to the leadership of other agencies of government—whether local, State, or Federal—in order for him to insure the full and effective implementation of the laws enacted by this Congress and entrusted to us.

It is for these two important reasons that I have taken certain steps to make the Office of the Commissioner—regardless of its incumbent—a more responsive and effective position in the Government. Within the Office of the Commissioner, and serving that Office directly, are four new units. These four units are not necessarily similar, Mr. Chairman, but I am discussing them together today because we developed their functions and proposed them all at the same time. For your assistance there are charts attached to this statement which depict the organization prior to May 2, 1966 (Chart A), and the proposed organization which has been approved by the Secretary (Chart B).

(The charts referred to follow:)

CHART A

FDA Organization Prior to May 2, 1966

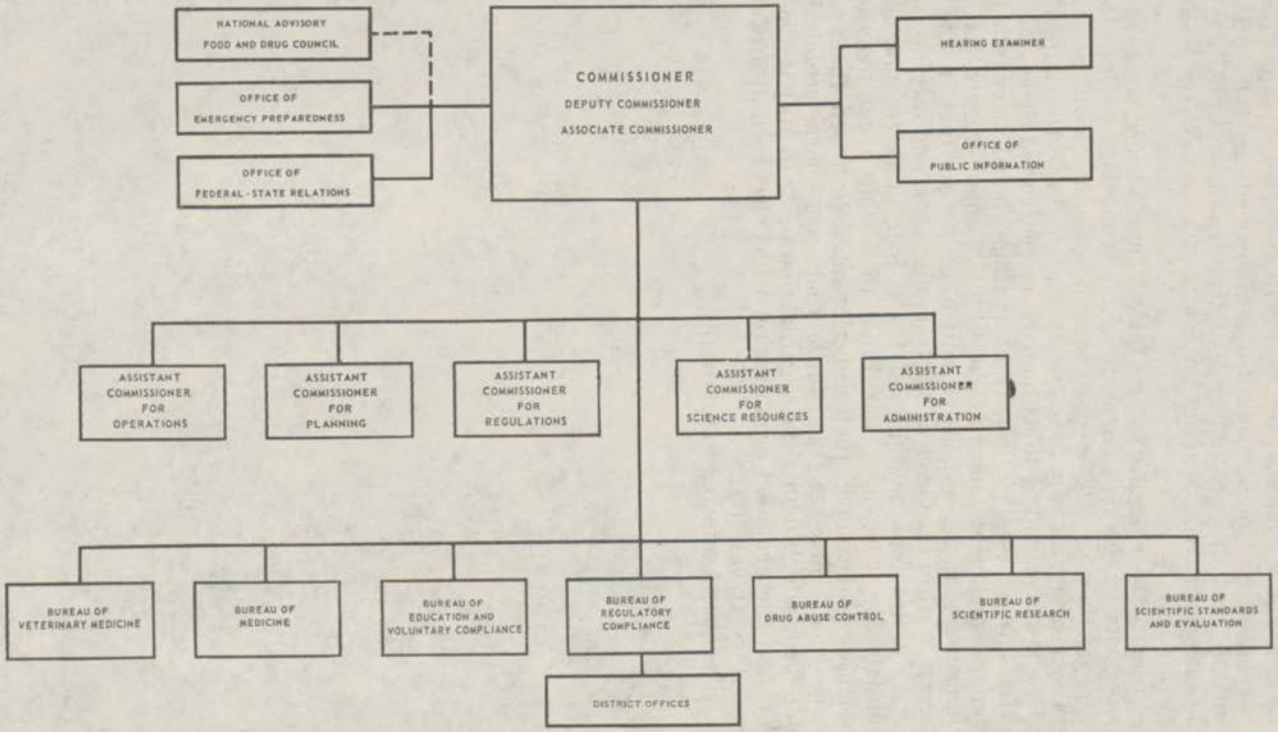
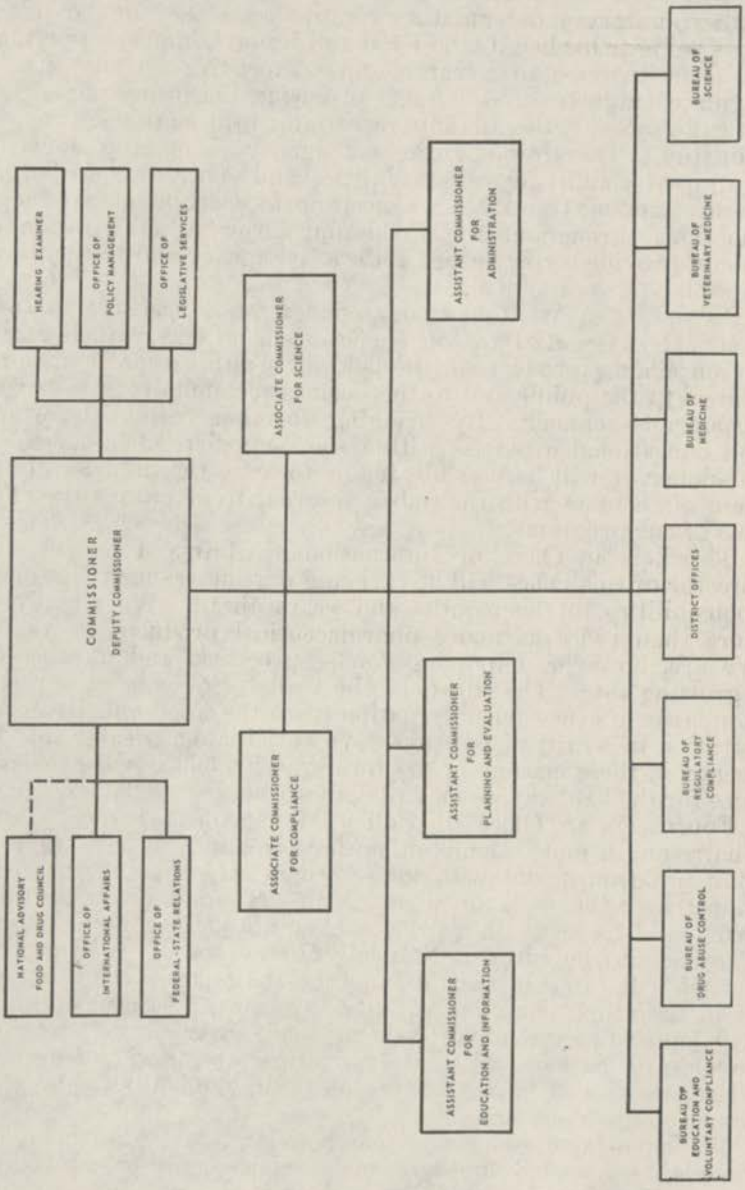


CHART B

Proposed FDA Organization



Dr. GODDARD. First, is an Associate Commissioner for Compliance, a coequal with the Associate Commissioner for Science, whom I have discussed already. The Associate Commissioner for Compliance will coordinate all the activities within the agency which are concerned with voluntary and regulatory compliance. The number of regulations being published by the Food and Drug Administration increases with the increase in research and competitive activity within the regulated industries. The legal problems, the inspectional and analytical problems, the administrative and informational problems all multiply. Therefore, before our agency becomes immersed in a swamp of conflicting responsibilities and contradictory judgments, we are moving to establish a position to coordinate the compliance functions throughout the Food and Drug Administration. This should provide better service both to the agency and to the industries as well.

Second, is an Assistant Commissioner for Education and Information. It is essential for an agency such as ours, which must take action against products in the field of health, to make these actions known to the public and to the business community in a reasonable, responsible manner. By bringing together certain informational and educational expertise within the immediate Office of the Commissioner, it will be possible for us to serve the public fully and to maintain contact with the public in order to determine the effectiveness of our programs.

Third, is an Office of International Affairs. I believe that the director of this Office will be carrying our increasingly significant responsibilities in the months and years ahead. We already export more than twice as many pharmaceutical products as we import. We are, however, importing foods—processed and unprocessed—at a growing rate. The efforts of the United States to raise the health standards in every friendly nation place the Food and Drug Administration in a critical position. We anticipate a greater role for our agency in these matters in the future. This Office will provide guidance for the best way we may play that role.

Fourth, is an Office of Policy Management. Once again, Mr. Chairman, I must sound an optimistic note. I have talked with industry groups and with many others interested in the regulated industries. There is no question in my mind but that the food, drug, and cosmetic industries are going to be making significant advances in the future. Naturally, every one of those product advances will—at one point or another—be monitored by our agency. It is, therefore, our responsibility to make sure that nothing we do will jeopardize the advances being made, even as we carry out our regulatory mission with determination and new strength. This Office, then, will have that responsibility and advise the Commissioner on those matters.

We have taken some additional actions, Mr. Chairman, and we have laid some plans and have made some suggestions on reorganization. We have, for example, consolidated our Advisory Opinions Group with our Division of Case Supervision so that a single individual, within the Bureau of Regulatory Compliance, can see the total picture of the effectiveness of advising members of industry, as against the instances of violations or noncompliance.

It would not be appropriate for me to go into detail on plans not yet submitted to the Secretary of Health, Education, and Welfare for his judgment and approval or disapproval. However, I can say that we are involved in two other major organizational changes:

First, we are seeking ways through which our field offices, spotted in 18 metropolitan centers about the country, can be in more direct and workable contact with the Commissioner of Food and Drugs. This would not necessarily reduce in any way the effectiveness of the Bureau of Regulatory Compliance, which has directed the operations of the District Offices. It may well be that the Bureau could carry on its programs with less of an administrative overload, should the District Office directors and the Commissioner of Food and Drugs be in immediate and direct contact. Naturally, the Associate Commissioners for Science and for Compliance, as well as the other aids within the Office of the Commissioner, would then be more accessible to the field, also.

Second, we are seeking ways to make the Bureau of Medicine more productive and more contemporary, as the drug industry continues its extensive research and development programs. We are exploring a "team" approach to the problem of drug review and appraisal. With such an approach a single group of medical officers will follow the histories of drugs which are similar in structure or use. The results of the investigational effort bear upon the new drug approval stage and the information from both these developments is useful as the drug is monitored during the course of its commercial life. This is the fundamental framework within which we are considering a reorganization of the Bureau of Medicine. We believe this is essential at a time when new drugs are coming on the market at the rate of one every other week and when we are about to review for efficacy all drugs cleared for safety before 1962 and still being manufactured, prescribed, and sold.

Briefly, Mr. Chairman, this is the direction in which the Food and Drug Administration is moving in order to be a more effective, more responsive, and more responsible agency of the Government. But I would like to make one final point which I feel can never be overlooked. Good organization does not guarantee that you have a good agency. Only good people provide that. So I would wish to assure this committee that, as we move forward in our efforts to reorganize and strengthen the Food and Drug Administration, we will be ever mindful that the quality of our personnel will be the final measurement of the quality of the agency.

Thank you, Mr. Chairman.

I will be happy to answer any questions.

Mr. ROGERS of Florida. Thank you, Mr. Commissioner, for your statement.

I think it is true, of course, as you say, no matter what organizational structure you have, it depends pretty much on the type of people you have.

Mr. Van Deerlin?

Mr. VAN DEERLIN. Dr. Goddard, when you took over a few months ago, a publication of the American Medical Association commented, in part:

Another task facing the new appointee is that of easing the sometimes bitter interagency squabbles between the "get tough" faction and the officials who believe in a cooperative approach with industry.

Have you found that this division runs deep, and how do you identify yourself as between these factions?

Dr. GODDARD. Sir, I was aware that this description had been applied to personnel of the agency and one of the steps that we have taken is to try to promote the idea that the scientific data available on the issues should determine the outcomes of the issues.

I think that the actions that we have taken have been supportable scientifically. Many of them had been pending for a long time. And so, we have had, as you are well aware, in the past 5 months what seemed like a flurry of actions directed against some of the industries we regulate.

Now, in every one of these, the scientific judgments, I feel, prevailed rather than a desire to get tough with industry. I have no desire to get tough with them. There are simply some rather clear ground rules that have been laid by Congress in the Food and Drug Act, and its amendments, and we are simply trying to handle the problems before us in a way that will insure the protection of the public whose interest we serve.

I do not see this deep division or cleavage today, to answer your question.

Dr. LEE. I think, also, Mr. Chairman, in the press, at least the problem tends to be oversimplified, painted either as a conflict or a sort of giveaway, and, as Dr. Goddard has pointed out, the situation is really much more complex, and certainly more complex than that statement from the American Medical Association would indicate. We certainly completely support, and the Secretary completely supports the approach that Dr. Goddard has taken in the Food and Drug Administration, developing the scientific base and the manner in which he has handled these very complex and difficult problems.

Mr. VAN DEERLIN. He has referred in his testimony to pressures which are always on the agency. Have these pressures been greater or less than you might have anticipated, Dr. Goddard, since you have been on the job?

Dr. GODDARD. I would say they have been somewhat less than I had anticipated. Of course, the great pressure that we face also is time. In our Bureau of Medicine, our backlog on new drug applications and investigational new drug exemptions is serious, and it is a difficult one to overcome. I am very pleased that on July 11 there will be a group of Public Health Service physicians, somewhere around 70 or 80 of them—I do not have a final count as yet—who will be detailed to the Food and Drug Administration, and with this many physicians coming at one time, we have developed a training program, using George Washington University's resources.

Mr. VAN DEERLIN. Are these county health officers?

Dr. GODDARD. No, sir. These are physicians who are coming into the Public Health Service, many of them to serve their 2 years of obligatory service. With their entry into the Food and Drug Administration, our major target will be to get rid of these backlogs within the next 12 months, and removal of those kinds of pressures

will do a great deal to alleviate other kinds of pressures that might develop.

Mr. VAN DEERLIN. I should imagine that last week's order in regard to new labeling requirements on vitamins could affect a rather large and well-heeled industry. Have you had some screams of anguish on that?

Dr. GODDARD. Only what I read in the newspapers, Mr. Van Deerlin. And, actually, if you study these proposals carefully, I feel that the industry can accommodate to the regulations. We do not know as yet, of course, whether or not they will file legal objections to them. That remains to be seen. But the substance of the regulations with respect to the vitamins, of course, brings our agency's standards into alinement with the National Academy's recommended dietary allowances which are soundly conceived, and I think a good basis for formulation of all of these products in the marketplace.

Now, we have not, in any sense, caused a situation which would require the removal of products from the marketplace but, rather, that they have to be formulated in a way that they meet the recommended dietary allowances.

Now, the other regulations with respect to special dietary foods, we felt, were badly needed because of the confusion that exists in the marketplace because of labeling that indicates low calories or lower in calories without any standards so that the consumer would really know what he was buying. So, I am hopeful that the industry will be responsive and responsible in their consideration of these regulations.

Dr. LEE. I would like to make one additional comment, Mr. Van Deerlin.

Dr. Goddard mentioned the assignment of Public Health Service physicians to the Food and Drug Administration. Some people might view this as of benefit primarily to the Food and Drug Administration, but we feel that is a great training opportunity and an opportunity for these physicians to gain experience with drugs that they could not get anywhere else.

After they finish this 2-year assignment, they may go back to the National Institutes of Health where they may be involved in research. They may go back to medical schools where they would be involved in clinical research on drugs, or certainly as they go back, many of them, into practice eventually, they will be far better physicians, able to handle the problems of the many new drugs that come on the market more effectively than they would without this experience.

So, we see this as a mutually beneficial relationship.

Dr. GODDARD. I would like to add also, we hope that some of them become interested enough in our kind of work that they become career employees in the Food and Drug Administration as well.

Mr. VAN DEERLIN. Were you pretty badly hurt by the departure of veteran employees under provisions of the Daniels Act which permitted them to take earlier retirement?

Dr. GODDARD. There were a number of retirements. I think, in most instances, we have been able to replace these individuals. In one sense, it is always helpful for the younger people coming up in an organization to be able to move ahead and not be blocked, as they feel, in their ability to be promoted. I do not think we are seriously hurt by this.

Mr. VAN DEERLIN. In expanding your regulation of the cosmetic field, do you think you are going to need new legislation in addition to more staff?

Dr. GODDARD. I have asked Secretary Gardner for a period of grace to study the problems related to the cosmetic field. Most of this would relate to whether or not these should be a preclearance of cosmetics based on the safety of the compound; not the efficacy, but rather whether or not it would be safe for marketing. I promised the Secretary to report early next year, calendar 1967, on whether or not we would need new legislation and what form that should take.

The same is also true in the field of devices. This is a very complicated field today and becoming increasingly so. So, we are studying both of these problems at the present time.

Mr. VAN DEERLIN. Your concern for the advertising of lipsticks and perfumes will turn purely on their safety-related attributes, rather than on what romantic things they can do for the user.

Dr. GODDARD. Correct.

Mr. VAN DEERLIN. One final question. It has to do with krebiozen. This is something that has worried many members of the Congress.

The feeling was then that there might be some—might logically be some line drawn between persons who were using krebiozen befor the Government clamped down on it, and prospective new users—especially in light of the admission that there was nothing harmful in it, that it merely lacked the beneficial qualities that were claimed for it. We have reached a rather strange situation wherein residents of Illinois can obtain krebiozen, while patients in other States have to resort to some illegality, or at least get it in Illinois.

Would you care to comment on the dilemma that we find ourselves in here?

Dr. GODDARD. The basic question that you pose involves a rather deep responsibility that the Food and Drug Administration has. Now, this is not the first instance in which a compound has been promoted for the cure of cancer. If the premise were accepted that because it did no harm and persons were already taking it, it therefore should continue to be made available, then we would have in existence today, I am certain, the Hoxie cancer cure in Texas, which was a pure fraud that was promoted nationally, and a number of other situations of this type.

We feel that our actions have been appropriate, that they are scientifically sound, and there is indeed a danger in the use of krebiozen. We do know of instances in which persons used this instead of accepted medical treatment and deprived themselves of modern therapeutic methods, and so there is, although seemingly no harm, a very real harm that can come when a person uses a compound that is advertised to cure cancer but for which there is no scientific basis in fact.

Mr. VAN DEERLIN. Your answer surely, as far as it goes, is valid. It disregards the possible benefits of faith healing, and disregards the idea that if somebody has a feeling that something is helping him, and—if the Government can't find where this particular product is hurting him—maybe in the interests of humanity we ought to let him

have it. But I know that this is something that runs counter to FDA doctrine.

It is a little difficult, though, to tell people who were using something they can now get it only in one State.

Dr. GODDARD. If I may, I would like to illustrate the problems that may arise with just one case.

Shortly after I entered office, a service officer requested an appointment with me. He was stationed here in Washington. I did not know the man. He came into the office and I spent some time with him.

He made the statement:

> You know, I have been in the military services now for about 18 years, and I know that your agency would not take the steps that you have with respect to krebiozen, its promotions, unless you had some good basis.

He went on to say:

> My problem is basically that my sister has a young son who has cancer of the spine and the child was discharged from a hospital and the mother was told it was cancer and she picked up krebiozen as the only hope, and the child has been treated with krebiozen for some 7 years.
>
> She has noted that when the treatments are interrupted, the child becomes a little worse with respect to his gait and loss of control of his bladder and bowels, and we are in this dilemma now, of them living in one State and not being able to obtain the drug, and I wanted to find out what could be done.

Well, this was a rather interesting situation, so I asked that he obtain the clinical record from the hospital that had originally treated the child.

In due time, it arrived in my office, and, indeed, the child had been operated on for cancer of the spine, astro cytoma. And the operative records indicated a very low degree of malignancy.

So, I called a neurosurgeon acquaintance of mine, and without telling him any of the background other than here was a child who had had this type of surgery performed, I asked what his opinion would be as to the long-term outcome. Keep in mind that he did not know but what that surgery had taken place a month ago or a week ago. He said, "Well, with that low degree of malignancy, this child probably will do very well. Of course, he needs to be followed up. He may need radiation therapy sometime in the near future, but he should do reasonably well."

I went on to describe that the child has occasional problems of bladder and bowels. "That," he said, "is understandable. In the area where they removed the tumor some of the nerve fibers would be affected, and if he gets a concomitant infection, or gets overly tired, this could occur."

Then, I said, "Doctor, this child was operated on in 1959, 7 years ago." "Oh," he said, "this child should lead basically a normal life. But it would be a good idea to have him get in and be seen again and determine whether or not radiation therapy might be needed, just remain under good medical followup."

Well, the officer came back and I discussed this with him and told him of the recommendations of the neurosurgeon, and he said "Now, look at the dilemma I have." He said, "This is a sensible thing. I can understand why the child has continued to remain well, but," he said, "the real problem goes back to when the child was operated on, no one ever sitting down and spending 10 minutes with

my sister to tell her what the expected outcome would be, so she has had great faith in Krebiozen all these years."

I am certain these kinds of cases have occurred in different parts of the country and lead people to believe that this drug is efficacious, when, in fact, independent review by nongovernmental scientists who are skilled in the field of cancer chemotherapy found that it is not effective. They took the 500 cases that Dr. Ivy had selected personally and studied them, and they found no benefit from the therapy at all.

So, you see, even though this would appear to be a harmless substance and could be given, if one accepted that premise—which I do not—there is still the problem of this child needing some continuing medical care in good medical centers. It is a dilemma, I admit, for the patient and for the family, but I think we would be denigrating our responsibility to the public if we permitted this to be done in today's circumstances.

Mr. ROGERS of Florida. Would the gentleman yield?

Mr. VAN DEERLIN. Of course.

Mr. ROGERS of Florida. As a matter of fact, we put into the law that we want efficacy of drugs to be considered as well, and if a drug does not do what it is claimed to be doing, this is something that Congress has a stated policy on and which your agency has the responsibility to act on.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. It has not been shown that there is any efficacy in Krebiozen.

Dr. GODDARD. That is correct.

Mr. VAN DEERLIN. Thank you, Mr. Chairman.

Mr. ROGERS of Florida. Mr. Younger?

Mr. YOUNGER. Thank you, Mr. Chairman.

Following that line of questioning, Dr. Goddard, would there be any objection to a doctor prescribing or permitting his patient to have krebiozen if, in his opinion, it is a terminal case?

I have known cases in our own district where the doctor said: "It is a terminal case, and I do not think it will do you any good, but if you want to take it, I certainly will prescribe it for you. It will not do you any harm." That is the general opinion on it. That which I have seen emanating from the Department, it is just like taking colored water.

Well, why should not a doctor be allowed to do that, if he wanted to?

Dr. GODDARD. The basic reason is that before any of these substances can move in interstate commerce, they must have been proved as far as safety and efficacy are concerned, and if we set aside these basic requirements of the law, then we are opening up Pandora's box.

Mr. YOUNGER. Then, you could not trust the doctors.

Dr. GODDARD. I do not believe it is a question of trust of the physician but rather the responsibility.

Mr. YOUNGER. If they could only get it through a doctor's prescription.

Dr. GODDARD. This is true of many compounds that are presented to us for our evaluation before they can be marketed. I am certain

that in the efficacy review that is underway at the present time, there are going to be drugs that physicians have believed for many years to be efficacious that will be judged not to be efficacious and will not be available for use throughout the Nation any longer. I think this is really the substance of the law under which we operate.

Mr. YOUNGER. You are going back now to review all of the drugs that are on the market?

Dr. GODDARD. All those new drugs marketed from 1938 to 1962. Under the amendments of 1962, we are required to determine that these products are efficacious, and the National Academy of Sciences has agreed to undertake this review for efficacy and provide us with their recommendations on the 4,000 drugs involved.

Now, the individual physician has a very difficult task if he attempts to judge efficacy. In order to determine efficacy of a drug, one has to engage in most instances in a double-blind controlled study where neither the physician nor the patient knows which drug is being administered, and then after the completion of the therapeutic trial on the group of patients, the statisticians break the code and analyze the outcomes. Through these kinds of mechanisms, efficacy data can be derived.

Now, simply administering a drug in the ordinary office practice and observing the patient may contribute some to the understanding of the drug, but generally it does not permit you to draw valid conclusions about efficacy. So, the physician is in a very difficult position in this instance.

Mr. YOUNGER. I am somewhat confused, because the Surgeon General in a great booklet gave a discourse about the efficacy of cigarettes.

Dr. GODDARD. I am familiar with the report.

Mr. YOUNGER. But I noticed that doctors repeatedly coming up here from the Department—and you have a close relationship, I think with the Surgeon General—many of them from that Department smoke cigarettes, a large share of them.

Dr. LEE. Not the Surgeon General, sir.

Mr. YOUNGER. What?

Dr. LEE. The Surgeon General——

Mr. YOUNGER. No, he smokes a pipe. We mentioned that when he was here before. And it seems to me that there ought to be some consistency about this efficacy of drugs, if a cigarette is a drug. If we can't get any compliance within the Department, how do you expect to get compliance outside of the Department?

Dr. LEE. I think, on cigarette smoking, it is a matter of education, and we are doing our best to educate our leading physicians. As a matter of fact, around the country, and I think including in the Department, in the Public Health Service, there has been a very sharp decline in smoking among physicians, a really very dramatic decline over the period of about the last 5 years when the evidence became very obvious of the clear relationship between smoking and cancer and smoking and other diseases.

I might say another word, too, Mr. Younger, about the question of krebiozen. When I was in practice, I was faced with this problem of whether we should not use it for terminal cancer patients. I must say I took the view then, and I would take the same view now,

that it is a disservice to the patient to give him a medicine that you know is a fake, and there was no evidence that this would be helpful. I actually, when I was requested by a patient, refused to give it to them, and I never found that a patient left me on that account, and in the end, they were always more grateful that we did not give them something that we knew was really a dishonest deal with the patient. I think many physicians have been faced with this problem, and the majority would prefer to deal in a very straightforward fashion with the patient rather than give something that they knew could not possibly be helpful. There are many other drugs that can relieve anxiety and can help the patient through the terminal period of illness, and I think more important is the relationship they have with their physician, the relationship they have with the family, rather than using some quack remedy.

Mr. YOUNGER. A lot of these drugs that relieve anxiety and make you feel fine, like LSD, but you do not want those circulated either.

Dr. LEE. Well, we want that used for research purposes, and one——

Mr. YOUNGER. Then the public will have a hard time having a good time.

Dr. LEE. One of the areas where research will be done with respect to LSD is, as a matter of fact, in the terminally ill individual.

Mr. YOUNGER. Dr. Goddard, you mentioned the efforts of the United States to raise the health standards of friendly nations. That places Food and Drug Administration in a critical position. Are you going to determine which is a friendly nation, or are you going to leave that up to the State Department?

Dr. GODDARD. The latter, sir.

Mr. YOUNGER. What?

Dr. GODDARD. The latter, sir.

Mr. YOUNGER. And they will tell you and your Department which nations should have their health raised.

Dr. GODDARD. No, sir. Rather, the international program such as that with which Dr. Lee was involved in his prior assignment before coming to the Department, are well formulated in advance, and it is our responsibility to provide them with technical assistance in the Agency for International Development with respect to foods, food standards, food additives, medications, et cetera.

Dr. LEE. And, in addition, the relationship with the World Health Organization. We are actually, of course, helping some nations that at times, at least, are not particularly friendly. So that we——

Mr. YOUNGER. That is correct.

Dr. LEE. We do not differentiate through the World Health Organization. We do in our bilateral aid programs, and I think this is what Dr. Goddard was specifically mentioning in his testimony.

Mr. YOUNGER. In your work with the U.N., you do not discriminate. What you had in mind here is just what you are going to do. But I am always concerned as to how we determine what is a friendly nation. If we applied that to the foreign aid, we would not be giving out very much foreign aid.

You have already covered the subject, but you are now going back and clearing all the drugs——

Dr. GODDARD. Reviewing those cleared from 1938 to 1962 on the basis of safety only.

Mr. YOUNGER. There is no such thing as a "grandfather" clause in the drug business.

Dr. GODDARD. Not for those new drugs marketed in that time period. There is a legal issue at stake. The pharmaceutical manufacturers have claimed that there should be a "grandfather" clause for certain of these drugs, and so we have a case pending in the Federal courts at the present time over that issue. This would involve some 1,000 of the 4,000 drugs that I mentioned.

Mr. YOUNGER. Dr. Lee—and we are always glad to welcome you, from our own district. Dr. Lee is from Palo Alto, Calif., and naturally is a little more experienced than other people. [Laughter.]

But you make a statement here, Dr. Lee, that is rather interesting to me. You say more pesticides are used to produce higher crop yields and better quality of agricultural products, but all I have read is that the Pure Food and Drug is opposed to these pesticides being used, and that they poison people.

Dr. LEE. Well, what our general approach to this is, Mr. Younger, is that we prefer some new pesticides developed, some that are safer than the ones that have been used in the past.

Mr. YOUNGER. What do you mean by "safer"? Do you mean they are still bad?

Dr. LEE. Less hazardous.

Mr. YOUNGER. Still hazardous.

Dr. LEE. Some of them are still hazardous, yes, sir, when they are consumed by individuals in large quantities. When they are applied improperly, and when people are exposed to toxic doses either in an acute exposure or possibly through chronic ingestion.

Mr. YOUNGER. Then, you are going to get into the agricultural field?

Dr. LEE. We work closely with the Department of Agriculture; both the FDA and Public Health Service work closely with the Department of Agriculture on the problem of pesticides.

Mr. YOUNGER. You say, in another statement, "and more economical." Is there anything more economical today in the way of food?

Dr. LEE. Well, if you can produce more with the same investment, hopefully the product will be more economical.

Mr. YOUNGER. Do you think the prices will go down?

Dr. LEE. I am not an economist. As a consumer, I would hope so.

Mr. YOUNGER. But as a member of the team, you do not think that your control over the pesticides is going to produce cheaper foods?

Dr. LEE. I do not think it will deter the development of less-expensive foods. I think that we have seen, of course, a tremendously increased productivity on the part of the agricultural industry in this country, and one of the factors in that increased productivity is the use of pesticides.

Mr. YOUNGER. That is correct.

Dr. LEE. And I think with all that the foods would be more expensive than they are today, rather than——

Mr. YOUNGER. I thoroughly agree with that, but I am just wondering whether you can get so control-minded over these products that pretty soon the farmer, like some of the businessmen, will not even know what to do and will give up the farm and go on relief and get more money.

Dr. GODDARD. There are no signs of that occurring, sir.

Mr. YOUNGER. There aren't.

Dr. GODDARD. Not with respect to use of the pesticides or the controls exerted. The U.S. Department of Agriculture has the responsibility of determining the usefulness of a new pesticide, the Public Health Service determines the effect upon humans, and the Food and Drug Administration sets the tolerances for residues on the crop coming into the marketplace.

Mr. YOUNGER. But who administers them? Is it the Agriculture Department or your Department? Who says they can be used or not used?

Dr. GODDARD. This is a joint determination. First, the proposed pesticide is studied for its usefulness by the Department of Agriculture, and then it is referred to us for determining whether or not a tolerance needs to be set to insure that unsafe residues will not remain on the crop when it is harvested.

Now, after this determination is made the firm that intends to market the product is given the green light and may go into the marketplace with it.

Now, as far as control, we sample food entering into interstate commerce. About 1 percent of the shipments of raw agricultural commodities in interstate commerce are sampled for pesticide levels to see that they conform with our regulations. We test them for some 27 residues simultaneously when we bring the samples into our laboratories.

Mr. YOUNGER. Do you expect to use more factory inspectors and more careful factory inspection in connection with your work?

Dr. GODDARD. In general, or on pesticides, Mr. Younger?

Mr. YOUNGER. No, in general.

Dr. GODDARD. Yes, we do. We do have the statutory obligation in the drug field of inspection of factories once every 2 years. We have the requirement of checking all imports. We have not had enough inspectors in that particular area to meet our responsibilities as well as we should. So, we have requested and have had approved additional inspectors for this coming fiscal year.

Mr. YOUNGER. But you will observe the rules that were laid down, I think by Congress, as to the inspectors going into the factories, that they must make themselves known, and so forth.

Dr. GODDARD. Yes, sir.

Mr. YOUNGER. So, we will not have any more trouble with that.

Dr. GODDARD. I hope not.

Mr. YOUNGER. That is all, Mr. Chairman.

Mr. ROGERS of Florida. Since we are on that particular subject, let me ask you this, Dr. Goddard. I was very much concerned some time back when I had reports that some of the FDA inspectors who were going into plants were taking recording machines on their persons, that they had hidden, and as they went into the plant to inspect, they never revealed to the personnel in the plant that all of the things they were saying were being recorded.

I wrote to the Commissioner about that, and he said it was going to be stopped, and then I later had other reports that it had not yet been stopped.

I think this is an area that you should look into right away to see if this is going on.

Dr. GODDARD. I will do so.

Mr. ROGERS of Florida. We are seeing so much of this now. I saw stories in the papers today, where we are seeing so much wiretapping and bugging, secret recordings, and I certainly do not think it was ever authorized—I know it was not authorized in the bills we have passed since I have been on this committee, and the original bill, I am sure, setting up the agencies did not intend that sort of operation, and I would like to have some assurance from Food and Drug that this is not being done now.

Dr. GODDARD. I am told by Mr. Kinslow that this practice was stopped prior to my becoming Commissioner, and I will make certain it has been.

Mr. ROGERS of Florida. I think it would be well for you, personally, to check into this. And I wonder: Do you do any wiretapping at all, or any bugging, or any of this type operation?

Dr. GODDARD. In our undercover work on the drug abuse control activities, we do have equipment that is used for recording conversations, for monitoring the conversations between an agent and the person from whom he is attempting to make a buy. We also use it to record oral promotional claims made by health food lecturers at public meetings and by door-to-door salesmen who offer such things as vitamins as cures for disease. We have consulted with the Department of Justice on the use we are making of these devices, and they have agreed that the use is lawful and proper.

Mr. ROGERS of Florida. Who authorizes this?

Dr. GODDARD. I have authorized its use primarily as part of the undercover work necessary in the Bureau of Drug Abuse Control and for the control of quackery by health lecturers and door-to-door salesmen. In part, it is related to the safety of the agents involved in dealing with these persons trafficking in dangerous drugs and making buys. There will be another agent within the immediate neighborhood monitoring the conversation, who can move in if trouble develops.

Mr. ROGERS of Florida. Yes.

Here is what I want to know: Is that recorded?

Dr. GODDARD. That is, as far as I know, tape recorded.

Mr. ROGERS of Florida. Now, do you authorize each specific case or do they have general authorization to do that?

Dr. GODDARD. Only the undercover agents would be authorized for use of this kind of equipment and its use is authorized on a case-by-case basis. Those agents who are doing factory inspections and checking on the records would not be.

Mr. YOUNGER. Will the gentleman yield?

Mr. ROGERS. Yes.

Mr. YOUNGER. Under the new Supreme Court decision, is that of any value?

Dr. GODDARD. As I mentioned, it is of value, in protecting the life of the agent involved, if nothing beyond that.

Mr. YOUNGER. I mean, in court cases it is of no value under the new Supreme Court decision; is not that true?

Dr. GODDARD. This kind of evidence is admissible under the most recent Supreme Court case on the subject. It was not, I do not believe, our primary intent to use this as court evidence but rather in the

general building of the case, recording the information and helping them work out the details of followup on the individual leads provided.

Mr. YOUNGER. That is all.

Mr. ROGERS of Florida. In other words, you use this recording device only when a person is making a contact?

Dr. GODDARD. Yes. It is my understanding——

Mr. ROGERS of Florida. One of your agents?

Dr. GODDARD. If I may, I would like to submit for the record how the Bureau of Drug Abuse Control now uses the recording devices and equipments they have in hand.

Mr. ROGERS of Florida. I think this would be well for the committee to have.

And, actually, who authorizes it, if it is a blanket authorization, or if it is done by case, or if it is done in conjunction with the Attorney General or any other agency.

Dr. GODDARD. We will do so.

Mr. ROGERS of Florida. I think this would be well to go into.

(The information referred to follows:)

STATEMENT OF THE FOOD AND DRUG ADMINISTRATION ON THE USE OF ELECTRONIC RECORDING EQUIPMENT

The Bureau of Drug Abuse Control is the primary user of electronic surveillance equipment within the FDA. The equipment is used for recording conversations between our agents (and persons assisting us) and other persons concerning buys of controlled drugs where there is a reasonable presumption that Federal law is being violated and that use of such equipment is essential to obtain evidence to support legal action against the suspected violators. (No recordings of telephone conversations are made without the permission of one of the parties involved in the conversation.) This equipment has also been used where it is required to safeguard the agent involved in investigating illegal sales of controlled drugs.

The Bureau of Regulatory Compliance has also used electronic surveillance equipment during the past year on infrequent occasions under the same limitations as described in the foregoing paragraph. These limited uses involved investigations in which oral representations made about a food, drug, cosmetic, or device resulted in the article being misbranded. Where door-to-door salesmen are involved, the recordings are made with permission of the person in whose home the sales presentation is made.

In all instances the use of electronic equipment is authorized on a case-by-case basis and only by responsible supervisory field or headquarters officials.

Strict control is maintained in the storage, security, authorization for use, and use of any electronic equipment and recording devices in the District Offices and Bureau of Drug Abuse Control Field Offices.

Attached is a copy of current operating instructions for use of such equipment by FDA employees. The policies enunciated in these instructions are in accord with Department of HEW's guidelines on the procurement, custody, and use of concealed electronic listening devices dated March 3, 1966.

The Attorney General has been fully advised of the circumstances under which the FDA makes use of electronic surveillance equipment and we are advised by the Department of Justice that such use is lawful and proper.

There has been no use of electronic listening or recording equipment during the course of establishment inspections since prior to September 20, 1962.

SUB CHAPTER 950. UNDERCOVER OPERATIONS

951 CONCEALED ELECTRONIC LISTENING DEVICES

951.01 Authority

951.011 Who May Authorize Use of Equipment. The use of concealed electronic listening devices shall be authorized only by one of the following:

(1) District Director
(2) Deputy Director

951.012 Who May Be Authorized To Use Equipment. Concealed electronic listening devices may be used only by those who have been thoroughly instructed in its operation and proper use.

951.02 Policy. Concealed electronic listening devices shall not be used in any investigation without prior authorization as provided in paragraph 951.01 above, and except in accordance with procedure in this Section. Concealed electronic listening devices shall not be used in any routine establishment inspection even where refusal to permit inspection is anticipated. The use of concealed electronic listening devices shall be limited to investigations where:

(1) There is a reasonable presumption that a federal law is being violated and the authorizing official believes that the use of such equipment is essential in obtaining the data to support legal action; or

(2) The authorizing official determines that the use of such equipment is required to safeguard the investigating agents.

The following programs and actions are typical of those which may require use of concealed electronic listening devices:

(1) Spielers and Lecturers.
(2) House-to-house salesmen.
(3) Surveillance and tailing in undercover operations.

951.02 Responsibility. You are responsible for strict observance of procedures specified in this Section. Reports of investigation where concealed electronic listening devices are used must clearly mention such use. While this equipment is in your custody, it shall not be used for other than the official business specified by its authorization for use.

951.1 Authorization Procedure.

951.11 Supervisor. Each authorization will state the specific use of concealed electronic listening devices. Such equipment will be logged in and out as provided in sub section 951.3.

951.12 Operator. Equipment will be used only for the specific purpose authorized and will be logged back to the custodian promptly upon completion of the assignment.

951.2 Security.

951.21 Equipment. The Chief Inspector is the custodian of all concealed electronic listening devices. Such equipment when not in use will be kept under secure storage.

951.22 Records and Transcripts. All records and transcripts are official documents. They will be handled as samples, with seals and sample numbers. They are subject to the same disclosure restrictions as other official information and records. See Sub-Chapter 130, Disclosure of Official Information and Records.

951.3 Records of Use. The custodian will maintain appropriate records to cover all use of concealed electronic listening devices. A log covering the use of each device will include the following:

(1) Inclusive dates and time (hour) of use.
(2) Identity of all agency personnel directly associated with use.
(3) Identity of the investigation (documentation by firm name, sample number, etc.)
(4) Nature of material being recorded (lecturer, spieler, house-to-house salesman, demonstration, surveillance, cover.)
(5) Maintenance or operating remarks as indicated.

951.4 Documentation.

951.401 Policy. All records shall be identified and documented in the same manner as other evidence. The procedure in this Paragraph will be followed to facilitate identification of the records and individuals involved.

951.41 Pre-recording. Prior to the recording of any type of evidence, pre-record (on site, if possible) the essential facts relating to the circumstances of the investigation. The following format, used for pre-recording a house-to-house salesman, illustrates the nature of information required in other recording circumstances:

"This is Inspector _____ of the Food and Drug Administration speaking in the living room of my home (or the home of _____) located at (street), (city), (state), on (date). It is now ____ a.m.—p.m. Present with me are (is) (Inspectors or Informants). Inspector _____ is monitoring this recording. We are awaiting the arrival of _____, Salesman _____ who is due to arrive at ____ a.m.—p.m."

Each other agency employee present should also identify himself prior to and following the recording of evidence.

951.42 Post-recording. Upon completion of recording of any type of evidence, post-record (on site, if possible) the essential facts relating to the circumstances of the investigation. The following format, used for post-recording documentation of house-to-house salesmen, illustrates the nature of information required in other recording circumstances:

"This is Inspector _____ speaking. It is now ____ a.m.—p.m. The (Firm) Salesman (Name) has just left my home (or the home of _____) located at (street), (city), (state). The voices you have heard are those of _____. The sales presentation was recorded on (date) on a _____ Recorder. The recording was made on (No.) reels/spools, which I identified by Sample Number _____, (date), and my initials _____."

951.43 Identification of Recordings. Identify individual reels and the boxes with the reel number, type of equipment used, the speed at which recorded, and whether single track or double track, etc. Officially seal all reals and identify with sample number, date of recording, and signature of the monitoring inspector.

Mr. ROGERS of Florida. Now, I do want to say at the beginning how much the committee has appreciated the fine cooperation they have received from the Department, Dr. Lee, particularly in the preparation of the "Background Material" documents for us, and we noticed, I think, an exceptional job by Food and Drug in this regard.

I wanted to express the committee's thanks to both of you for a very fine job done.

Now, it seems to me that the main problems are, first of all, in your new drug applications, in the backlog of drugs to be investigated for efficacy that you just testified to; then, it seeems to me, we are beginning to see the problem that needs to be dealt with in foods more than ever before, cosmetics, and foreign drugs.

So, I want to briefly go over a few of these areas with you.

Do you feel that your organization will involve any changes in your Bureau of Medicine which will speed up the approval of new drug applications?

Dr. GODDARD. Yes, I do, very much, Mr. Chairman.

Mr. ROGERS of Florida. In what way?

Dr. GODDARD. At the present time, we have——

Mr. ROGERS of Florida. In fact, you might just describe to us quickly the process of handling a new drug application.

Dr. GODDARD. Well, when a firm decides to investigate in humans a drug that it has tested within its laboratories and in animal studies, it sends to the Food and Drug Administration a Notice of Claimed Investigational Exemption for a new drug. We have, at the present time, some 2,000 of these. They all have been given a quick review, but some of them have not been reviewed in depth.

Mr. ROGERS of Florida. Is this by your Bureau of Medicine?

Dr. GODDARD. This is done by our Bureau of Medicine, in the Investigational Drug Branch of the New Drug Division.

Now, these studies progress through three phases. Phase 1 is the study of the effect of the drug in a small group of human volunteers where they monitor the patients very carefully with detailed labora-

tory studies. Phase 2 is the time at which the drug is used in patients who have the disease they seek to prevent or cure. Again, this involves relatively small numbers of patients and relatively small number of investigators. Phase 3 is where the drug is used under the anticipated conditions of general use, if the drug were to be marketed, so there are larger numbers of patients, larger numbers of investigators and fewer controls in terms of laboratory tests. As the drug moves through these stages, additional reports are received by the people monitoring the drug in the Investigational Drug Branch.

Now, if the drug appears to be one that is marketable, the sponsor will then submit to the agency a new drug application, and, as you well know, this may at times reach from floor to ceiling. At that point in time, it becomes the function of a second group within the agency (the Medical Evaluation Branch) to undertake the review of this enormous amount of data.

Mr. ROGERS of Florida. What division is that?

Dr. GODDARD. This also is in the Division of New Drugs. Dr. Ralph Smith is the Division Director.

Now, the personnel of that Branch, it is true, are free to consult with those who have followed it in its earlier stages as an investigational new drug, but there seems to be a loss of efficiency here where you change from one person to another and someone has to learn all of this material de novo. So, one of the thoughts is that by creating a team of physicians who would be responsible, let us say, for the review of all drugs affecting cardiovascular and renal systems, they would follow the drug from the time they first gained knowledge of it through the IND Exemption Notice, through the marketing stage and, perhaps, even after marketing since this is also our responsibility.

So, we think this would provide greater efficiency.

Another problem also occurs. An individual will carry the responsibility for a drug over a number of months, be reviewing it, and then he may resign or may become ill and someone else has to pick it up again de novo. By using the team approach, there would be other members of the team who were knowledgeable and could readily pick this up.

So, we think these kinds of inefficiencies would disappear under the system that we are considering at the present time.

Mr. ROGERS of Florida. When do you intend to put this system into effect?

Dr. GODDARD. As I say, we are studying the proposal now, from the Bureau of Medicine, and I hope to go forward to the Office of the Secretary in the very near future, with a proposal.

Mr. ROGERS of Florida. Would you let this committee know when that decision is effected?

Dr. GODDARD. We will be happy to do so.

(The information requested follows:)

STATEMENT OF THE FOOD AND DRUG ADMINISTRATION ON THE REORGANIZATION OF THE BUREAU OF MEDICINE

On July 11, 1966, Secretary Gardener approved the proposed reorganization of the Food and Drug Administration's Bureau of Medicine. The attached release dated July 25, 1966, describes in broad terms the new organizational units

and their functional responsibilities. [The comprehensive reorganization proposal approved by the Secretary is included in Appendix H, Part 2, of the Subcommittee's Report.]

A fully-coordinated system for processing new and investigational drugs was put into operation today by the Food and Drug Administration.

Key staff appointments also were announced as the FDA completed the reorganization of its Bureau of Medicine.

Food and Drug Commissioner James L. Goddard, M.D., said the reorganization will enable the Bureau to carry out more efficiently, more effectively, and with greater economy its primary mission of evaluating the safety and efficicacy of drugs and devices.

Applications for marketing new drugs or for investigating experimental drugs will be processed by specialized units dealing with drugs in six pharmacologic and physiologic classifications.

Other organizational changes combine all drug surveillance activities in one unit and bring together regulatory functions in another.

Robert J. Robinson, M.D., will continue as acting director of the Bureau. B. Harvey Minchew, M.D., was named acting deputy director.

Robert H. Hodges, M.D., is acting director of the Office of New Drugs. Its divisions and acting division directors include: Cardiopulmonary and Renal Drugs, John W. Winkler, Jr., M.D.; Dental and Surgical Adjuncts, William J. Gyarfas, M.D.; Metabolism and Endocrine Drugs, Marion J. Finkel, M.D.; Anti-Infective Drugs, Harold C. Anderson, M.D., and Oncology and Radiopharmaceuticals, Frances O. Kelsey, M.D. A director has not yet been named for the Division of Neuropharmacological Drugs.

Each division contains the medical and scientific skills necessary to review all aspects of investigational drug and new drug applications.

An Office of Medical Review, headed by Howard I. Weinstein, M.D., will provide medical opinion and support in the regulatory area and will carry out the Bureau's responsibilities under the Drug Abuse Control Amendments. It consists of a Division of Case Review, Division of Medical Advertising and Division of Medical Devices.

The Office of Drug Surveillance, headed by John J. Jennings, M.D., will monitor the use of drugs and will operate an adverse reactions detection and analysis system. It also will review drug supplements. It consists of a Division of Supplement Review, Division of Epidemiology, and Division of Drug Monitoring.

Each of the three program offices will have an administrative office to relieve the professional staff of as many administrative duties as possible.

Appointments within the Bureau Director's office include Arthur E. Wentz, M.D., acting director of clinical investigation, and Vaughan E. Choate, executive officer.

Acting assistant directors are Jean D. Lockhart, M.D., medical resources and liaison; Arthur Ruskin, M.D., and Earl L. Meyers, scientific investigation; John F. Palmer, M.D., industry coordination, and Ralph G. Smith, M.D., National Academy of Sciences coordination.

Mr. ROGERS of Florida. So, at present, you are still operating under the old system, where one agency looks at the investigational stage and then another division looks at it when they file their new drug application.

Dr. GODDARD. Yes; that is correct.

Mr. ROGERS of Florida. So that there are two different looks at it, in effect, by different divisions.

Dr. GODDARD. And there is even a third, once the drug is marketed and there are amendments or supplements to the new drug applications. A third group reviews, again, much of the same material.

Mr. ROGERS of Florida. Now, I understand—you have how many applications for new drugs?

Dr. GODDARD. Pending at the present time, 232 I think was the last count.

Mr. ROGERS of Florida. Do you expect to complete action on these 232, or whatever it may be, in 12 months?

Dr. GODDARD. I hope to have it down to within—well within—the 180 days allotted. Our Bureau of Veterinary Medicine, I might add, is now down to within 90 days. They have reduced their backlog since the first of the year, and they hope to get down within 30 days as being current; so they are processing their applications in a very expeditious manner. We hope to do the same thing.

We must keep in mind at all times that some of these are inherently just so complicated and difficult that they will require perhaps the full 6 months.

Mr. ROGERS of Florida. I realize that there will be exceptions, but I think the thrust of what you want to do is to get it down certainly to within 180 days.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. And how long do you think—do you anticipate it will be before you get the new drug approvals down to within the 180 days?

Dr. GODDARD. I think within 6 months of the July 11 date when these new officers come on board, we should achieve a significant reduction.

Mr. ROGERS of Florida. So you will be functioning within the intent of the law there in getting new drug application approvals.

Dr. GODDARD. Our objective is not to get just within the 6 months, but to do much better.

Mr. ROGERS of Florida. I think that is excellent, and this committee will be interested in being advised when this comes about.

Now, one thing I am concerned about in the testing of new drugs is whether you have a set application form, a set procedure. In other words, must a new drug be tested so long on animals before it is then moved to humans, or does it vary?

Dr. GODDARD. This varies because the nature of the compounds that are involved themselves vary, and it will vary with the intended use of the drug also. The drug that is intended for long-term use obviously requires longer term chronic toxicity studies in animals than those that are to be used for short periods of time. So, a determination is made—both by the sponsoring firm and independently by us—as to the appropriateness of animal experimentation that precedes human testing.

Mr. ROGERS of Florida. Who actually makes the decision?

Dr. GODDARD. We actually determine whether or not the information provided at the time of the initial IND Exemption Notice suffices for the project to continue into human testing. This is within Dr. Frances Kelsey's activity, and she and her immediate staff do a quick review of each IND application as it comes in. If they perceive no immediate problem and the type of animal testing that has been carried out seems to fit well with the intended usage, it is put in with the others that constitute what I call the backlog. But she points out very strenuously that every one of these is reviewed upon receipt and a determination is made. It is not the in-depth review she and the members of her staff ultimately carry out and would like to be carrying out on a current basis, but that, again, is one of our objectives—to get that done.

Mr. ROGERS of Florida. Have you asked for the necessary personnel?

Dr. GODDARD. We think that the provision of the additional physicians from the Public Health Service this summer will give us that kind of capability.

Mr. ROGERS of Florida. Will some of them be assigned to this office?

Dr. GODDARD. As I mentioned, if we reorganize, that activity and the new drug review activity would be combined, and the teams would handle both phases: the IND and the NDA work.

Mr. ROGERS of Florida. Because I have understood that some of the drugs that have gone to that office, in previous correspondence, are far behind schedule, and it was just by luck that some things did not happen, because it just was not handled properly.

Dr. GODDARD. I understand.

Mr. ROGERS of Florida. And you feel this can be corrected?

Dr. GODDARD. Yes, sir.

Mr. ROGERS of Florida. Now, do you set any regulation or do you check to see whether in the testing of drugs on humans that their consent has been obtained?

Dr. GODDARD. We do have a requirement that the consent of the individuals will be obtained by the investigator. This was included in the investigational drug regulations published in the Federal Register in 1963.

It is incumbent upon the investigator to obtain the consent of the individuals involved.

Mr. ROGERS of Florida. What kind of consent form does that take? Will you submit that for the record?

Dr. GODDARD. I will be happy to do so. I would like to add that we have under consideration the issuance of a policy statement which would emphasize the clinical investigator's responsibility to inform all subjects involved in clinical experiments that investigational drugs are being used, except in those instances where this is not feasible or, in the investigator's professional judgment, is contrary to the best interests of the subjects. As you know, we have discussed this matter with your staff.

(FDA statement, and forms referred to, follow:)

STATEMENT OF THE FOOD AND DRUG ADMINISTRATION ON THE REQUIREMENT TO OBTAIN PATIENT CONSENT IN CLINICAL INVESTIGATIONS

The investigational drug regulations published in the Federal Register on January 8, 1963, provided the format for a Statement of Investigator (Clinical Pharmacology) (Form FD 1572) and a Statement of Investigator (Form FD 1573) which each sponsor of an investigational new drug is required to obtain from clinicians who will investigate the sponsor's new drug. The regulations require that the investigator agree to abide by all requirements of the statement he signs as a condition of eligibility to receive and use investigational drugs.

Form FD 1572 contains the following statement:

"The investigator certifies that he will inform any patients or any persons used as controls, or their representatives, that drugs are being used for investigational purposes, and will obtain the consent of the subjects, or their representatives, except where this is not feasible or, in the investigator's professional judgment, is contrary to the best interests of the subjects."

Form FD 1573 contains the same type of certification.

Copies of these forms are attached (see item 6(g) of FD 1572 (figs. 1 and 1A) and item 4(g) of FD 1573 (figs. 2 and 2A).)

FIGURE 1.

FORM FD-1572 (8/64)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
FOOD AND DRUG ADMINISTRATION

STATEMENT OF INVESTIGATOR
(Clinical Pharmacology)

TO SUPPLIER OF THE DRUG *(Name and Address)*	NAME OF INVESTIGATOR *(Print or Type)*
	DATE
	NAME OF DRUG

Dear Sir:

The undersigned, _____, submits this statement as required by section 505(i) of the Federal Food, Drug, and Cosmetic Act and §130.3 of Title 21 of the Code of Federal Regulations as a condition for receiving and conducting clinical pharmacology with a new drug limited by Federal (or United States) law to investigational use.

1. A STATEMENT OF THE EDUCATION AND TRAINING THAT QUALIFIES ME FOR CLINICAL PHARMACOLOGY.

2. THE NAME AND ADDRESS OF THE MEDICAL SCHOOL, HOSPITAL, OR OTHER RESEARCH FACILITY WHERE THE CLINICAL PHARMACOLOGY WILL BE CONDUCTED.

3. THE EXPERT COMMITTEES OR PANELS RESPONSIBLE FOR APPROVING THE EXPERIMENTAL PROJECT.

4. THE ESTIMATED DURATION OF THE PROJECT, AND THE MAXIMUM NUMBER OF SUBJECTS THAT WILL BE INVOLVED.

5. A GENERAL OUTLINE OF THE PROJECT TO BE UNDERTAKEN. *(Modification is permitted on the basis of experience gained without advance submission of amendments to the general outline.)*

(Continued on reverse)

FIGURE 1A.

6. THE UNDERSIGNED UNDERSTANDS THAT THE FOLLOWING CONDITIONS GENERALLY APPLICABLE TO NEW DRUGS FOR INVESTIGATIONAL USE GOVERN HIS RECEIPT AND USE OF THIS INVESTIGATIONAL DRUG:

a. The sponsor is required to supply the investigator with full information concerning the preclinical investigation that justifies clinical pharmacology.

b. The investigator is required to maintain adequate records of the disposition of all receipts of the drug, including dates, quantity, and use by subjects, and if the clinical pharmacology is suspended or terminated to return to the sponsor any unused supply of the drug.

c. The investigator is required to prepare and maintain adequate case histories designed to record all observations and other data pertinent to the clinical pharmacology.

d. The investigator is required to furnish his reports to the sponsor who is responsible for collecting and evaluating the results, and presenting progress reports to the Food and Drug Administration at appropriate intervals, not exceeding 1 year. Any adverse effect which *may* reasonably be regarded as caused by, or is probably caused by, the new drug shall be reported to the sponsor promptly; and if the adverse effect is alarming it shall be reported immediately. An adequate report of the clinical pharmacology should be furnished to the sponsor shortly after completion.

e. The investigator shall maintain the records of disposition of the drug and the case reports described above for a period of 2 years following the date the new-drug application is approved for the drug; or if no application is to be filed or is approved until 2 years after the investigation is discontinued and the Food and Drug Administration so notified. Upon the request of a scientifically trained and specifically authorized employee of the Department, at reasonable times, the investigator will make such records available for inspection and copying. The names of the subjects need not be divulged unless the records of the particular subjects require a more detailed study of the cases, or unless there is reason to believe that the records do not represent actual studies or do not represent actual results obtained.

f. The investigator certifies that the drug will be administered only to subjects under his personal supervision or under the supervision of the following investigators responsible to him,

_____

_____

_____

_____.

and that the drug will not be supplied to any other investigator or to any clinic for administration to subjects.

g. The investigator certifies that he will inform any patients or any persons used as controls, or their representatives, that drugs are being used for investigational purposes, and will obtain the consent of the subjects, or their representatives, except where this is not feasible or, in the investigator's professional judgment, is contrary to the best interests of the subjects.

Very truly yours,

_____

(Name of Investigator)

_____

(Address)

_____

FIGURE 2.

FORM FD-1573 (8/64)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
FOOD AND DRUG ADMINISTRATION

STATEMENT OF INVESTIGATOR

TO SUPPLIER OF DRUG (Name and Address)	NAME OF INVESTIGATOR (Print or Type)
	DATE
	NAME OF DRUG

Dear Sir:

The undersigned, _____, submits this statement as required by section 505(i) of the Federal Food, Drug, and Cosmetic Act and §130.3 of Title 21 of the Code of Federal Regulations as a condition for receiving and conducting clinical investigations with a new drug limited by Federal (or United States) law to investigational use.

1. THE FOLLOWING IS A STATEMENT OF MY EDUCATION AND EXPERIENCE:

a. Colleges, universities, and medical or other professional schools attended, with dates of attendance, degrees, and dates degrees were awarded.

b. Postgraduate medical or other professional training: Dates, names of institutions, and nature of training.

c. Teaching or research experience: Dates, institutions, brief description of experience.

d. Experience in medical practice or other professional experience: Dates, institutional affiliations, nature of practice, or other professional experience.

e. Representative list of pertinent medical or other scientific publications: Titles of articles, names of publications and volume, page number, and date.

(If this information has previously been submitted to the sponsor, it may be referred to and any additions made to bring it up to date.)

2. IF ANY HOSPITAL, INSTITUTIONAL, AND CLINICAL LABORATORY FACILITIES, ETC., ARE AVAILABLE AND WILL BE EMPLOYED IN CONNECTION WITH THE INVESTIGATION, AN IDENTIFICATION OF EACH FOLLOWS:

(If this information has previously been submitted to the sponsor, reference to the previous submission will be adequate.)

(Continued on reverse)

FIGURE 2A.

3. THE INVESTIGATIONAL DRUG WILL BE USED BY THE UNDERSIGNED OR UNDER HIS SUPERVISION IN ACCORDANCE WITH THE PLAN OF INVESTIGATION DESCRIBED AS FOLLOWS: (Outline the plan of investigation, including approximation of the number of subjects to be treated with the drug and the number to be employed as controls, if any; clinical uses to be investigated; characteristics of subjects by age, sex, and condition; the kind of clinical observations and laboratory tests to be undertaken prior to, during, and after administration of the drug; the estimated duration of the investigation; and a description or copies of report forms to be used to maintain an adequate record of the observations and tests' results obtained. This plan may include reasonable alternates and variations, and should be supplemented or amended when any significant change in direction or scope of the investigation is undertaken.)

4. THE UNDERSIGNED UNDERSTANDS THAT THE FOLLOWING CONDITIONS, GENERALLY APPLICABLE TO NEW DRUGS FOR INVESTIGATIONAL USE, GOVERN HIS RECEIPT AND USE OF THIS INVESTIGATIONAL DRUG:

a. The sponsor is required to supply the investigator with full information concerning the preclinical investigations that justify clinical trials, together with fully informative material describing any prior investigations and experience and any possible hazards, contraindications, side-effects, and precautions to be taken into account in the course of the investigation.

b. The investigator is required to maintain adequate records of the disposition of all receipts of the drug, including dates, quantities, and use by subjects, and if the investigation is terminated to return to the sponsor any unused supply of the drug.

c. The investigator is required to prepare and maintain adequate and accurate case histories designed to record all observations and other data pertinent to the investigation on each individual treated with the drug or employed as a control in the investigation.

d. The investigator is required to furnish his reports to the sponsor of the drug who is responsible for collecting and evaluating the results obtained by various investigators. The sponsor is required to present progress reports to the Food and Drug Administration at appropriate intervals not exceeding 1 year. Any adverse effect that may reasonably be regarded as caused by, or probably caused by, the new drug shall be reported to the sponsor promptly, and if the adverse effect is alarming, it shall be reported immediately. An adequate report of the investigation should be furnished to the sponsor shortly after completion of the investigation.

e. The investigator shall maintain the records of disposition of the drug and the case histories described above for a period of 2 years following the date a new-drug application is approved for the drug; or if the application is not approved, until 2 years after the investigation is discontinued. Upon the request of a scientifically trained and properly authorized employee of the Department, at reasonable times, the investigator will make such records available for inspection and copying. The subjects' names need not be divulged unless the records of particular individuals require a more detailed study of the cases, or unless there is reason to believe that the records do not represent actual cases studied, or do not represent actual results obtained.

f. The investigator certifies that the drug will be administered only to subjects under his personal supervision or under the supervision of the following investigators responsible to him, _____, and that the drug will not be supplied to any other investigator or to any clinic for administration to subjects.

g. The investigator certifies that he will inform any subjects, including subjects used as controls, or their representatives, that drugs are being used for investigational purposes, and will obtain the consent of the subjects, or their representatives, except where this is not feasible or, in the investigator's professional judgment, is contrary to the best interests of the subjects.

Very truly yours,

_____
(Name of investigator)

_____
(Address)

_____

*(This form should be supplemented or amended from time to time if new subjects are added or if significant changes are made in the plan of investigation.)

Mr. ROGERS of Florida. Well, now, I would like to go into this in some detail. I have just seen an article quoting Dr. Henry K. Beecher of the Harvard Medical School. He is a professor there. He says medical testing without consent involved 1,000 humans. I do not know whether you saw this article or not.

Dr. GODDARD. Yes, I did.

Mr. ROGERS of Florida. Would you dispute that?

Dr. GODDARD. No, I would not dispute Dr. Beecher.

Mr. ROGERS of Florida. Well, evidently, the provisions of the law are not being carried out as we passed it in 1962 to require consent before drugs are tested on humans in many instances. Would you say that is true?

Dr. GODDARD. Well, I would like to reserve judgment on that and try to get some facts from our own records. If Dr. Beecher says it has happened in 1,000 instances, I would not quarrel with him at the present time.

Mr. ROGERS of Florida. Well, I would be very much interested to see what we are going to do to carry this out, to see that the law is enforced. I think this is important, and certainly it was the intent of Congress that if human beings are going to be used to be tested upon, they certanly should know and give their consent.

Dr. LEE. We completely agree, Mr. Chairman.

Mr. ROGERS of Florida. Now, it appears that the Department has done nothing to enforce it, and I think steps should be taken immediately, and, as you come into your job here, I think this is a very important area, Dr. Goddard, to go into.

Also there is the question of the moral issue, I think, that is involved, whether people who have a disease and in this testing are given placebos, which is a sugar—not a drug at all, but they think it is something that might cure their disease, and they are not told what it is; therefore, they are taking, in effect, the same thing as Krebiozen; aren't they?

Dr. GODDARD. Yes.

Mr. ROGERS of Florida. It has no efficacy.

Dr. GODDARD. That is right.

Mr. ROGERS of Florida. Without their knowledge. If it is with their knowledge, that is a different matter. But I see here, that in one case that he quotes, in a group of 408 charity patients with typhoid fever, about 157 were denied chloramphenicol in a test of the drug's effectiveness. Of those who received the drug, 7.97 percent died. Of those who did not, 22.9 percent died.

So, I think examples like this show that something must be done to carry out the provisions of the law.

Dr. LEE. In some of these cases that he reported, Mr. Chairman, such as the use of penicillin in the Army personnel, and the use of chloramphenicol, these were drugs that have been in use for a considerable period of time, so they would not actually fall under the new drug investigational requirements of the Food and Drug Administration, but certainly it would very clearly be incumbent in any case on the physcians who were carrying out the testing, and from our standards, we clearly look into the areas of our responsibility and make certain that the law is being carried out and that——

Mr. ROGERS of Florida. Because I think the Congress would be interested to know, if they are deficient, what we should do to make sure that people who are going to be experimented upon at least give their consent. This is all that we care about, that people should know this, and I think that this is most important and a very basic approach in the testing of drugs, and we did give this responsibility to the Department and evidently it has not been carried out, and the Department should do something, I think, about that immediately. This is a very important area.

Dr. LEE. We will submit a statement to you on this.
(The statement referred to follows:)

USE OF HUMAN SUBJECTS IN CLINICAL RESEARCH

The Department of Health, Education, and Welfare has long been aware of the transcendental legal, moral and ethical considerations involved in the participation of human subjects in clinical research. In December 1965, the National Advisory Health Council made recommendations emphasizing the need for formulating a specific policy to protect the rights and welfare of such subjects.

On February 8, 1966, the Surgeon General of the Public Health Service issued a statement to all institutions conducting research supported by Public Health Service grants. In this statement, which followed the recommendations of the Council, it was emphasized that no grant in support of clinical research and investigation involving human beings shall be awarded unless the Public Health Service is assured that there be prior review of the judgment of the principal investigator or program director by a committee of his associates.

This review should assure an independent determination of:

(1) The rights and welfare of the individual or individuals to be involved as subjects;

(2) The appropriateness of the methods used to secure informed consent from these subjects; and

(3) The risks and potential medical benefits of the investigation.

(See Attachment A)

On March 30, 1966, the Surgeon General issued a similar policy statement applying to all pertinent research and investigations conducted in as well as supported by the Bureau of Medical Services, the Bureau of State Services, and the National Institutes of Health.

(See Attachment B)

On July 1, after several months of experience, the policy and the related procedures were revised and modified whereby after October 31, 1966, the requisite assurance should be made on a continuing institution-wide basis rather than on an individual basis for each application. It was stated that ,effective November 1, 1966, "no new, supplemental, renewal, or continuation application for a Public Health Service grant or award to support investigations involving human subjects will be accepted for review unless the Public Health Service has approved an institution-wide assurance."

The Public Health Service likewise stated that nothing in the institution-wide assurance, or in the interim policy procedure being used in some cases until November 1, 1966, should "inhibit Public Health Service staff, advisory groups, or consultants (1) from identifying concern for the welfare of human subjects, and communicating this concern to the grantee institution, or (2) from recommending disapproval of the application if the gravity of the hazards and risks so indicate."

The revised procedures apply to all grants and awards of the Public Health Service in the support of research, training and demonstration projects, including projects supported through general research support and those of fellows and trainees.

(See Attachment C)

Similar procedures are now in the process of development and implementation in the other operating agencies of the Department of Health, Education, and Welfare.

The Department will continue its study of the issues of investigations involving human subjects. As experience shows the need for revised or augmented policy or procedures, these will be developed.

ATTACHMENT A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
Washington, D.C., February 8, 1966.

To: The Heads of Institutions Conducting Research with Public Health Service Grants.
From: Surgeon General, Public Health Service.
Subject: Clinical research and investigation involving human beings.

Expanding Public Health Service support of clinical research and investigation involving human beings emphasizes the need for more formal attention to the critical issues raised by such research.

In December 1965 the National Advisory Health Council, after study of these critical issues, made certain recommendations to me which I have now formulated as the following Public Health Service grant policy:

No new, renewal, or continuation research or research training grant in support of clinical research and investigation involving human beings shall be awarded by the Public Health Service unless the grantee has indicated in the application the manner in which the grantee institution will provide prior review of the judgment of the principal investigator or program director by a committee of his institutional associates. This review should assure an independent determination: (1) of the rights and welfare of the individual or individuals involved, (2) of the appropriateness of the methods used to secure informed consent, and (3) of the risks and potential medical benefits of the investigation. A description of the committee of the associates who will provide the review shall be included in the application.

Effective immediately, this policy will be included in all future statements of Public Health Service research and research training grant policy. The wisdom and sound professional judgment of you and your staff will determine what constitutes the rights and welfare of human subjects in research, what constitutes informed consent, and what constitutes the risks and potential medical benefits of a particular investigation.

I wish to define more explicitly, however, what is meant by a committee of his institutional associates to assure an independent determination because the policy requires that the application include a description of the associates who will provide the review. The committee would need to be made up of staff of, or consultants to, your institution who are at the same time acquainted with the investigator under review, free to assess his judgment without placing in jeopardy their own goals, and sufficiently mature and competent to make the necessary assessment. It is important that some of the members be drawn from different disciplines or interests that do not overlap those of the investigator under review.

The policy does not ask for the names of the members of the committee. It does ask for a description of its composition; e.g., the number of members and the professional or public interests they reflect.

I have directed all my staff who administer the initial review of applications for grants for clinical research and investigation involving human beings—regardless of whether these applications are for new, supplemental, renewal, or continuation support—to ascertain that each application includes the information required by this policy and to obtain this information, whenever necessary, in a document signed by both the principal investigator or program director and the official for the institution.

I know that you are as deeply concerned with this issue as are any of us in the Public Health Service. I urgently request that you give my staff your cooperation in making this policy an effective instrument for the good of the public and science.

WILLIAM H. STEWART, M.D.

U.S. PUBLIC HEALTH SERVICE,
DIVISION OF RESEARCH GRANTS,
Bethesda, Md., February 8, 1966.

Subject: Clinical Investigations Using Human Subjects.
Applicability: All PHS Research and Research Training Grants in Support of Such Clinical Investigations (including General Research Support Grants).
Effective date: Immediately.

BACKGROUND

The National Advisory Health Council on December 3, 1965, recommended to the Surgeon General as follows:

"Be it resolved that the National Advisory Health Council believes that Public Health Service support of clinical research and investigation involving human beings should be provided only if the judgment of the investigator is subject to prior review by his institutional associates to assure an independent determination of the protection of the rights and welfare of the individual or individuals involved, of the appropriateness of the methods used to secure informed consent, and of the risks and potential medical benefits of the investigation."

The Surgeon General accepted the recommendation of the Council and instructed the Grants Policy Officer to develop implementing procedures for research and research training grants.

STATEMENT OF POLICY

No new, renewal, or continuation research or research training grant in support of clinical research and investigation involving human beings shall be awarded by the Public Health Service unless the grantee has indicated in the application the manner in which the grantee institution will provide prior review of the judgment of the principal investigator or program director by a committee of his institutional associates. This review should assure an independent determination: (1) of the rights and welfare of the individual or individuals involved, (2) of the appropriateness of the methods used to secure informed consent, and (3) of the risks and potential medical benefits of the investigation. A description of the committee of associates who will provide the review shall be included in the application.

PROCEDURE

The above policy becomes effective immediately and will be incorporated in all PHS research and research training grant regulations and research and research training policy statements as soon as possible. In the meantime, the attached memorandum from the Surgeon General explains the policy to grantee institutions.

The PHS staff who administer the initial review of applications for clinical research and investigation involving human beings (including the administrative review for continuation applications) shall ascertain that each application includes the information required by this policy and shall obtain this information, if necessary, in a document signed by both the principal investigator or program director and the official authorized to sign for the institution.

ERNEST M. ALLEN.

ATTACHMENT B

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
March 30, 1966.

To: Chief, Bureau of Medical Services,
Chief, Bureau of State Services,
Deputy Chief, Bureau of State Services,
Director, National Institutes of Health.

From: William H. Stewart, M.D., Surgeon General.

Subject: Clinical Investigations Using Human Beings as Subjects.

On December 8, 1965, I discussed with the Public Health Service Bureau Chiefs the National Advisory Health Council resolution on the above subject. On December 17, 1965, I reminded each Bureau by memo that you had been asked at the December 8th meeting to develop appropriate procedures to cover all activities conducted or supported within your Bureau involving clinical research on humans not specifically covered by the policy statement being prepared by the PHS Grants Policy Office.

Attached for your information are copies of PPO #129, dated February 8, 1966, and my letter of the same date to grantee institutions promulgating the new PHS policy concerning clinical research on humans.

As regards clinical research on humans conducted either by PHS investigators or PHS contractors, I now wish to adapt the recommendations of the National Advisory Health Council in the following PHS policy statement:

"No clinical research and investigation involving human beings shall be conducted by Public Health Service personnel or by PHS contractors without (1) prior review of the judgment of the principal investigator or program director by a committee of his associates not directly involved in the research and (2) prior written approval by the Bureau Chief or by the Institute Director if the Bureau Chief formally delegates the responsibility to him. This review should assure an independent consideration: (1) of the rights and welfare of the individual or individuals involved, (2) of the appropriateness of the methods used to secure informed consent, and (3) of the risks and potential medical benefits of the investigation. Each study protocol along with the names and recommendations of the review committee and the written approval of the Bureau Chief (or his official delegate) will be placed on file in the office of the Division responsible for the study before the study is initiated."

Effective immediately, this policy will be included in all future statements of Public Health Service research and research training policy. You will have to rely on the wisdom and sound professional judgment of yourself and your staff to decide what constitutes reasonable regard for the rights and welfare of human subjects in research, what constitutes adequate consent, and what constitutes the risks and potential medical benefits of a particular investigation. I wish to define more explicitly, however, what is meant by a committee of institutional associates to assure an independent consideration. The committee would need to be made up of PHS or contractors' staff or consultants who are acquainted with the investigator who will conduct the research, free to assess his judgment without placing in jeopardy their own goals, and sufficiently mature and competent to make the necessary assessment. It is important that some of the members be drawn from different disciplines or interests that do not overlap those of the investigator under review.

While various units of the Service already have policies and procedures on this subject, I am asking that you re-examine all such policies to assure conformity with the above PHS policy statement and that, where necessary, you institute new or modified procedures.

As soon as they are ready, please send me descriptions of your Bureau policy and procedures for OSG use in program and management evaluation and for planning what further steps, if any, may be necessary to assure that PHS research on human beings is ethically and morally exemplary.

ATTACHMENT C

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
July 1, 1966.

To: All PHS Extramural Programs.
From: Grants Policy Officer, PHS.
Subject: Transmission of PPO #129, Revised.

I am pleased to transmit to you the revised policy and procedure issuance governing investigations involving human subjects, including clinical research. The attached document supersedes the previous PPO issuances on this subject.

While this policy adheres to the principles of the Surgeon General's statement of February 8, 1966, it provides greater latitude for the grantee institutions in development of internal procedures and structure for the review and surveillance of investigations involving human subjects. Procedure is simplified to provide for—and indeed require—institution-wide assurances to the Public Health Service. When an assurance is provided by an institution, the institution will no longer be required to submit a detailed assurance with each application. Note that the Public Health Service intends to secure institution-wide assurances from each grantee institution sponsoring investigations involving human subjects by November 1, 1966.

Although the responsibilities of PHS staff and consultants are implicit in the Surgeon General's statement and PPO #129, clarification may be desirable. In general, it is the responsibility of all PHS extramural program offices, including those concerned with scientific evaluation, to ascertain that no grants are awarded unless appropriate assurances have been received according to policy. Furthermore, nothing in this statement of policy and procedure should inhibit PHS staff, advisory groups, or consultant (1) from identifying concern for the welfare of

human subjects, and communicating this concern to the grantee institution, or (2) from recommending disapproval of the application if the gravity of the hazards and risks so indicate.

ERNEST M. ALLEN, Sc.D.

U.S. PUBLIC HEALTH SERVICE,
DIVISION OF RESEARCH GRANTS,
Bethesda, Md., July 1, 1966.

Subject: Investigations Involving Human Subjects, including Clinical Research: Requirements for Review To Insure the Rights and Welfare of Individuals.
Applicability: All Public Health Service Grants and Awards.
Effective date: Immediately.
Supersedes: PPO #129, February 8, 1966; PPO #129 Supplement, April 7, 1966.

I. BACKGROUND

Culminating several years of study by various Public Health Service staff and advisory groups, the National Advisory Health Council passed the following resolution on December 3, 1965:

"Be it resolved that the National Advisory Health Council believes that Public Health Service support of clinical research and investigation involving human beings should be provided only if the judgment of the investigator is subject to prior review by his institutional associates to assure an independent determination of the protection of the rights and welfare of the individual or individuals involved, of the appropriateness of the methods used to secured informed consent, and of the risks and potential medical benefits of the investigation."

II. POLICY

The Surgeon General accepted the resolution of the National Advisory Health Council and promulgated the following policy statement on February 8, 1966:

"No new, renewal, or continuation research or research training grant in support of clinical research and investigation involving human beings shall be awarded by the Public Health Service unless the grantee has indicated in the application the manner in which the grantee institution will provide prior review of the judgment of the principal investigator or program director by a committee of his institutional associates. This review should assure an independent determination: (1) of the rights and welfare of the individual or individuals involved, (2) of the appropriateness of the methods used to secure informed consent, and (3) of the risks and potential medical benefits of the investigation. A description of the committee of the associates who will provide the review shall be included in the application."

III. REVISED POLICY

By decision of the Surgeon General, the application of this policy has been extended to all grants and awards of the Public Health Service in the support of research, training, or demonstration projects, including the projects supported through general research support and those of fellows and trainees. The policy is not applicable to grants in support of construction, alterations, renovations, or research resources—it is obviously applicable to the PHS projects using these facilities and resources.

This policy will be included in all pertinent grant program policy and instruction statements, and will be among the conditions of award agreed upon by grantee institutions and the Public Health Service. The policy applies to all investigations involving human subjects, including clinical research.

A. Assignment of responsibility

Safeguarding the rights and welfare of human subjects involved in research support by PHS grants is the responsibility of the institution to which the grant is awarded. The institution must assure the Public Health Service that in the case of investigations and activities supported directly by the PHS, it will provide group review and decision, maintain surveillance, and provide advice for investigators on safeguarding the rights and welfare of human subjects. The institution also has the responsibility to provide whatever professional attention or facilities may be required for the safety and well-being of human subjects. The institution shall be responsible for developing the administrative mecha-

nism for review, surveillance, and advice; however, the PHS requires that, prior to inception of each course of investigation, objective decisions be made on the three points cited in the Surgeon General's policy statement (above) by an appropriate committee of associates of the investigator having no vested interest in the specific project involved. The grantee institution may utilize staff, consultants, or both to carry out the review. Any group responsible for review should possess not only specific scientific competence to comprehend the scientific content of the investigations reviewed, but also other competencies pertinent to the judgments that need to be made.

The grantee is required to make and keep written records of the group reviews and decisions on the use of human subjects and to obtain and keep documentary evidence of informed consent relating to investigations carried out with the assistance of PHS financial support.

B. Timing of review

While this policy requires that review be conducted prior to the use of human beings as subjects, there are advantages to both the PHS and the grantee in having the review conducted *prior to* application for PHS support. The PHS encourages the institution to do so, if the review can be accomplished without causing unreasonable delay in the application process and if the application is of the type that normally contains a reviewable scientific protocol.

IV. PROCEDURAL REVISIONS—ASSURANCES OF APPLICANTS AND GRANTEES

Upon issuance of this policy statement, the PHS will require necessary assurances from the grantee institutions which sponsor investigations involving human subjects, including clinical research. These assurances will cover both the general principles of safeguarding human rights and welfare in the conduct of research and the specific points of the Surgeon General's policy. The assurance should provide explicit information on the policy and procedure it employs for review and decision on the propriety of plans of research involving human subjects. The descriptions will include the competencies represented in the committees of associates utilized for review, the sources of consultants (if used), the administrative mechanisms by which surveillance is provided for projects involving human subjects—particularly to deal with changes in protocol or emergent problems of investigations, the means of guidance and advice provided for investigators, and the manner in which the institution will assure itself that the advice of the committee of associates will be followed. Copies of documents of institutional policies on these issues should be attached to the memorandum of assurance. An example of an acceptable assurance is attached.

Assurances can be provided which apply only to individual major components of universities or other large institutions in those instances where assurances covering the total institution are impracticable or inadvisable.

Each assurance and its attachments shall be transmitted to the Public Health Service, in care of the Chief, Division of Research Grants. When the Public Health Service has reviewed and accepted the assurance, the Chief, Division of Research Grants, shall so notify both the responsible official of the grantee institution involved and all Public Health Service extramural research program offices.

Each grantee institution shall report currently any changes in its policies, its procedures, or the competencies represented on its committee of associates.

For each application that includes or is likely to include investigations involving human subjects, including clinical research, the applicant institution should make reference to the certification as follows:

"The investigations encompassed by this application have been or will be approved by the committee of associates of the investigator(s) in accordance with this institution's assurance on clinical research dated _____."

Until an institution-wide assurance has been accepted by the PHS, the institution can fulfill requirements of this policy for individual studies by submitting an assurance with each application for PHS financial support, stating that prior to inception of investigations, the requirements of section III. A. of this Policy and Procedure Order will be followed. The statement must also describe the composition of the group which will conduct the review.

This interim procedure will be acceptable until *November 1, 1966. After that date no new, supplemental, renewal, or continuation application for a Public Health Service grant or award to support investigations involving human subjects will be accepted for review unless the PHS has approved an institution-wide assurance.*

Nothing in the institution-wide assurance or in the interim policy procedure used in some cases until November 1, 1966, should inhibit PHS staff, advisory groups, or consultants (1) from identifying concern for the welfare of human subjects, and communicating this concern to the grantee institution, or (2) from recommending disapproval of the application if the gravity of the hazards and risks so indicate.

In the case of awards to U.S. citizens receiving fellowships for training abroad, special conditions or circumstances relating to the place at which the training is being provided may upon occasion justify modification of these requirements. Requests from the sponsor for approval of such modifications must be reviewed by the Office of International Research, NIH, and approved by the PHS bureau chief concerned.

ERNEST M. ALLEN.

(Example of an Acceptable Assurance)

INSTITUTIONAL ASSURANCE ON INVESTIGATIONS INVOLVING HUMAN SUBJECTS, INCLUDING CLINICAL RESEARCH

The (name of institution) agrees with the principles of the Public Health Service policy (identified as Policy and Procedure Order 129 dated July 1, 1966) with regard to investigations involving human subjects, including clinical research. This institution agrees that review independent of the investigator is necessary to safeguard the rights and welfare of human subjects of research investigations and assures the Public Health Service that it will establish and maintain advisory groups competent to review plans of investigation involving human subjects, prior to initiation of investigations, to insure adequate safeguard. Group revews and decisions will be carried out in reference to (1) the rights and welfare of the individuals involved, (2) the appropriateness of the methods used to obtain informed consent, and (3) the risks and potential medical benefits of the investigations.

The institution also agrees to exercise surveillance of PHS-supported projects using human subjects for changes in protocol which may alter the investigational situation with regard to the criteria cited above. The Institution further assures the Public Health Service that it will provide advice and consultation to investigators on matters of employing human subjects in investigation, and also that it will provide whatever professional attention or facilities may be required to safeguard the rights and welfare of human subjects involved in investigation. Records of group review and decision on the use of human subjects and of informed consent will be developed and kept by the institution.

Attached as part of this statement are copies of policy and procedure of this institution with regard to use of human subjects in investigation, as well as a description of the groups utilized to review projects for enforcement of these policies and the manner in which the institution will assure itself that the advice of the committee of associates is followed.

Signature _____
Title _____
Date _____

Mr. ROGERS of Florida. Now, another field I am concerned about is foreign drugs.

You have been most helpful in supplying information to us. It is my understanding that perhaps you plan to establish an Office of International Affairs which will help to overcome some of the problems that have been developed and are still with us.

As you know, this committee has been very much concerned. We have had discussions with you along the idea of very infrequent factory inspections conducted by FDA of foreign drug manufacturers who ship their drugs into this country, and also the fact that many of such drug shipments are not even sample tested by the FDA as required by law.

I understand that of 43 foreign drug manufacturers who have made sales of certifiable antibiotics to U.S. purchasers, 12 have not been inspected at all by FDA since 1962, and 25 others have been inspected

only once since 1962, and I noticed, for example, from the information furnished by Food and Drug, that there were approximately 1,000 commercial shipments alone into this country last year that were not tested by FDA, plus an unknown number of private drug shipments.

Now, what would be your comment on this, Dr. Goddard?

Dr. GODDARD. First, we have added more inspectors this year to the monitoring of international shipments of both food and drugs.

Secondly, it was for these reasons, among others, that I requested permission to establish the Office of International Affairs to examine as a first priority of business how we can better accomplish this mission and to provide the necessary safeguards to make certain that imported drugs meet the same standards that we require of our own manufacturers.

Mr. ROGERS of Florida. This was the intent of the law that we passed as I recall in 1962 again.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. But it has not been carried out by the Department.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. And they are, in effect, in many instances, allowing foreign drugs to come in without checking, without factory inspection, which we require of our own drug manufacturers in this country.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. And there is no way to tell where those drugs go, is there?

Dr. GODDARD. We do have knowledge from the Bureau of Customs of the consignees that receive the drugs and could and have, in fact, had to track down some of the imports because of problems associated with them.

Mr. ROGERS of Florida. Yes, but what of these we do not inspect? We do not know where they are going.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. Or what is happening, or what effect they may have on the American people.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. Now, when is the Office of International Affairs to be established?

Dr. GODDARD. That has been approved by the Secretary, and we are now looking for a person to head this activity up and get started within the next few weeks.

Mr. ROGERS of Florida. And are you going to be able to get the necessary personnel to staff it?

Dr. GODDARD. I believe we are, sir. I have an ample number of vacancies at the present time, unfortunately, and we will use some of those to staff it.

Mr. ROGERS of Florida. Will you keep this committee advised on this?

Dr. GODDARD. Yes, sir.

Mr. ROGERS of Florida. Should these drug shipments be stopped until we have the necessary personnel?

Dr. GODDARD. Well, as I mentioned, we have added inspectors this fiscal year to do import work, and I will provide you with a report, an up-to-date report, of the percentage of the bulk shipments that are now being checked. I believe we are in better shape now than we were at the time of the report you cited.

Mr. ROGERS of Florida. How long do you think it will be before we can check all of the drugs coming into this country as was intended by the law?

Dr. GODDARD. I hope to be able to tell you that we are doing this within the next few months.

Mr. ROGERS of Florida. We will be interested very definitely. Should there be a ban on these, do you think, until this is done?

Dr. GODDARD. The samples that we have taken, particularly in the antibiotics area have not revealed significant problems, but as you point out, it has not been a 100-percent sampling, and I would like to reserve judgment on that until I get a more recent report.

Mr. ROGERS of Florida. Will you look into that and see if you think it should be done?

Dr. GODDARD. Yes. I will look into it right now.

Mr. ROGERS of Florida. What about the efficacy of these drugs? Is this being tested?

Dr. GODDARD. Many of these products are new drugs and those that predate 1962 would come under the same requirements for review of efficacy as we impose upon our domestic drugs and will be judged at the time recommendations are made by the Academy.

Mr. ROGERS of Florida. What about the drugs that are coming in that are being tested? Have they been tested yet for efficacy?

Dr. GODDARD. Only in the same sense that our own drugs manufactured by our own firms have been tested for efficacy.

Mr. ROGERS of Florida. Well, in other words, you are testing them for efficacy as you test them; is that correct?

Dr. GODDARD. We do not test the drugs for efficacy, but those developed since 1962 were required to meet the same standards of efficacy as those produced domestically.

Mr. ROGERS of Florida. So they are being tested, if they have been introduced since 1962 and are coming into this country.

Dr. GODDARD. Their efficacy has been established. Let me state it that way.

Mr. ROGERS of Florida. Have you found any of these drugs coming in that do not meet the standards of efficacy, or would you like to give a——

Dr. GODDARD. I can provide you with some of the detentions that we have made of imported drugs.

Mr. ROGERS of Florida. This has happened.

Dr. GODDARD. Yes.

Mr. ROGERS of Florida. So, many of the drugs that are not being tested could also be guilty of this lack of efficacy as well.

Dr. GODDARD. More of our detentions involved safety. For example, we have seized contaminated lots of bulk thyroid powder which are contaminated with salmonella organisms, and there have been other instances where potency has been below the required standards, and those have been detained.

Mr. ROGERS of Florida. Now, as I understand it, you will put 30 additional inspectors on to help meet this problem, or is that a wrong impression?

Dr. GODDARD. We have put additional inspectors on this year and will add even more this coming fiscal year, beginning in July. The exact number I will have to supply for the record.

Mr. ROGERS of Florida. Now, getting back to "patient consent" for a moment, what do you do to check whether investigators obtain consent?

Dr. GODDARD. In two ways: Through the examination of the records of the firms when we do a factory inspection, and also through the submittals that they make in their IND submittals. Their followup reports.

Mr. ROGERS of Florida. They get the patient's consent, or does the doctor say: "I have obtained it"?

Dr. GODDARD. The doctor must certify to the sponsor that he will obtain the required consent. There is no requirement that this consent be in writing, however.

Dr. LEE. Mr. Chairman, might I ask to be excused? I have to be at another meeting with the President at 12 o'clock. So, with your permission, I will depart prematurely.

Mr. ROGERS of Florida. We will let the Executive assume precedence over the legislative in this regard.

Dr. LEE. Thank you, sir.

Mr. ROGERS of Florida. But there only.

Dr. LEE. Thank you very much.

Mr. ROGERS of Florida. Thank you for being here. We appreciate your help and information.

I think the law requires a person to certify to the manufacturer that he will inform any human being on whom an experimental drug is being tested about the drug. But you inspect the factory records?

Dr. GODDARD. We can check those consent records.

Mr. ROGERS of Florida. Evidently, we need to do more, because it is not being done, and I think this would warrant your attention right away, because with the reports that we have, very positive reports here, obviously we are not carrying out the intent of the law.

Now, you mentioned Salmonella in your work in checking food production.

What problem does this bring forth?

Dr. GODDARD. Well, the problems of contamination of food products and, to a limited extent, some of the bulk drug products have been a quite serious one, and of increasing concern in recent years. We have been working very closely with the Communicable Disease Center. In fact, when I was chief of the Communicable Disease Center, we collaborated with the Food and Drug Administration in the problem of Salmonella Derby outbreak involving many of the large hospitals in the eastern half of the United States.

Mr. ROGERS of Florida. Could you explain salmonella to the committee?

Dr. GODDARD. Yes. This family of organisms, I believe about 800 in all, possesses rather unique characteristics, almost like fingerprints in the sense that you can distinguish each of them in the laboratory, and Salmonella Derby is an example. This particular organism had

only been seen in this country once or twice in very limited outbreaks prior to the outbreak involving the use of cracked or chipped eggs in hospitals in 1963.

Now, salmonella distribution seems to be rather ubiquitous today. I believe the Communicable Disease Center, in their annual report, indicates that there were about 25,000 cases reported to them by State departments of health in the past year. And each year for the past 5 years, there has been an increase in the reported number of human cases. In this matter you might say we are dealing with an iceberg phenomenon in terms of the unreported cases, since they probably exceed the reported cases by a factor of at least 10 to 1 and perhaps 100 to 1.

The National Health Survey, if I recall correctly, indicated that based on their questioning of the families in their survey program there are about 6½ million episodes of gastrointestinal illnesses in the United States. How many of these are due to salmonella and how many due to staphylococcal contamination of food is difficult to estimate, but we do know that salmonella has been present in animal feeds being derived from contamination at the processing plant and can be transmitted through the animals to humans in a variety of mechanisms.

Poultry are particularly common vehicles of salmonella infections and, occasionally, other products that enter into the marketplace. We have had cake mixes, prepared desserts, and packaged desserts to which you simply add water that were contaminated.

Mr. ROGERS of Florida. These would be the products that you would normally find——

Dr. GODDARD. That are frequently involved, let me say, or have been involved in the past. Cream custard fillings in bakery products have been involved.

Mr. ROGERS of Florida. How about dry milk, coffee milk?

Dr. GODDARD. We are at the present time working on a problem of salmonella in instant nonfat dried milk. And these are very difficult problems to handle, because one must track down the source, and this involves the entire distribution problem of the industry involved and its practices of handling the bulk product, its storage, and its initial processing. We have had great cooperation from the U.S. Department of Agriculture, the Communicable Disease Center, and State agencies in all these matters as well as from the industry involved.

I would say that the industries, where this problem has cropped up, have recognized very quickly the need to move in. They have recalled the lots that have been incriminated and have cooperated, I believe, in an outstanding fashion. But it does not lessen the seriousness of the problem nor diminish the effort that must be made to get rid of this as part of our problem with foods in the years ahead.

Mr. ROGERS of Florida. Do you anticipate that you will have to use section 404, "Emergency Permit Control," that that might be necessary to meet this problem?

Dr. GODDARD. I would hope not. If necessary, we will, however.

Mr. ROGERS of Florida. What would that require?

Dr. GODDARD. Well, release of shipments would be contingent upon our providing the emergency permit.

Mr. ROGERS of Florida. In other words, the food industry would have to submit a sample or a testing?

Dr. GODDARD. We would obtain the tests, the results of tests, or conduct the tests ourselves, depending on the situation.

Mr. ROGERS of Florida. Either they could submit certified tests to assure there is no contamination?

Dr. GODDARD. Yes.

Mr. ROGERS of Florida. Do you think the problem is widespread enough for this at this time?

Dr. GODDARD. No; I do not at this time. Most of the problem has been centered on relatively few producers, and they are being worked with intensively both by Food and Drug, the Department of Agriculture, and the State agencies involved. The States have been very helpful in this regard.

Mr. ROGERS of Florida. Have you had to make any seizures because of this?

Dr. GODDARD. Yes, we have.

Mr. ROGERS of Florida. What products, mainly?

Dr. GODDARD. Nonfat instant dried milk. There have been seizures in this area.

Mr. ROGERS of Florida. Whenever a seizure is made, you of course follow that to whatever distribution has been made of it?

Dr. GODDARD. Yes.

Mr. ROGERS of Florida. Recall it?

Dr. GODDARD. Yes. And here the manufacturers have voluntarily recalled the lots involved.

Mr. ROGERS of Florida. All right.

Now, you mentioned that the States helped a great deal.

What about your Federal-State relationship, particularly your reorganization? As I recall, the Public Administration Service in February of 1965 made a number of specific recommendations whereby the FDA might assist the States to assume greater responsibility for certain State-local programs. What measures have been taken by FDA to implement these recommendations, and what further measures might be desirable to encourage States to assume greater responsibility?

Dr. GODDARD. One that I can point to specifically in recent weeks has been the development of a pilot program with six States to obtain their assistance in the drug abuse control activities that we are carrying out, and, in particular, arranging for these six States to check the pharmacists at the local level for their compliance with the 1965 Drug Abuse Control Amendments.

Mr. ROGERS of Florida. This is where they must keep a record of the number of drugs that are to be controlled that come in, and the distribution of them; is that correct?

Dr. GODDARD. That is correct, sir, and one of the States entering into this agreement is your home State of Florida.

Mr. ROGERS of Florida. This is just being entered into.

Dr. GODDARD. Yes, sir.

Mr. ROGERS of Florida. I see. When will they be concluded, these agreements?

Dr. GODDARD. It is going to be announced publicly later today, I understand.

Mr. ROGERS of Florida. Late today. All right.

Dr. GODDARD. This is one example.

Mr. ROGERS of Florida. It is encouraging.

Dr. GODDARD. I think it is necessary that we do more of this, because the job that confronts us in the months and years ahead is a rather enormous one, and we hope the States will assume their portion of the responsibility. One of the things that is pending before the House Interstate and Foreign Commerce Committee is an administration proposal to facilitate the training of State employees in the Food and Drug activities. One of the difficulties that many State agencies encounter is the lack of travel moneys for out-of-State travel for attendance at scientific sessions, seminars, and training programs. If this bill, the Professional Training and Cooperation Amendments of 1966, H.R. 13884, is passed, we would provide regional seminars for State food and drug officials to increase their professional competence and get them more directly involved in the protection of our food and drug supplies in the United States.

Mr. ROGERS of Florida. I am encouraged that you are trying to—encouraged at the use of our States for these activities. How will this work—the contract that you are working on with these six States as a pilot program?

Dr. GODDARD. In these States, the agency which has responsibility for supervision of pharmacists will employ individuals who will visit the pharmacists, inspect their records according to our criteria and provide us with the reports of compliance. In the instances where there are deficiencies, these will be brought to our attention.

Mr. ROGERS of Florida. Then, your agency would help.

Dr. GODDARD. Yes, we do have, as you know, intrastate authority in the Drug Abuse Control amendments, to act; and so far, we have had good cooperation from all State agencies involved—enforcement agencies, and State boards of pharmacists as well. I think, in the years ahead, we are going to have to go beyond the professional training activities if we are going to be successful in carrying out the total responsibility of protection of the health of the public. It matters little to the person who becomes ill whether the food ever entered into interstate commerce or not. He is just as sick with something that developed in an intrastate shipment. And so we think there is a need perhaps in the future for providing funds to build laboratories and provide the kinds of technical equipment that are necessary in doing the job. This would be another step that could be taken. We think that there are many kinds of activities that could best be carried out at the State level, perhaps, the pesticide monitoring program. There are some States—California, Florida, New York; several others, including Connecticut, I believe—that have excellent programs in monitoring the levels of pesticide residues on foods in their marketplaces. This needs to be encouraged and developed more widely. Hopefully this can be done through this program, this legislative proposal, and through other activities.

Mr. ROGERS of Florida. Just a few more questions. I notice the recent report of the World Health Organization suggests the desirability of a long-range controlled study to thoroughly look into questions of possible harmful side effects which may result from the use

of oral contraceptives. Has your agency taken any position on this as to a controlled study?

Dr. GODDARD. Of course, we believe such a study is desirable, and I was very pleased to note recently that the National Institutes of Health are going to fund such a study, involving perhaps as many as 20,000 patients here in the District of Columbia. Dr. Shannon has expressed concern with the problems related to safety of oral contraceptives in hearings of last year and has now followed through, and they are making the arrangements, I understand, for this study to be initiated and carried out here in the District.

Mr. ROGERS of Florida. Now, would this study then be made available to your agency?

Dr. GODDARD. Oh, yes. We have very close working relationships with the Institutes.

Mr. ROGERS of Florida. So, you do not think it is necessary for your agency to undertake this.

Dr. GODDARD. No, sir; and I am very fortunate in having them do it for our agency, because these kinds of prospective studies are extremely expensive.

Mr. ROGERS of Florida. How about reporting of side effects? What difficulty do you have, do you find, with these new drugs, and so forth, in reporting side effects?

Dr. GODDARD. Well, the problem is getting the physicians and hospitals to provide the reports on unexpected side effects. Now, we could be literally snowed under if we got every penicillin reaction that occurred in the United States reported to us.

Knowledge of these penicillin reactions would not be particularly helpful, but what we do badly need from the practicing physicians in their everyday activities are reports of unexpected side effects, adverse reactions, so that their fellow practitioners may be informed to be alert to these, and so that assessment can be made of the risks involved in taking a particular drug.

Now, our reporting system is increasing as well as the number of reports received. However, we are not satisfied that we are getting either the number or quality of reports that we really require to do the job effectively.

Mr. ROGERS of Florida. I would be interested to have for the committee's information the procedures used in a controlled study; because, as I understand it, often they will give, say, the pill to physicians to administer for testing, and they may just turn over the pills to a patient, and then we may never have any report from them. They say: "Have you had any trouble?" And they say: "No." But they may have stopped taking the pills. They do not know how many pills they have taken. Often the reports are not very conclusive or effective, and, therefore, we do not get reports of side effects as I understand it.

Dr. GODDARD. It is true that this occurred in the past, but the investigational drug regulations were designed to eliminate such practices.

Mr. ROGERS of Florida. Well, we would like to know the procedure.

Dr. GODDARD. We will be happy to provide you with that.

Mr. ROGERS of Florida. If you could supply that for the record.

(The information requested follows:)

STATEMENT OF THE FOOD AND DRUG ADMINISTRATION ON THE PROCEDURES USED IN A CONTROLLED INVESTIGATIONAL DRUG STUDY

The investigational drug regulations (21 CFR 130.3) implementing the new drug provisions of the Federal Food, Drug, and Cosmetic Act require that the sponsor of a new drug investigation provide the FDA with information describing the protocol for the investigation which the sponsor wishes to undertake. While the FDA does not specify in detail the type of testing which may be required, there are general criteria which apply to all new drug investigations. These criteria include strict accountability by the sponsor for all quantities of the drug distributed for testing. This requirement is passed on to the individual investigator. He is required to submit reports to the sponsor of the therapeutic effects and side-effects or adverse reactions observed in *all* patients to whom the drug is administered. The sponsor, in turn, is required to submit periodic progress reports to the FDA on *all* investigations involving the drug. The progress reports must include all reports of adverse reactions occurring in subjects receiving the drug, whether or not the sponsor believes such reactions are drug-regulated. The sponsor must *promptly* investigate and report to the FDA any "significant" adverse reactions. Any "alarming" adverse reactions must be reported to the FDA *immediately*.

The periodic progress reports must be submitted even though the sponsor might ultimately decide to abandon the investigation or be required by the FDA to do so. Failure to comply with these requirements constitutes a violation of the Federal Food, Drug, and Cosmetic Act.

Section 130.3(a)(2)–(13) of the regulations outlines the type of information a sponsor must provide for in drawing up the protocol for his clinical trial of a drug.

Mr. ROGERS of Florida. Now I know a number of us have wondered about the advisability of having a Division of Biologics Standards out at the National Institutes of Health as an enforcement activity when NIH is supposed to be really a research-oriented facility. What is your thinking on this? It seems to me that where you have an enforcement requirement that has been placed upon you by the Congress, it would be more logical to have one agency do this enforcement rather than have a division of a research agency also do enforcement.

What is your reaction?

Dr. GODDARD. Well, that could be carried out by the Food and Drug Administration, and I understand the Secretary has this under consideration at the present time, along with many other matters in the total reorganization of the Public Health Service.

Mr. ROGERS of Florida. You believe that your agency could do it if the Secretary so decided.

Dr. GODDARD. Yes.

Mr. ROGERS of Florida. Are there any other major approaches that you would like to advise the committee of, as to reorganization?

Dr. GODDARD. I believe not, sir. I think we have covered the major ones that are pending. I must say, as we move along and have experience with these changes, we may have to make adjustments in the months and years ahead? This is, of course, part of the business of administration.

Mr. ROGERS of Florida. You have the necessary authority, or the Secretary does, to make whatever changes are necessary in Food and Drug?

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. Which was unlike the Public Health Service, the organization of which was specifically set forth by law.

Dr. GODDARD. That is correct.

Mr. ROGERS of Florida. So that, if you see any necessity for any changes, this can be done.

Mr. GODDARD. Yes indeed.

Mr. ROGERS of Florida. You will keep this committee advised, I presume.

Dr. GODDARD. I will be happy to do so.

Mr. ROGERS of Florida. Counsel?

Mr. SLOAT. Dr. Goddard, I notice the organizational charts at the end of your statement show the FDA district offices reporting directly to you rather than to the Chief of the Bureau of Regulatory Compliance, as they do at present, I believe. Would you describe what would be the relationship between these district offices and the Bureau of Regulatory Compliance under the new setup, particularly in regard to budgetary control?

Mr. GODDARD. Mr. Lannon?

Mr. LANNON. All of the details have not been worked out, but at present we plan to have the district directors prepare their budgetary requests, forward them to the Bureau of Regulatory Compliance for a coordination job in the Bureau. This would be coupled at the Bureau level, with the work plan coming from the districts.

Mr. SLOAT. So there will be joint review of the district officers' budgets by the Commissioner's office and the Bureau.

Mr. LANNON. Yes.

Dr. GODDARD. We plan to involve the district directors in the development of the forthcoming year's work plan, along with the directors of the bureaus, because we are broadening our concept of what will be carried out in the districts.

For example, Dr. Clarkson, Director of the Bureau of Veterinary Medicine, is going to be assigning veterinary offices to the districts for the first time. There will be more educational activities, more in the area of voluntary compliance carried out, so it will be necessary for the bureau chiefs to come forward with a work program that can be discussed with the district directors and with the Office of the Commissioner and some agreement reached as to how the manpower and resources will be used for the forthcoming year.

Mr. SLOAT. The implications of the chart are correct, then, that the district directors will be reporting primarily to you?

Dr. GODDARD. Yes.

Mr. SLOAT. Just briefly on the question of the new procedures for reviewing new drug applications, can you tell us how many medical persons would substantively review new drug applications under the new procedures before permitting a drug to go on the market?

Mr. GODDARD. You mean after July 11?

Mr. SLOAT. Yes.

Dr. GODDARD. I can't give you the exact figure. I can supply that for the record in a relatively short period of time, perhaps within the next 10 days.

Mr. SLOAT. The size of these teams of specialists is what I meant.

Dr. GODDARD. This would be approximately 8 or 10 members per team; minimum figure of 8 or 10, I believe.

Mr. SLOAT. And will these teams of specialists be set up by drug classes or medical specialties, or——

Dr. GODDARD. Our current thinking is that it will be more by the organisms involved such as drugs affecting the cardiovascular and renal system, drugs affecting the central nervous system.

Mr. SLOAT. Thank you. I have no further questions.

Mr. ROGERS of Florida. Let me ask you: Who handles the budget for the Bureau of Medicine, for instance? Is it drawn up through the Assistant Commissioner for Administration?

Dr. GODDARD. No. It is drawn up at the Bureau of Medicine and then at the budget review they present their requirements to the Commissioner. The Assistant Commissioner for Administration has an opportunity to comment on it at that time, as do the other Bureau chiefs, because there are necessary interrelationships.

Mr. ROGERS of Florida. Do you have a budget officer?

Dr. GODDARD. Yes, we do.

Mr. ROGERS of Florida. Well, now, you are letting all your bureaus go directly to your budget officer, then, but your district officers are still running, for budgetary purposes, through the Bureau of Regulatory Compliance.

Mr. LANNON. It is a coordinating function in the Bureau of Regulatory Compliance. They will still come ultimately to the budget officer.

Mr. ROGERS of Florida. I realize that, but you are still making them dependent upon this bureau and yet giving them direct access to the Commissioner. Didn't you say you are letting them go direct to the Commissioner, your district offices, and yet you are making them run their budgetary problems through a bureau?

Dr. GODDARD. I am not certain that is the way it will be. Rather, I think the district directors, meeting with the Commissioner and the Bureau chiefs, will have a work plan for their district for that year which will lay out certain manpower and budgetary requirements. Then, the Commissioner's office will review this work program with the district director involved and the bureau chiefs and whatever adjustments have to be made will be made with discussions involving the district director and the bureau chiefs, so that they will have ample opportunity to express their views as to their own particular needs in that district.

Mr. ROGERS of Florida. You do not feel that is still keeping your same basic structure by letting the monetary affairs be in effect influenced by the Bureau of Regulatory Compliance?

Dr. GODDARD. I am not certain that the Bureau of Regulatory Compliance is going to have that much say over the monetary affairs. Rather, each bureau will have to make a determination of what their workload goals are for the coming year. Then, obviously, there has to be some agreement with the Office of the Commissioner that these are appropriate or have to be scaled back. And then at that point in time, we will discuss the impact on each district, and the district director will have the opportunity for adjustment in his workload activity.

Mr. ROGERS of Florida. I just wondered if it would be easier for the Commissioner to have his budget officer doing that rather than running these through a particular bureau which has the same standards as the bureau and yet, in effect, it is having a say-so on what their activities would be.

Dr. GODDARD. Well, as I say, I am not certain that they will be run through the Bureau of Regulatory Compliance. That has not yet been determined.

Mr. ROGERS of Florida. This is what I understood the testimony was.

Dr. GODDARD. That is one of the plans being considered, but one of the primary considerations is that we give the district directors the opportunity to have a voice in formulating the plans, setting out their budegtary needs and showing where there are special problems in their own districts that are different than the other districts. I can assure you this will be done no matter what the mechanism of handling the actual paperwork with the budget is.

Mr. ROGERS of Florida. We will be interested in knowing what you finally come upon. Let us know that.

Also, as I understand it, you have decided not to go in for regional offices, but to keep your present 18 district offices because of the workload involved. Is that true?

Dr. GODDARD. That is our present thinking, sir.

Mr. ROGERS of Florida. Any other questions?

We appreciate very much your being here, Dr. Goddard; and Mr. Lannon, glad to see you.

Mr. LANNON. Thank you.

Mr. ROGERS of Florida. Thank you so much for being present. The committee will recess subject to the call of the Chair.

(Whereupon, at 12 noon, the special subcommittee recessed, subject to the call of the Chair.)

APPENDIXES

APPENDIX I.—Form letter of August 20, 1965, requesting comments of State Governors and health agencies re relationship with the Department of Health, Education, and Welfare, and replies thereto.

APPENDIX II.—Form letter of April 4, 1966, requesting views of State Governors re Federal-State-local relationship in public health matters, and replies thereto.

APPENDIX I

FORM LETTER OF AUGUST 20, 1965, REQUESTING COMMENTS OF STATE GOVERNORS AND HEALTH AGENCIES RE RELATIONSHIP WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, AND REPLIES THERETO

AUGUST 20, 1965.

Hon. ——— ———,
Governor of ——— ———.

MY DEAR GOVERNOR———: The Special Subcommittee on Investigations of the Committee on Interstate and Foreign Commerce is conducting a study into the organization, structure, and activities of the Department of Health, Education, and Welfare. Emphasis is being placed on the general field of public health and thus, on the Public Health Service (including the National Institutes of Health) and the Food and Drug Administration. It is obvious, however, that we cannot ignore the health activities which cut across virtually every subdivision of the Department. I am enclosing a copy of the April 14, 1965 statement of the Hon. Oren Harris, Chairman of the Committee on Interstate and Foreign Commerce, outlining the purposes of our study.

There is considerable sentiment, both within and outside Congress, to the effect that the rapid growth of the Department of Health, Education, and Welfare in recent years has created enormous administrative problems. Our efforts will be directed toward determining where these problems exist and what can be done about them.

Federal health activities, of course, do not function in isolation from State and local programs: our study must take into account the Federal-State relationship. Accordingly, I am writing to ask your assistance in obtaining the participation in this important effort of all agencies of your State government having public health responsibilities. It would be particularly helpful during this initial phase of our study if our staff could have the benefit of whatever comments or observations, whether favorable or unfavorable, which these agencies may have regarding their relationship with the Department of Health, Education, and Welfare in general, and with the HEW regional offices, the Bureau of State Services, the National Institutes of Health, and the Food and Drug Administration, in particular. Any additional information, comments or suggestions deemed relevant to this study will also be welcome. I would appreciate your arranging for the circulation of this letter to the appropriate State agencies for whatever comments they may have on this subject.

In addition to obtaining the views of the appropriate State agencies, the subcommittee would welcome your personal views regarding the public health-related problems of your State, and any suggestions you may have for more effective coordination of Federal and State efforts in these fields.

It would be particularly helpful to the work of our Subcommittee if we could have the benefit of your views and those of your public health officials as soon as possible in order to help us develop and pinpoint the major organizational problem areas for further detailed study by the subcommittee staff.

I want to assure you that your cooperation will be greatly appreciated. I am confident, moreover, that your contribution to this endeavor will eventually result in substantial benefit to the people of your State.

With kindest regards, I am,

Sincerely yours,

PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation.

REPLIES (In Alphabetical Order of States)

STATE OF ALABAMA,
GOVERNOR'S OFFICE,
Montgomery, Ala., October 14, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE ROGERS: This is in response to your recent inquiry regarding our views concerning the study into the organizational structure and activities of the Department of Health, Education, and Welfare. We are well aware of the expanding number of programs in each of the activities of DHEW. Health activities have become complex for States as well as the Federal government. It seems that numerous new programs have been added in the last few years and the amount of appropriations for research and special studies continues to increase.

We are concerned about the change in direction on the part of the Public Health Service emphasizing research and stimulatory programs with the exclusion of support beyond the demonstration and initiation phases.

With the increasing number of health and health-related programs, it would seem appropriate to consider a separate Federal Department of Health. From our viewpoint, this would permit us to deal with a single agency rather than a multiplicity of agencies.

We have real difficulty in long-range planning at the State and local levels because no uniform national health goals or general policy have been established. Federal funds are often appropriated several months after the new fiscal year begins, and this makes continued programs difficult.

With the rise of special categorical programs and the tremendous research funds from the National Institutes of Health, we believe there should be more uniformity in communications between the various program interests within the Public Health Service. The grant policies of the National Institutes of Health and that of the Bureau of State Services may vary widely in administrative detail and some of these programs require direct funding from the national office rather than through the regional office system. This adds to the confusion if you are using funds and participating in programs having different rules made by the same agency.

We would hope that your investigations would enable the proper Federal accounting for Federal funds and yet permit flexibility to meet the different health needs for the several States.

I am confident that representatives of our State Health Department and our State Department of Finance, as well as our universities, would be happy to discuss any of these points in detail. We continue to give serious thought to the relationship and balance between the Federal government and our State and local needs and requests for Federal assistance.

Please be assured that we will watch with interest for the findings and recommendations of your investigation.

Sincerely yours,

GEORGE C. WALLACE, *Governor.*

STATE OF ALASKA,
DEPARTMENT OF HEALTH AND WELFARE,
Juneau, Alaska, September 16, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health, Education, and Welfare Investigation,
Rayburn Office Building, Washington, D.C.

DEAR REPRESENTATIVE ROGERS: The Governor of Alaska has requested me to send you comments, invited in your letter to him dated August 20, 1965, concerning your study of the Department of Health, Education and Welfare. Since emphasis in that study is being placed on public health, I shall confine my remarks to that field.

Investments in human capital are of importance not only for increasing future earnings but also, especially in health and education, for assuring future well-

being in benefits not reflected in earnings. Rapid increasing federal support of health and medical services rightfully recognizes this importance, but the very rapidity of the increase has contributed to scattering of these services throughout several federal agencies, the various components of the Department of Health, Education and Welfare among others. Assignment of segments of health and medical programs to a number of different federal agencies has made it difficult to develop a national health policy, and has puzzled and handicapped state health officials who must deal with and satisfy disparate federal offices. I would be able to discharge my public health responsibilities effectively if many of the scattered federal health programs were associated in a single "Department of Health" which included a major Office of Planning for the purpose of advising the Administration, the Congress and the Department on health policies and goals for the Nation.

Alaska presently has no independent local health departments, and the State's Division of Public Health not only is charged with carrying out a coordinated statewide program of public health but also serves as the local health agency, depending for a major portion of its support upon Department of Health, Education and Welfare grants. The current federal grant strutcure poses us two major problems which I would like to see considered. First, grants to Alaska are often effective on July 1 and run for one year, although Congressional appropriations are usually not known until two or three months of the grant preiod have elapsed, making a shambles of intelligent state planning; I recommend that the Department of Health, Education and Welfare notify states of the amount of aid they will receive several weeks in advance of the beginning of the grant period, and also that notice of grant termination be given sufficiently in advance of the termination date to permit smooth phasing out. The second problem is with the continuing rigidity of categorical grants, as a result of which states may be encouraged to initiate or perpetuate programs or practices regardless of comparative need or state planning; here I recommend that any categorical grants be so designed as to foster cohesion of programs rather than fragmentation, and that grant policy recognize the responsibility of the federal government to share with the states the cost of sustaining the full range of public health services necessary.

Specifically commenting on our relations with the Department of Health, Education and Welfare, we find that uderstanding is often distorted by time, distance and unfamiliarity; for that reason we would welcome the HEW regional offices' having a greater degree of responsibility and authority in program plans as distinct from fiscal plans. It may be noted that the field offices of the Food and Drug Administration appear to have a commendably greater degree of autonomy than do those of the U.S. Public Health Service.

The final point which I shall note is that in this state Indian reservations as such do not exist, Alaska natives being integrated into the general population and being considered first-class citizens. Thus we find the Bureau of Medical Services' Division of Indian Health applying independently to Alaska native public health codes, such as furnishing free comprehensive medical care, which have been designed for numerous Indians living on reservations in other states. This Division-wide policy may in some cases work a hardship on the state's public health program and on its non-native citizens, and may prevent the Division of Indian Health's accomplishing its stated objective "to encourage State and local governments to help Indian citizens meet their health needs through the same community resources and health programs that are available to their non-Indian citizens." Here again it is believed that with its local knowledge the HEW regional office, if given more authority, could plan Alaska Native Health programs which, while possibly at variance with Indian Health programs in other states, would more realistically meet the admirable objectives of the Division of Indian Health, and would be in greater conformity with the state's public health policies.

I appreciate your interest very much and shall be glad to be of assistance to you at any time.

Very truly yours,

HENRY A. HARMON
(For Levi M. Browning, M.D., Commissioner).

PHOENIX, ARIZ., *September 20, 1965.*

Hon. PAUL G. ROGERS,
U.S. Representative,
Chairman, Subcommittee on HEW Investigation,
Rayburn House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE ROGERS: Reference is made to your letter of August 20, 1965, concerning the study of the U.S. Department of Health, Education, and Welfare currently being conducted by the Special Subcommittee on Investigations of the Committee on Interstate and Foreign Commerce.

Discussions with State and local agencies having health, education and welfare responsibilities yield the following conclusions:

1. The question of the internal administrative structure of the DHEW is beyond appropriate comment from the State and local level, with reference to size, complexity, desirability of specific administrative changes, etc.

2. Relationships between the DHEW and Arizona have been marked by personal cordiality and professional competence.

3. Economy of effort and coordination of objectives might be enhanced by administrative consolidation of a number of currently separated functions in this regard.

For example:

a. All health services should be under a single administrative jurisdiction (National Institutes of Health, health aspects of Children's Bureau, Vocational Rehabilitation, Food and Drug Administration, etc.). Similar coordination is suggested for education and welfare activities.

b. Program authority and grant authority should be under the same administrative jurisdiction.

c. Achievement of a. and b. above should be accompanied by a simplification and standardization of reporting to DHEW, with particular emphasis on reversing an apparent trend toward over-reporting, i.e., requiring reports of such frequency and in such detail as to be a deterrent to effective programs.

d. The consolidated and simplified program and grant authority should be exercised through consistent administrative channels from the national to the regional, to State to the local level, reversing an apparent trend toward direct national to local program and grant relationships.

e. A policy of decentralization should be pursued with a view toward strengthening the authority and effectiveness of each successive level of the consistent channel outlined above. Regional, State, and local authorities should be permitted to make decisions of increased stature in terms of dollars and program implications for health, education and welfare organizations respectively.

In summary, we feel that we could do a better job of bringing the resources of DHEW to the benefit of the people of Arizona if we had a single administrative channel to deal with, encompassing both program and grant authority for all health services, and an increased latitude concerning their use.

I should emphasize that the suggestions I have made are offered with the most constructive intent in response to your request. The job done by DHEW to date has been most impressive. With the help of your Committee, I am sure it will be even more effective in the future.

Very truly yours,

SAMUEL P. GODDARD, *Governor.*

STATE OF ARKANSAS,
OFFICE OF THE GOVERNOR,
Little Rock, Ark., September 22, 1965.

Congressman PAUL G. ROGERS,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: This is in reply to your inquiry of August 20th with attached statement by the Honorable Oren Harris, Congressman from Arkansas.

I referred this matter to Dr. J. T. Herron, head of the State Health Department for Arkansas.

Attached is copy of his reply to me (attachment A) dated September 17, 1965. Perhaps the information and suggestions provided by Dr. Herron will be of some use to you in making a determination on the questions which you had in mind.

If I can be of any further help, please call on me.

Most sincerely,

ORVAL E. FAUBUS, *Governor.*

[Attachment A]

ARKANSAS STATE BOARD OF HEALTH,
Little Rock, Ark., September 17, 1965.

Hon. ORVAL E. FAUBUS,
Governor of Arkansas, State Capitol,
Little Rock, Ark.

DEAR GOVERNOR FAUBUS: Reference is made to your memorandum of September 2, 1965 and the attached letter from Congressman Rogers, together with the statement of Hon. Oren Harris.

The activities of the Department of Health, Education and Welfare are, as you know, very extensive and expanding every year. The number of programs and projects carried out by this Agency are so great that it is difficult to keep up with them. We feel that because of the many health directed programs already in existence and those that will probably be put into operation within the next few years, that there should be a separate Department of Health, the director being a physician. In the past, there has been a scattering of health and medical services in several federal departments. Most of these programs should be brought under the above mentioned Department of Health. We believe that the National Institutes of Health should be a single Division under the Department.

Our relationships with the Department of Health, Education and Welfare in general have been good. As you know, most of our contact is through the Regional Office in Dallas, with representatives of the U.S. Public Health Service and U.S. Children's Bureau. These two agencies have been especially helpful and, in my opinion, our relationships have been good. We do not have much contact with the Bureau of State Services, and practically no contact at all with the National Institutes of Health. We do have some contact with the Food and Drug Administration, but this has not been especially close nor satisfactory. We think that this program should be under the administration of the U.S. Public Health Service, or certainly in the Department of Health if such a department is established. In the past, the National Institutes of Health has established many programs in the states without any contact at all with the state health departments. State health departments should have some part in the planning of these projects, and certainly all of them should be cleared with state health officials prior to putting them into effect. In the past, the Food and Drug Administration has not always been very helpful to us because after making investigations of cases of violations of the law, they have been inclined to drop the matter rather than pursue it to its proper solution.

If any additional information is needed, please call on me.

Very truly yours,

J. T. HERRON, M.D.
State Health Officer.

STATE OF ARKANSAS,
OFFICE OF THE GOVERNOR,
Little Rock, Ark., September 28, 1965.

Congressman PAUL G. ROGERS,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: This is in further reference to your recent communication, with attached statement by the Honorable Oren Harris, Congressman from Arkansas.

I referred this matter to Mr. Jim Phillips, Commissioner of State Welfare Department of Arkansas, and copy of his reply is enclosed (attachment A). I hope the information and suggestions supplied by Mr. Phillips will be of

some benefit to you and the Special Subcommittee on Investigations of the Committee on Health, Education, and Welfare.

Most sincerely,

ORVAL E. FAUBUS, *Governor.*

[Attachment A]

ARKANSAS STATE DEPARTMENT OF PUBLIC WELFARE,
Little Rock, Ark., September 20, 1965.

Re Letter from Paul G. Rogers on Subcommittee on HEW Investigation.

Hon. ORVAL E. FAUBUS,
Governor, State of Arkansas,
State Capitol, Little Rock, Ark.

DEAR GOVERNOR FAUBUS: I have reviewed the letter that you referred to this office from Mr. Paul G. Rogers and the statement by the Honorable Oren Harris, and in keeping with your request, would like to make the following comments.

The Department of Health, Education, and Welfare has been making increasing demands for service each year. Many times the demand for service is not made on a request basis but is made mandatory upon the States in order to obtain any Federal matching monies. The funds for staff for these services vary from fifty per cent to seventy five per cent and the administrative tasks of determining the exact amount of Federal monies is many times tremendous. We would suggest that all Federal funds for services be set out on a seventy five per cent matching basis. In this way, it would justify administrative costs and somewhat compensate for the many additional duties that the Federal Government places upon the various State agencies.

The second suggestion that I would like to make is in regard to the Health Department services themselves. Many of our indigent persons are assisted materially by the Health Department services for such things as inoculations for children and health services for our aging, but there are many more services that Arkansas needs and services that are available from the Federal Government on a matching basis, if funds were available. At the present time, the money of the health services is dependent upon matching funds from the county or local level and when the county is unable to match the funds, the Health Department is unable to extend services to these areas. Many times, the areas that need the services the most are those that are denied the services because of lack of local funds. We would, therefore, request that the Federal Government make available for rural areas the same Health Programs that are available to the cities. Since the rural areas do not have money for matching funds—these programs should be set up entirely by Federal funds.

A third comment I would like to make is in regard to the rapid extension of the size and activities of the Department of Health, Education, and Welfare. The expansion has been so rapid that even at this time the department functions as three departments rather than as one co-ordinated department. We find that we are able to co-ordinate matters with other departments, such as the Department of Agriculture, almost as easy as we are able to co-ordinate matters that would fall under the Department of Health, Education, and Welfare. For this reason, we feel that there should be a Department of Health, a Department of Education, and a Department of Welfare so that the expansion of each department might be made receptive to the needs of the various states and communities.

Sincerely yours,

JIM PHILLIPS, *Commissioner.*

STATE OF CONNECTICUT,
STATE DEPARTMENT OF HEALTH,
Hartford, Conn., September 10, 1965.

Hon. PAUL G. ROGERS,
House of Representatives, Committee on Interstate and Foreign Commerce,
Rayburn House Office Building, Washington, D.C.

DEAR REPRESENTATIVE ROGERS: Governor John Dempsey has referred your letter of August 20, 1965 concerning a study of the Department of Health, Education and Welfare to me for reply.

Generally speaking relationships between this department and the federal department of Health, Education and Welfare have been excellent.

In most of the categorical programs and in relation to consultative services the Public Health Service through its various divisions has been cooperative and helpful. Research studies and surveys made in the Communicable Disease Control Center in Atlanta, at the Taft Engineering Center in Cincinnati and in other divisions of the agency are of such a nature that they are of invaluable practical help to state agencies.

There is however one aspect of the relationship that I feel deserves some constructive comment and action. Until 8 or 10 years ago the Public Health Service and particularly the Bureau of State Services was most careful to work closely with state health departments in connection with community health programs which might be operated with voluntary agencies and with city or county health departments within the state.

Within recent years however there has been an unfortunate trend for consultants and "experts" including division heads both in the Bureau of State Services and the National Institutes of Health to deal directly with local nongovernmental and governmental persons with little or no clearance or other liaison with the state department of health. This means that the state department of health then has no opportunity to contribute to consultation on the problems which involve not only the municipality in question but also the relationship of steps to attack health problems in that community with approaches being taken in nearby municipalities, and other sections of the state with similar health problems.

I do not want to give the impression that such situations are a major part of our relationship because the bulk of our relationship with both the regional offices and the Federal agency is a most harmonious one. However, particularly in certain of the categorical programs administered in Washington there appear to have been Federal consultants or branch or section chiefs who lack an understanding of program relationships between city and state health departments and who therefore in recent years have ignored the need for making the state health department a member of the team developing plans concerning a specialized problem in a single community.

A suggestion to correct this situation would be for Congress to insist that in the study or solution of any community health problem within a state whether on a 1, 3 or 5 year project basis or any other approach to the problem the Federal agency should be required to include the state health department as a member of the consultation group.

The other aspect of the relationship relates to the grants-in-aid available under the various categorical programs. Although we realize the intent of Congress to stimulate action in these fields, Federal requirements all too frequently have been excessively restrictive in terms of limiting state wide flexibility in planning and operating the newer categorical programs. Greater flexibility is needed because of the vast differences between the states and the consequent nature of the problems and resources to aid in their solution in the various states. Two things could be done to assist the states in attacking these problems more vigorously. First of all it would be well if some categorical programs such as heart, cancer, stroke, arthritis, neurological diseases and blindness could be grouped together under a heading such as "chronic disease control" permitting a certain degree of transfer of funds within the state so as to design and operate a more effective program utilizing the limited number of professionally qualified personnel available to attack these problems on a broader basis. Similarly funds such as those for vaccination assistance, venereal disease control and tuberculosis control might be given greater flexibility under a broad heading such as "communicable disease control" or "infectious disease control". Another broad category might be the general field of environmental health.

The second suggestion in this connection is that there is a far more urgent need for "formula grants" than for "project grants" in which there is less flexibility and the requirements of annually rejustifying in excruciating detail every aspect of the "project". I am convinced there is a need for project funds, but the relative sums of money available have been out of proportion to the basic need for a broad, long term attack on problems such as cancer, strokes, heart disease, communicable disease and environmental health situations all of which involve deep-seated problems which will be with us for a long time to come and not so amenable to approach on a 1 to 3 year "project" basis.

Concerning the National Institutes of Health I have only two thoughts. First of all they should be continued as they are a major division of the Public Health

Service and not made a separate agency as has sometimes been suggested. Secondly I feel much more can be accomplished if additional funds allocated to the various institutes under the National Institutes of Health could be made available through the Bureau of State Services for state and community programs which would make studies and assist in applying the results of research knowledge more rapidly in the health programs carried on in various parts of the United States.

With the Childrens Bureau in the welfare administration likewise there has been sometimes undue restriction on use of funds with a constant need to limit the activities of personnel in these fields to work with mothers and children. If there could be greater tolerance for some persons such as public health nursing consultants, physical and speech therapists to work with both children and adults it would again be possible to utilize services of professional personnel more effectively in certain geographic areas. My comments above about Federal consultation bypassing the state health department do not apply to the Childrens Bureau however and they should be commended for working so closely with the state health departments.

With respect to the Food and Drug Administration our relationship has been harmonious and I have no suggestions here.

The entire field of public health is so large in scope that I hope your Committee will also give thought to setting up a separate department of health with cabinet status. Such a department would make it far easier for the Congress to deal directly with problems in the field of health, medical care and research and would also enable such a department to work more effectively with the various states.

It is good to know that the Committee on Interstate and Foreign Commerce is making this kind of review of the programs of the Department of Health, Education and Welfare. Your evaluation certainly will result in improvement in the already excellent job that these agencies are doing and for which they deserve a high degree of credit.

Sincerely yours,

FRANKLIN M. FOOTE, M.D.,
Commissioner.

STATE OF DELAWARE,
EXECUTIVE DEPARTMENT,
Dover, Del., September 24, 1965.

Hon. PAUL G. ROGERS,
Congress of the United States,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you very much for your kind letter of August 20th, in regard to the activities of the Special Subcommittee on Investigations of the Committee on Interstate and Foreign Commerce.

Per your request, I brought the matter to the attention of the Executive Secretary of the State Board of Health, Dr. Floyd I. Hudson. I am enclosing a copy of a memorandum prepared by Dr. Hudson for your consideration.

Very sincerely yours,

CHARLES L. TERRY, Jr., *Governor.*

MEMORANDUM

Date: September 13, 1965.
To: The Honorable Charles L. Terry, Jr., Governor of the State of Delaware.
From: Floyd I. Hudson, M.D., Executive Secretary of the State Board of Health.
Subject: Comments on the Organization, Structure and Activities of the Department of Health, Education, and Welfare for the Special Subcommittee on Investigations of the Committee on Interstate and Foreign Commerce in Response to the Letter of August 20, 1965, from the Chairman The Honorable Paul G. Rogers, Florida.

The attached comments have been put together in compact form after discussions with Local Health Officers in Delaware and key professional personnel employed by the State Board of Health.

The concept presented is basic and we will be glad to furnish details to the Subcommittee under Chairman Rogers at any suitable time.

COMMENTS ON THE ORGANIZATION, STRUCTURE AND ACTIVITIES OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE FOR THE SPECIAL SUBCOMMITTEE ON INVESTIGATIONS OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE IN RESPONSE TO THE LETTER OF AUGUST 20, 1965, FROM THE CHAIRMAN THE HONORABLE PAUL G. ROGERS, FLORIDA

National Congresses have, over the years, made several Federal Agencies responsible for the administration of segments of health and medical programs. Many of these programs have been placed in the subdivisions of the Department of Health, Education, and Welfare. Others are operated by Federal Agencies outside HEW. The primary reason why these health and medical programs have been placed within several Agencies would appear to be that no *National Health Policy* has ever been defined in the past. What does the nation want to do in the health and medical fields? What are the goals of the Federal government in supplying health and medical programs to assure the best health for all Americans? It is, therefore, recommended that a sound National Health Policy be developed. This will enable the Federal Agencies, State and Local Health Departments to devise programs directed toward putting such national policies and goals into effect.

In the general field of public health, the Public Health Service (including the National Institutes of Health), the Food and Drug Administration, the Welfare Administration, the Social Security Administration and others have been given enormous health and medical care administrative problems. State and Local Health Officers have, in the past, been handicapped and somewhat confused by having to deal with so many different Federal Agencies on health and medical matters. The majority of State and Local Officers, therefore, believe that these scattered health programs should be given strong and unified leadership either within the Department of Health, Education, and Welfare by the creation of an Office of Health and Medical Affairs, or by the creation of a separate National Department of Health. The person in charge of such a unified program must be responsible for tying together all major health programs now spread throughout the Department of Health, Education, and Welfare. It is desirable that the Head of the unified Health Agency be a physician with vision and initiative, knowledgeable in the administration of public health programs. He should preferably be trained and widely experienced in Preventive Medicine and Public Health.

The National Institutes of Health needs to be a single division directly responsible to the Head of the new unified Agency. In the past NIH has established programs in states and localities without any contact with the State or Local Health officials in the jurisdiction involved. The Health Officers in these jurisdictions frequently have no knowledge, therefore, of NIH projects until they are published months later. It is recognized that the National Institutes of Health must engage in extensive and widely scattered health research projects. These projects when located in states or localities should be made known to State and Local Health officials prior to being put into effect.

It is also recommended that the Regional offices which operate through HEW at the present time be continued and strengthened. The Regional Office, Public Health Service staff has been one of the strong points of the present Federal organization. This will enable the Federal unified Agency to maintain a close working relationship with State and Local Agencies to bring services to the citizens who reside in the Region involved.

Health Officers generally agree with the statement made by Chairman Rogers in his letter of August 20, 1965, that "Federal health activities, of course, do not function in isolation from state and local programs: our study must take into account the federal-state relationship". It would appear that the above basic recommendations, when implemented, would provide the best features for an organizational structure at the Federal level to assure the coordination and working together of Federal, State and Local organizations interested in health and medical service programs at the grass-roots.

STATE OF FLORIDA,
OFFICE OF THE GOVERNOR,
Tallahassee, Fla., September 10, 1965.

Hon. PAUL G. ROGERS,
Congress of the United States,
House of Representatives,
Rayburn House Office Building,
Washington, D.C.

DEAR PAUL: In accordance with your request of August 20 I have obtained the views of some of the agency heads in Florida who have public health responsibilities. My own ideas on this subject may be summarized as follows:

The rapid acceleration of old public health programs, the development of new ones, and the appropriation of more funds for all of them, particularly at the Federal level, have brought about many administrative problems in Florida, as well as in the other states. There has been a fragmentation and a dispersion of responsibilities among public and private agencies at all governmental levels which causes confusion. Appropriations have become more categorized, and due to the growing use of the project technique of distributing funds from the Federal level—the state or local recipient agency is unpredictable. There is also continuing uncertaintly as to who are to be the beneficiaries from the standpoint of political subdivision. Also, due to the proliferation of Federal appropriations by categories and the frequent distribution of funds by project, difficulties have developed in administration and accountability for funds. These have grown out of proportion to the sums involved.

It seems, therefore, that these, at least in part, are the cause of difficulties in the planning, coordination and administration of a nationwide public health program; the multiplicity of the sources of funds—national, state and local—public and private; the multiplicity of the recipients of these funds, including individuals, voluntary agencies, institutions, teaching and other as well as Federal, regional, and state and local official agencies; and the multiplicity of governmental jurisdictions involved in delivering health services, including Federal, multi-state, state, intrastate, regional, as well as city, county, and local school districts, and local districts for public health purposes. Furthermore, there is a lack of agreement, uncertainty, and confusion as to the roles to be played by the various levels of government, Federal, state and the local; and as to the purposes of Federal funds, whether intended for stimulation and development, or for the basic support of on-going programs.

Because of the magnitude of the problem, the amount of money involved, and the importance of the problems to be handled at all levels of government, I believe that it is time to develop and follow a consistent philosophy on the roles of the various levels of government, and to simplify patterns of administration. The problem now appears to be of sufficient magnitude to justify a Federal Department of Health; and within this department relationships with state governments should be concentrated in one of its bureaus or the equivalent. Also, it seems to me that the Federal level administration should be carried on consistently through regional offices which would maintain close contact with the states; and that the latter should be responsible for planning and coordinating programs within the several states. I believe that some national understanding should be reached on a cost-sharing formula for the Federal, state and local governments for sharing formula for the Federal, state and local governments for community health services and that the Federal Government should recognize its responsibilities by contributing its share of the costs primarily on a consistent and predictable grant-in-aid formula, based principally on population.

There is, of course, a role for categorical programs and for the use of the project method of distribution. These should not, however, be misused as a means of financing broad and continuing programs affecting all segments of the population.

This is a hasty summary of my views on the subject and some of them are presented in more detail by materials enclosed from members of my staff. (See attachments A and B.)

Best personal regards.

Sincerely,

HAYDON BURNS, *Governor.*

[Attachment A]

COORDINATION AND ADMINISTRATION IN THE FIELD OF PUBLIC HEALTH

(Delivered before Conference of City and County Health Officers at Texas Medical Association Meeting, San Antonio, Tex., Friday, April 30, 1965, by Wilson T. Sowder, M.D., State Health Officer Florida State Board of Health, Jacksonville, Fla.)

Gentlemen, it is with considerable anxiety and trepidation that I have crossed the Brazos and appear before you bringing advice on a difficult and controversial subject. I know very well that many a man has been shot for this, and for less, in your fair state. However, being aware of your traditional hospitality, and of your warm invitation for me to come here, gives me a sense of security. I also know that the code of fair play in Texas requires that you give your target an opportunity to draw first, and that you also at times, as a special gesture of mercy, give offenders an opportunity to leave town. I promise in advance to do this by sunrise of Sunday morning.

On the other hand, we may very well find that we are in agreement on many things. We have a lot in common. I born and bred in the same state and within fifty or so miles of where your Sam Houston was born and bred. And, the state from which I now come has much in common with Texas, except for size and oil. My state of Florida has had five flags too, those of Spain, France, England, the Confederacy, and the Star Spangled Banner, and it came into the Union in 1845 as did Texas, and was out four years during the Civil War as was Texas. And going farther back, Hernando DeSoto, or his followers, visited both states in 1539–1542. Furthermore, all of us are in public health work together. I have been a county health officer and I have worked in a city health department, and in fact, as you perhaps already know, I have worked in Texas. I have been a homeowner and taxpayer here, and my Florida medical license shows my residence as Dallas, Texas.

If time and exposure, sometimes called experience, should mean much, which I doubt, I should have something to offer you. But I am skeptical about any marked correlations between experience and wisdom, and I have often said that anyone ought to be able to learn to do anything in five years or give up. Furthermore, I strongly suspect that we old-timers in public health, like boxers, get a bit punch drunk with the years and with repeated mental and emotional trauma. You many want to take that possibility into consideration when pondering what I have to say today.

But, lets get on with the subject—Coordination and Administration in the Field of Public Health. Now there was a time when I looked with considerable disdain upon the word coordination and all its connotations. I felt that coordination and administration were as far apart and as incompatible as oil and water. For many years I operated on the principle, or thought I did, that I would attend to my business, and others could attend to theirs. I felt that problems under my own administrative control were my concern, and any others were not. Nevertheless, I did realize that it was necessary to get along with other people not under my direction, and with other agencies, otherwise, I would not have survived very long as State Health Officer.

It is true though that in Florida, perhaps more so than in Texas, possibly because our state has been slower and later in developing a public health program in some ways, our public health services have tended to be concentrated in single official health agenices coordinated at the state level through the state health department. For that reason, and up until relatively recently, most public health business was carried on through administrative channels within the official health agencies, and the necessity for coordination was not so great.

But times have changed and are changing. Florida has changed, and is changing, and it is likely that Texas and the rest of the nation are undergoing similar changes. To me nothing seems to be quite as neat and orderly as it was in the past. Our public health agencies throughout the country, and at all levels of government are being charged with more and more, and with more and more complex, duties and responsibilities. And, generally these new tasks have been given us without adequate resources in money and personnel to perform them.

Also, there has been a splintering, a scattering, a dispersion and fragmentation of jobs and responsibilities among public and private agencies at all govern-

mental levels which causes and compounds confusion. And financing, while there has been an upward trend in appropriations, has become more and more categorized, spasmodic, and unpredictable as to its beginning and duration; and as to the recipient and beneficiary from the standpoint of geography, agency and problem. Furthermore, red tape and administrative techniques have grown apace at local, state, and federal levels so that it appears to me at least that it nowadays takes two or more ergs of energy to perform a one-erg task. I even get the impression at times that our own national edifice of health is being constructed without the benefit of an architect, and that subcontracts are being let directly for wiring and plumbing; and for individual rooms and patios, without concern that the end-product will stand up, look right, and be useful.

For these and many other reasons, good administration and maximum coordination in the field of public health are becoming increasingly important. They are also becoming progressively indistinguishable. We need good coordination and administration not only to get the job done, but also in order to minimize the inevitable stress and strain, and to conserve physical, mental, and emotional energy for increasingly greater tasks.

Most of the principles leading to successful coordination are needed and work equally well in internal administration. I am not going to give an experienced group like ours a specific set of rules for running your agencies. I am going to stick to some rather common and widespread problems that we all have—and perhaps give most emphasis to those that have been discussed the least in the past. I have already referred to the greater liberality of the powers-that-be in allotting more duties and responsibilities to us than funds for performing them. It won't do any good for me to bewail this fact to you—you can think of as many choice expletives on this subject as I can—and properly directed they will do more good. I suspect however that, in this, we face a more or less permanent or at least a recurrent and perennial problem—common to all public agencies. In fact, I sometimes sense a similarity between this situation and my personal family budget and responsibilities. We should struggle constantly to balance the deficit between our resources and our need. But at the same time we should recognize the fact that this does force us to review our work and to set priorities of relative importance. We would not do this so readily if we always had plenty of money to do everything.

Another universal, continuing or recurrent and perennial problem in public health administration is the low salary scale. There is no good side to this so far as I know, although I have heard the argument advanced that it is best for public agencies not to be too efficient lest all facets of our lives be taken over by them. I don't agree with this—I think the result of low salaries is, ultimately at least, inefficiency and waste, and the real loser is the taxpayer. In the long run, and on the average, well paid employees are much more likely to be worth the money they are getting than are poorly paid ones. I have a saying which I always deliver with my tongue in my cheek, and with some bitterness, that my state has a munificent compensation plan—comparable to any in the country—that a part of this compensation is in the joyful opportunity for public service, a part in our well-known balmy fresh air and sunshine; and some of it is even in currency. Unfortunately, over my years in public health, when on a few occasions reasonable salary adjustments were made, the progressive inflationary process canceled out their effectiveness in a short time.

Closely related to the salary problem is the difficulty of finding well-trained and competent personnel. While in-service training programs as well as the more formal programs in schools of public health and other health related institutions are essential, they will not solve the manpower problems we have until attractive and challenging jobs are provided—paying adequate salaries—and in places where there is the greatest need. Unfortunately, but understandable, too great a proportion of our more competent and better trained people in public health gravitate from areas of greatest need in local and state health departments to better paying positions in teaching institutions, in voluntary health agencies, and in federal health agencies. Even worse, too many leave public health entirely.

But these are only some of the old and garden variety problems of public health administration. These are the Johnson grass or ragweed of the fields of public health which require constant chopping and tending. Without careful husbandry the weeds take over and the fields become unproductive. And these are the topics that have provided source material for speeches in pubilc health for decades and will continue to do so for decades to come.

But we do have some new ones, or else some old ones with a new look and added importance. Today I shall list these but plan to discuss them in more detail tomorrow in my talk before the Public Health Section of the Texas Medical Association on "Community Health Services Today and in the Future." After agreeing to the subjects of these two talks before you good folks here in Texas, I found it difficult to think of one without the other. And for that reason the talk tomorrow will be a continuation, extension, and elaboration of the one I am giving now.

The new problems that I am talking about now, while of vital importance to city and county health departments, are also of vital importance to state and federal health agencies, and to voluntary health agencies—they are not local, state, or regional concerns, but are national problems of first magnitude. They are closely associated with money—or the financing of community health services. It is surprising how many things have to do with money.

But from an overall standpoint in the coordination and administration in the field of public health, one of the big latter-day problems is the multiplicity of sources of funds, national, state, and local—and public and private. A second problem is the multiplicity of recipients of these funds, including individuals, voluntary agencies, institutions—teaching and other, as well as federal, regional, state, and local official agencies. A third problem is the multiplicity of governmental jurisdictions involved in delivering health services. These include federal, multi-state, state, intrastate, regional, as well as city, county, and local school, and local districts for special health purposes.

Fourthly, the lack of agreement, uncertainty, and confusion as to the roles to be played by the various levels of government, the federal, state and local. What is, and what ought to be, the purpose of federal funds? Are they basically intended for stimulation and development or for basic support of ongoing programs. What is or ought to be the role of the states and the local governments? Should some national understanding be reached on some sort of cost-sharing formula for the federal-state and local governments for community health services? And, what are the abilities and capabilities of the several levels of government to furnish any agreed upon share of funds?

Fifthly, who, or what agency, should be the primary recipient of federal funds? Should this be the state only and distribution within the state left to the state; or should federal funds be distributed, as now, to the state and local official agencies, to individuals, voluntary organizations, institutions, etc. on the "best story" basis as now?

Sixth, should federal funds be appropriated for broad general health problems and distributed on a formula basis, or by health categories such as heart disease, cancer, diabetes, chronic illness, sanitation, et cetera? And whether the funds are appropriated for broad general purposes or for narrow categorical purposes, should these be distributed on a project or "best story", or "grantmanship" basis, or on a planned and systematic basis? And, what is the proper balance between funds for research and for services?

Now all these problems may not weigh very heavily on your minds at present. But it may be wise for all of us to consider the old Italian proverb to the effect that he who does not protest when the calf is laid on his shoulders is soon forced to carry the cow. And there is another thing that we should all remember in connection with the problems listed. Although money appears prominently and in the foreground, the more basic problem is the relative role of the federal, state and local governments in our lives. Our first President, George Washington, left a timeless message for us in this regard. He said "Government is not reason, it is not eloquence—it is force! Like fire, it is a dangerous servant and a fearful master; never for a moment should it be left to irresponsible action." But I will discuss this subject in more detail at the Public Health Section meeting tomorrow.

Awhile ago I mentioned the incompatibility of oil and water, but they do mix with the diligent application of soap—soft soap; and I am convinced that this is a necessary ingredient for coordination. But I would never agree or recommend it as a suitable substitute for a conviction or a principle. Because, as James Thurber has said, "You might as well fall on your face as to lean over too far backward". But it *is* urgent that we physicians in the field of public health and particularly those at the state and local levels, unite and coordinate our efforts to remove the unnecessary hindrances to obtaining the maximum benefits for our people for every public health dollar available to us. Even this, coordination within the family, is not easy.

We all have our separate viewpoints and philosophies, as well as individual responsibilities. But to paraphrase someone else's saying—coming together is a

beginning; keeping together is progress; working together is—difficult. But—difficult or not, it must be done. It does get results. Executive ability has been described as the art of getting the credit for the hard work that somebody else does. Coordination might be called the process of getting a job done, even though it may call for some work by all concerned, and even though the credit may not be distributed in proportion to the work.

But who are the principals in this game of Administration and Coordination? Now I am very conscious of the fact that this is a Conference of City and County Health Officers. But, I take for granted that there are also in the audience some school health officials, as well as state and federal public health physicians. In any case, your relationships with all of these are important. All of them are principals in the delivery of health services in this country. And, besides these more closely kindred health agencies, there are many others such as the Federal Food and Drug Administration, the Welfare agencies at the federal, state and local levels, and so on and on. Then we have our voluntary health organizations at federal, state and local levels, and our organizations of health professions in the fields of medicine, dentistry, nursing, public health, et cetera. All of these have a stake in and a role in public health. We must all live and work together.

But quite often harmonious working relationships are handicapped by basic and conscientious differences of opinion—sometimes on goals and objectives, but more often on the role to be played by each agency. These differences are sometimes friendly, sometimes not. Some are of short duration and some are long and drawn out. Some result in coolness, some in cold wars, and some in all out pitched battles. Sometimes the problems are resolved by Legislative action or by higher executive authority—but often not.

During my career I have had an opportunity to observe and even to be a participant in many situations involving both concord and discord. I have seen examples of working together harmoniously, as well as battling aimed at annihilation. I have seen such harmonious agreement on methods and objectives as could only be arranged in heaven, but with no results, because no one wanted to move. I have seen agreement on objectives come to nothing due to violent disagreements on methods and the who-does-what problem. I have seen open warfare on all counts, and although I never saw it settle anything satisfactorily in itself, I can't say it is always bad. I have seen peace, understanding, harmony and cooperation on projects of mutual interest follow such battling. Perhaps war is necessary for the peace that follows, and the storm is needed for the following sunshine. Storms do produce the rainbow but so far no one has found the proverbial pot of gold at its end. But having talked of battles and storms, it is only fair to say that we have all seen very satisfactory relationships established and maintained, without conflict, between state agencies; and between state and local and state and federal health agencies, in spite of moderate differences of opinion in some areas. This always, however, involves free and frank discussion.

Most of you have seen these same things, and I have no reason to think that I am a more talented observer or a better reporter than any of you. The problems of Coordination and Administration are complex and I shall make no pretense of offering you even partial solutions to its problems. I would be happy if I could bring you even one small fresh idea on this difficult subject.

To achieve maximum coordination requires many conditions, a few of which I shall list and discuss. Among these are agreement on problems and objectives, agreement on methods of attaining them and agreement on the role of the various agencies involved. Ideally the federal, state, and local laws should be in harmony—and clearly define the roles of all agencies involved. Any areas of doubt should be resolved by the appropriate executive authority. Then there must be a meeting of the minds on timing, intensity of effort, plus the many details of operation. Wherever possible in interagency enterprises, the heads of agencies concerned should be actively involved. And in the utopian picture I am describing all participants are patient, tolerant, tactful, knowledgeable, and wise. They subordinate their agency interests in favor of a higher loyalty to the people they work for and serve. And with these ingredients, plus communication and contact, comes friendship, agreement, and understanding.

Unfortunately, most of us can only aspire, and do our own parts, to bring about such a Shangri-La. We still live in a world and in an age that is not quite perfact, and the practical conditions under which we work are often quite difficult; and these are modified and sometimes magnified by our own attitudes and outlook. Yet we have no choice but to try and to do our best.

We have to harmonize our efforts as best we can in both the vertical and horizontal directions. For the public to be best served and get its money's worth for the public health dollars spent, requires that there be cooperation between city and county health departments and their counterpart state and federal agencies. I don't say this is easy—and I don't say that all the cooperation should be at one level of government—and certainly not all at the local level. I know it is not easy because working at the state level I have to face problems in both directions—and our own county health officers do not always seem to understand the problems we have in our federal relationships, and the federal health people do not always seem to understand or seem to care about the maintenance of good state-local relationships. It is likely too that we at the state level are too preoccupied with our own thoughts to properly appreciate the viewpoints and difficulties of our fellow workers at the federal and local levels.

It is not at all surprising if most of us see things from the viewpoints of our several agencies and levels of government. But we must strive to avoid prejudice because as Ambrose Bierce said, "Prejudice is a vagrant opinion without visible means of support". We must endeavor to make necessary corrections in our conclusions in order not to be misguided by our points of observation. The German philosopher Nietzsche said that seeing and *not* believing is the prime virtue of a thinker; and that appearance is his greatest temptation.

I can't talk about the subject of views and viewpoints without thinking of the story of the aging Confederate general who finally decided to write a book about his experiences in the Civil War. He gave the book the title: An Unbiased and Impartial Account of the Late War Between the States—From the Southern Point of View.

In addition to this vertical structure we face the necessity for maintaining good working relationships with other interested agencies at our own levels of government—official, voluntary, and professional. To maintain all this requires a lot of juggling—and it is not at all surprising that some of us drop a ball occasionally. Sometimes, all this coordination is about as easy as the childhood game of patting your own head with one hand and rubbing your chest with the other—a skill which I was never able to master. But all of you have skills in the problems of coordination and administration or you wouldn't be in your line of work.

Some people think of a cooperative effort as being like pushing an automobile out of a mudhole, where at a signal everybody pushes at once, and relaxes at once. I think that this concept does not fit many of our needs or situations. Although I know little or nothing about music, I do like to listen to it and I like to think of cooperative effort, as applied to our problems, in terms of a band or orchestra. Here every member is responsible for his own instrument and each toots his own horn or beats his own drum. Sometimes the score calls for a lone member to perform while the others wait their turns. This does of course presume that there is a musical score and a band leader. In my concept of public health administration at the local level, the local health officer writes the score, acts as band leader, and calls the tune. And it is his job, hard though it may be, to develop and maintain a symphony of effort, his own and others, and to be sure that the volume is sufficient for the music to be heard. I do not mean to infer that the local health officer should be like an independent baron in the Middle Ages. I am talking about leadership rather than dictatorship.

I can think of no better final thought on coordination than that voiced by B. Brewster Jennings when he said: "Man's greatest discovery is not fire—nor the wheel—nor the combustion engine—nor atomic energy—nor anything in the material world. It is in the world of ideas. Man's greatest discovery is teamwork by agreement."

[Attachment B]

COMMUNITY HEALTH SERVICES TODAY AND IN THE FUTURE

(Delivered before Section on Public Health, Texas Medical Association, San Antonio, Tex., Saturday, May 1, 1965, by Wilton T. Sowder, M.D., State Health Officer, Florida State Board of Health, Jacksonville, Fla.)

I greatly appreciate the honor of being asked to speak to much the same group for even a third time in three days. They say, you know, that a speaker is a man who talks in someone else's sleep; but your sleep is important and even if you take advantage of this occasion to catch up with it, I'm still flattered.

However, I'll try not to let all this go too much to my head, having noted that all the guest speakers of the Texas Medical Association at this meeting are giving from three to five talks, and I can't help but ascribe at least some of this to the excellent coordination and administration of its affairs.

I hope, though, that I can do better with these opportunities than to prove to you that I am one of those "who think too little and talk too much" as the poet, Dryden, put it. Another put it a different way, "They never taste who always drink; they always talk who never think."

But perhaps I can persuade you to look upon my talk with the view that Oliver Wendell Holmes, Sr., expressed as follows: "Talk, to me, is only spading up the ground for crops of thought".

Community Health Services is a hard subject to get into, but I remember a piece of advice given me years ago when I was growing up on a farm in Virginia. I was getting ready to go to a county fair in town when one of the men said, "Hey, son, why don't you get one of the girls round here to go with you?"

I was sort of backwards even at that age and I confessed that I just wouldn't know how to ask one.

It was then he gave me the advice I remember now. He said, "Heck, son, there ain't no *wrong* way."

Hoping there's no wrong way to start this talk, I'd like to mention again some of the problems and issues I discussed yesterday before the Conference of City and County Health Officers. These problems not only involve and make coordination and administration difficult, but they also have a vital bearing on the planning and delivery of community health services today and in the future.

These problems or issues are:

(1) The large and growing number of sources of funds for health purposes. This applies to federal, state, and local governmental bodies, as well as private sources.

(2) The large and growing number of recipients of these funds. These include federal agencies with funds for them, for direct operations, as well as funds for state and local aid programs; state health and non-health agencies with funds for direct operations, as well as for local aid programs; local official health and non-health agencies; individuals; and voluntary agencies.

(3) The present multiplicity and the increase in numbers of governmental jurisdictions that are involved. We not only have those at the traditional federal, state and local levels but we have multi-state agencies, and multi-county agencies, as well as local jurisdiction besides cities not covering entire counties.

(4) There is lack of agreement, lack of consistency, uncertainty and consfusion as to the roles to be played in community health services by the various levels of government. What is, and what ought to be, the purpose of federal funds? For instance—are they, or should they be, intended basically for stimulation and development; or should they be for basic support of on-going programs? What is, or what ought to be, the role of the states and of the local governments? Should some national understanding be reached on some sort of cost-sharing formula for federal, state, and local governments for financing community health services? And what are the abilities and capabilities of the various levels of government to furnish any agreed upon share of funds° And if funds are to come from higher to lower levels of government, to what extent should restrictions and controls follow them?

(5) Who, or what agency should be the primary recipient of federal health funds? Should the federal government engage in direct operations within the states? If not, should the federal government give direct aid to the state *and local* operating agencies? Or should the states be responsible for distributing federal funds to the ultimate operating units? Should agencies—and epecially voluntary agencies; should individuals; and should institutions—especially teaching institutions—be subsidized by the federal government to perform community health services? Does this put them in competition with the official health agencies and cause duplication and confusion?

(6) What is the proper balance for federal funds, for instance, between research and service operations?

(7) Should federal funds be distributed on a planned and agreed upon formula basis, or should they be distributed through year by year project grants based on application and approval?

(8) Should federal funds continue to be appropriated mainly for narrow categorical purposes or would broader and more flexible general health grants be more useful?

These are some of the problems and issues of our day, and if you think my prejudices show in the framing of these, I hasten to say that they are all based on a collection and amalgamation of unpublished but written statements from responsible public health administrators at all levels of government. I see all these problems, too, in my own work but I can only claim credit for recognizing these issues along with many others.

Now if I emphasize the problems of federal funds more than others, it isn't because there are, up to now, more federal funds going into public health, nor is it that I think there ought to be. It's because I can't very well do justice to the entire field—and further, federal funds are what we all get in common, Texas and Florida, as well as Maine and California. And all the states, and the counties and cities within them, are concerned in one way or another with federal funds. We're very much like the men in a parable several thousand years old. There were three of them in a boat and none of the men could swim. When the boat got out to midstream, one of them took out a knife and started cutting a hole in the bottom. The other two asked, "What in the world are you doing?"

"Mind your own business," he said, "I'm cutting a hole on *my* side not yours."

"But," they shouted, "we're *all* in the same boat!"

And we are all in the same boat today and need to work out our problems and our plans for the future together.

As for our present problems, federal funds represent most of them, and largely because these are already substantial and increasing. While some of my friends in public health feel that money for public health obtained under almost any conditions is good, I don't agree. I believe that appropriations for health programs are inevitable—and that those of us with knowledge and experience in public health should form opinions and express them as to how much, and for what, money should be appropriated—and how it may best be distributed and spent.

In fact, my agency at times get funds for purposes and under conditions that makes me less than enthusiastic about accepting them. At times I feel like acting as John D. Rockefeller, Jr. is supposed to have done once when he was a little boy. His father, in spite of his great wealth, gave him only a small weekly allowance which was supposed to cover all his expenses. On one occasion when the boy was invited to a friend's birthday party, he asked his father for a small supplemental sum because he was expected to buy a gift. The old man wouldn't hear of it and reminded him that his allowance was to cover all his expenses. "You must learn to live within your income," he said. A few days later he asked the boy what he had done about buying the gift for his friend. "I took care of that", John D., Jr. told him. "I picked a fight with him the day before the party and he took back his invitation."

All of us are at times, I am sure, inclined to do just that.

Now there are two kinds of problems that we shouldn't and needn't worry about, or do anything about. The first are those that are obviously unsolvable, and the second are those that will go away themselves in a reasonable length of time. The ones I'm talking about don't fall clearly in either of these categories so we ought to give them some thought. There are, in fact, definite trends in the matter of federal funds that are obvious to all of us. These are increasing, and they are increasing in proportion to funds appropriated by state and local governments. In fact, counting all expenditures for health and medical purposes together, it has been estimated that about half the total bill is already paid by the federal government. But in our own somewhat ill defined field of public health there is no such high proportion of federal expenditures, although I have no definite figures on this except in my own field and for my own state. But the proportion of federal funds to state and local funds in the field of public health is increasing no matter how broadly or narrowly you define it. Also, the trend is toward increasing the kinds of grants and number of categories. There are 45 now. And there are increasing numbers of recipients and increasing numbers of kinds of categories of recipients.

In Washington, I am told, two out-of-town visitors were riding down Constitution Avenue in a taxi and they passed the National Archives Building. As you know, inscribed on the building are the words: "What is past is prologue". One of the men asked the driver what it meant. The cabbie was a wise man. He said, "*That* is government language. And it means, 'Brother, you ain't seen nothing yet'."

Now we could sit idly astride the fence of the present that separates the prologue of the past from the events of the future and do nothing. We can let the

future take care of itself. We can let posterity look out for itself since, as they say, up to now it has done little or nothing for us. The trouble with this is that most of us will be around for awhile yet and will have to live and work under the conditions that we permit or help to develop. These are real issues or problems that I have listed and it is evident to me that they are not going to just fade away. We therefore need to face them and decide how we would like to carry on community health services in the future.

Napoleon once said that "simpletons talk of the past, wise men of the present, and fools of the future". But considering how he ended his career, I can't help but think that he might have done better if he had used his brilliant mind a little more in thinking of the future and where he might be going. And neither do I agree with him with regard to the past. The past is the storehouse of our entire individual and total human experience—and a recollection of it is the only guide we have in planning our future. Lord Halifax said the best way to suppose what may come is to remember what is past. A lot of nonsense has been written and spoken on this subject, generally equating the mere remembrance of the past with standing still, or looking backward or even going backward. I think that remembering and profiting by the past is entirely consistent with a forward and liberal outlook and rapid progress. To think otherwise puts a high value on amnesia and might cause us to get burned twice or more by the same fire.

Until relatively recent years, the generally recognized functions of local health departments were more or less limited to six: laboratory services, communicable disease control, vital statistics, maternal and child health, sanitation, and health education. Preventive services were primarily the role of the health department, while treatment was the exclusive concern of the private physician. But times are changing, and although we may not like some of the changes, we have to live and adjust ourselves to the conditions that confront us, unless we can successfully mold them to our liking. Due to our past successes, infectious diseases are now largely controlled; and as a result, chronic illness in an aging population is becoming a primary problem. A whole new range of community health services—above and beyond what was offered for acute illness—are needed and demanded by the public. And this new range, on the community level, must be supplied by the private physician and by private agencies and institutions and supplemented by the work of health departments; working harmoniously together as far as possible.

In the past, physicians waited for patients to come to them. They treated the maladies, and released the cured patient. But today his responsibilities are not completed with the treatment of an acute episode. With the growing number of aging patients, and the rise of chronic disease, the physician's role is changing, too, and he is developing more interest in prevention as well as treatment. He understands the increasing importance of caring for the apparently well in addition to the sick. And just as the services of the private physician are changing, so is the once-clear-cut role of the health department in community services.

These observations are intended to gain pardon in advance for expressing a feeling of nostalgia for the good old days of public health, the halcyon days, when nearly all of our efforts were aimed at one class of diseases, those that are communicable. I even look back to my own early days in public health when the more generalized approach to communicable disease control was complicated by almost the first category—the venereal disease program. My own thoughts, efforts, and responsibilities were at first limited to this small and select group of communicable diseases. So I know the viewpoint and the fun of being categorically-minded and a specialist. I had a sort of feeling and attitude of "to heck with everybody who doesn't have a venereal disease"—unless of course they were trying hard to get one.

Today our responsibilities have increased in both depth and breadth. And furthermore, as I have pointed out, there are a lot more fingers in the pie nowadays, as well a lot more pies to put fingers in. I believe the Spanish have a saying for that: "Asno de muchos, los lobos le comen." I understand this literally means, "The Ass with many owners is eaten by the wolves." I prefer to think of it as: "Everybody's business is no one's work."

However, back in the days when our work was limited largely to communicable disease control, some of us though we were having a hard time with such large problems and with such pitifully small resources in money and personnel. But outbreaks of such things as typhoid fever, diphtheria and malaria helped us

to do our job. These fanned the flame of public interest in us and our work and created for us a wonderful image in the minds of the public. We were not only needed but necessary and essential. We were all knights in shining armor holding back the dragons of disease and plague. But the accolades come less often now and a kick in the pants is more common. Not that these hurt so much, or so long, after you get accustomed to them—unless you try to sit too much on the affected part!

The point is that public health has become more complex and less dramatic. As our successes have multiplied so have new duties. In the past in the public eye our work had the air of a crusade. We were ill equipped and tattered but we were carrying on a holy war. But today, with the war against disease and disability expanded on many fronts, we don't have this emotional support. We are more likely to be looked upon as merely another group of public employees. The public does not applaud us today for our dramatic accomplishments of yesterday.

But whatever the public may think of us, and even if we are not now the glamor boys of public service, public health is still a challenging game. This is an era of feverish activity and excitement in the entire field of community health. Things are happening whether we like all of them or not. We hardly have time to catch our breath from the launching of a campaign against one "number one health problem" when we find ourselves involved in the next. And each one is seemingly more urgent and important than the preceding. Each one is accompanied by frenzied and not always enlightened questions as to whether our existing agencies are suited to carry them out. Those of you who have been in public health for any substantial part of the past thirty years have watched these parades, and have marched in most of them. Some of these, you will recall, have been maternal and child health, crippled children, venereal diseases, mental health, mental retardation, mosquito control, water pollution, air pollution, radiological health, and so on and on—but all have had in common the aim to protect and improve the health of the people in some particular way. These are all community health services. The question is, how should these—and new programs supplementing them—be planned, organized, and administered in the future. The increasing recognition of needs in the field of chronic illness and the aged will undoubtedly influence future programs and the organization for their delivery. Although there are differences of opinion about methods, we all agree that we should do our best for the ill and aged. Our generation is deeply in debt to the one that preceded us and we have an obligation to remember this. Our public health programs have always been aimed at producing mentally and physically healthy old people. But in a definite sense physicians in public health, and the medical profession generally, are overwhelmed by our success. We are hoist on our own petard. We've got the old people all right, lots of them, but as they get older they inevitably have more disabilities and illness; and in spite of this, unbelievable numbers of people are living to advanced ages, and creating health and social problems not dreamed of back in the days when we were trying to keep the same people from dying of typhoid fever and diphtheria.

But whatever the nature of the problem, we in community health work are expected to plan and carry out a well balanced health program which will protect preserve, and improve the health of all the people from all the things that threaten or ail them. But how can sound and sensible planning, and consistent and stable operations, be accomplished under the more or less uncertain conditions of financing that we face today. Our source of funds, as I have said, are multiple, coming in numerous and too often unrelated allotments from federal, state and local governments, and even from private sources. The multiplicity of sources would be healthy and would promote stability if these were ordered and orderly. But too often the special purpose funds available don't match up with the special problems we face. The trend toward more and more categorical funds at the expense of the more flexible general support funds is making it more and more difficult to plan and implement a rational community health program aimed at the problems actually existing. And the trend toward project grant fund distribution at the expense of the more orderly formula grant method inevitably accelerates the confusion and results in a patchy pattern of health services. Sound planning and stable operations are impossible under a system of federal grants where the amount and continuity of the funds are unpredictable, where there is no consideration of overall need, nor even any certainty as to what agency may be the recipient and executor of the funds. A health agency

under this system may have no better chance, if as good, of getting funds for health services as any other agency. And a successful application really depends on who puts up the best story—a latterday skill known as grantsmanship. And this, in my opinion, is but a euphemistic term for begging and, in my opinion, this technique and method of seeking and distributing federal funds should be sharply limited and controlled. It compels fragmentation and makes both planning and following plans difficult or impossible. And it centralizes control in Washington. Any service activity financed on a project basis is condemned to an uneasy and precarious existence. Only one eye can be kept on the job and the other must be busy watching for signs as to how to get the grant renewed for another year.

I will not attempt to give you easy answers to these questions I have raised, because I am afraid there are none. I do think there is a proper place for categorical funds and for project grants. They have their place, but they should be supplements and appendages to a general financial support plan, and be kept in proportion to the overall problem. The tail should not wag the dog.

I do know that I, and many others, are concerned with the growing number of recipients of federal funds, and with the multiplicity of health jurisdictions.

I know that it is bad when there is uncertainty, confusion, and a lack of consistency as to play what role in community health services.

And I firmly believe that something should be done. But what? That is the sixty-four dollar question. Not having pat answers I'd like again to remind you that my major purpose in this talk is to "spade up the ground for crops of thought". I believe the field is fertile enough to keep us all busy raising these crops of thought for some time to come.

I do, however, have some ideas on the subject of my own. I have expressed some of them and inferred others. I cannot, however, better express my own thoughts in some of these areas than to quote from some recommendations made by the Association of State and Territorial Health Officers at its annual meeting in 1964. One recommendation was that in considering the necessary extension of legislative authority in the Public Health Service Act that such legislation should:

> Establish in law the concept of the federal government sharing with the states and communities the cost of sustaining the full range of public health services necessary in each state.
>
> Separately provide authority for categorical grants (both formula and special project) in problem areas identified by the Congress as being of significant national interest.

The major purpose of these recommendations was not to seek more federal funds but to provide that those we do receive be distributed to us in a more systematic manner.

Among other outstanding recommendations made were the following:

> Categorical grants, particularly project grants, should be so designed as to foster cohesion of programs rather than their fragmentation.
>
> The federal agencies should strive to the maximum extent possible for uniformity and consistency in forms, policy, and procedures among different grant programs.
>
> Categorical grants, especially of the project type, should be limited in their use to the following:
>
> Stimulation of the "growing edge" of public health.
>
> Experimentation and demonstration of newer or improved methods of rendering service.
>
> Assistance with problems of limited geographical nature.
>
> Assistance in unique health problem fields (poverty, industry, etc.).
>
> Provision for specialized training.

It will be another year before the present law comes up for renewal and possible change. It has been tacitly agreed that we should not oppose the recommendation of the President that the present law be extended for one year. Five year authorizations are customary so that this one year of grace gives us time to work out a more satisfactory way for federal funds to come to us. We are hopeful that we can get the agreement and support of the U.S. Public Health Service and the Children's Bureau in revising this law to our mutual satisfaction. I was appointed to a committee to work on this problem but it is not going to be an easy one to solve.

We in state and local health departments may have to go it alone. If we do, I hope we can all stick together. I recognize that some of the trends in the dis-

tribution of federal funds in recent years have had the possible effect, intended or otherwise, of bringing about closer and more direct relationships between local health departments and the federal health agencies—to the exclusion of the state agency. I hope that here in Texas you have been able to stick together under the fine leadership of your State Health Officer, Dr. Peavy, and will continue to do so. Here in the shadow of the Alamo it would be the ultimate presumption for me to advise you as to where your hearts and loyalties should be. I know that on any question of Texas versus any other, you will stick with Texas. In my humble opinion, your sentiments on this subject are sound and will actually be in the best interests of the country as a whole.

STATE OF GEORGIA,
EXECUTIVE DEPARTMENT,
Atlanta, Ga., August 25, 1965.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: This will acknowledge and thank you for your letter of August 20th, relative to the study you are conducting into the organization, structure, and activities of the Department of Health, Education and Welfare.

I am forwarding your letter to Dr. John H. Venable, Director of the Georgia Department of Public Health, with the request that his Department cooperate in every way possible with your request.

You should hear from Dr. Venable within a few days, and I am sure his assistance will prove of value. (See attachments A and B.)

If I can be of further service, please do not hesitate to call on me.

With kind regards, I am,

Cordially,

CARL E. SANDERS, *Governor.*

[Attachment A]

STATE OF GEORGIA,
DEPARTMENT OF PUBLIC HEALTH,
Atlanta, Ga., September 3, 1965.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR MR. ROGERS: As you know, Governor Sanders has referred your letter of August 20 to me for reply. It is a pleasure and a privilege to have the opportunity to submit some ideas which I hope will be of value to you in your Special Committee.

First, let me give you a little of the background from which I speak. In Georgia more than in any other state, perhaps, health activities have been concentrated in one department. The Georgia Department of Public Health is the state authority in relation to the Department of Health, Education, and Welfare for the hospital and medical facilities planning and construction program (Hill-Burton), for mental health, for radiation control, air pollution and partially for water pollution. Moreover, this Department for the past six years has been responsible for all of the mental institutions, the mental retardation institution and for alcoholism. Governor Sanders has named this Department as the state agency for the development of the newer programs in comprehensive community mental health and mental retardation as well as the agency for the administration of federal grants for the construction of mental health and mental retardation centers. As a consequence my viewpoint is naturally "anti-fragmentation" and based on the experience of trying to coordinate a total approach to the total health of the individual.

Our relationships with the Public Health Service, the Children's Bureau and other parts of the Department of Health, Education, and Welfare have been pleasant, profitable and effective; however, as your Special Committee has recognized, there are problems to which careful attention should be devoted.

The organization of DHEW is such as to stimulate fragmentation of health services in certain important respects. For example the separate units in DHEW for public health, the Children's Bureau, Office of Vocational Rehabilitation, Food and Drug Administration tend to stimulate such fragmentation at the

state level. I have seen many evidences of efforts to coordinate these various functions but there have been numerous instances where lack of coordination between these DHEW units had unfortunate results within the states.

Another problem about which we have concern, since we have total mental health responsibility as well as public health, is the quite different pattern of organization of DHEW in this field. As you know, other programs relate to the states through the Bureau of State Services but the National Institute of mental Health not only serves in its capacity as an institute but is the administrative contact for mental health authorities. Efforts to coordinate this with the Bureau of State Services have been ineffective.

We have intense concern at the moment at the possibility that history may repeat itself in that in the tremendously important recent legislation such units of DHEW as the Social Security Administration may fail to coordinate adequately with existing state agencies.

I would not presume to suggest solutions to these problems other than to voice a personal opinion that they can be effectively solved only by some combination of reorganization as well as Department level emphasis on coordination.

The second area of problems that should be brought to your attention is that of effective mechanisms of financing all health programs. By implication your letter to the Governor indicated the Committee feels that this should be a joint federal-state-local effort. In this view we enthusiastically concur but there have been serious problems in planning effective and continuing support of needed programs because of legislation and policies and regulations of DHEW.

States depending on federal grants for partial support of their programs have been unable to plan effectively because the amounts of these grants have not been determined until well into the fiscal year in which they must be spent. In more than one instance categorical program grants have become available after the beginning of the fiscal year and before states had sufficient time and funds to plan for an effective expenditure. A solution to this general problem could lie in providing the initial grant in a new program area for planning in the first year with operation grants to follow. Also most helpful would be additional authorization permitting a carry-over of unexpended federal funds from one fiscal year to the next, at least in the early years of a program.

Another problem in the area of joint financing is the fragmentation of grants into multiple categorical areas with too little interest and support in the area of General Health.

This entire complex has been intensively studied by the Association of State and Territorial Health Officers and the Public Health Service. As a member of the Executive Committee of the Association of State and Territorial Health Officers, but without authorization from that body, I am taking the liberty of enclosing with this letter a copy of a current proposal which seems to us to resolve most of the differing viewpoints and to have a great potential in solving such problems as those just discussed.

One other area deserves brief mention and that is the method of operation of the National Institutes of Health as well as certain parts of the Public Health Service in relation to demonstration grants, project grants and research grants.

While there is real need for project grants their use, in our view, has been abused. In many instances project grants have by-passed state authorities or come to the attention of that authority too late for careful modification which violates to a considerable degree the responsibility of the State Health Department for coordination of health services throughout the state. Project grants have been used for program support where more effective programs could have been established and operated with a continuing type of support.

Lastly, entirely too few study sections which have the authority to recommend approval or disapproval of project, demonstration and research grants have had adequate representation of the public health agency viewpoint. The tendency in the research grant program has been directed most exclusively to university people, both in the decision making and as a consequence in the awarding of research grants. While it is true that the mission of the university is primarily training and research and the mission of the public agency is primarily service, we are convinced that a proper admixture of these two in both decision making and the eligibility for grants would be much more effective than the present pattern.

As supplementary material I am taking the liberty of enclosing with this letter not only the current proposal for federal-state financing mentioned above

but a paper I read to the Southern Governors' Conference in San Antonio last year and a paper jointly with Doctor Addison Duval read by him to the American Psychiatric Association this year, both of which relate to certain parts of what I have said.

It has been a pleasure to have the opportunity to submit our ideas and I hope that you will let me know if there is any other information either in other areas or more specific detail that you would like to have.

Sincerely yours,

JOHN H. VENABLE, M.D., *Director.*

[Attachment B]

STATE OF GEORGIA,
DEPARTMENT OF PUBLIC HEALTH,
Atlanta, Ga., February 14, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives,
Rayburn House Office Building,
Washington, D.C.

DEAR MR. ROGERS: Thank you for your kind letter of February 7 asking certain questions in further amplification relative to my letter of September 3, 1965.

I am happy to provide the following items with respect to the two specific questions you ask:

1. THE ORGANIZATION OF DHEW

(1) The separation of water pollution control activities from other environmental health programs in the Public Health Service has de-emphasized health aspects of such programs and created duplicate channels of communication between the federal, state, and local agencies.

(2) The "in fact" separation of the National Institutes of Health similarly requires different channels of communication and completely ignores regional public health service establishments.

(3) The absence of regional office counterparts fosters the type of separation and lack of orderly communication that is evidenced in some respects by state agency relationships with the Communicable Disease Center, the National Institute of Health, and some of the environmental health programs, etc.

(4) The lack of adequate authority at regional office level to fully deal with problems of the states results in significant losses of time and personnel efforts when matters must be cleared with the Washington offices of the Public Health Service and, as is inferred above, in many cases are encouraged to bypass the regional office in dealing with specific health matters.

(5) The separation into semi-autonomous agencies of various public health functions at the regional level brings about many and varied regulations, policies, and procedures governing grant-in-aid and grant administrative requirements, including a multiplicity of forms, etc.

2. PROJECT GRANTS

(1) Project grants are not simply considered fragmentation of health services—they are, in fact "fragments" of programs and in no way can they be designated to comprehensively meet the health needs of any population group.

(2) Coverage is customarily spotty in terms of geographic areas, population or time. This creates imbalances between project grant supported and other health programs on a completely arbitrary and artificial basis without substance in terms of good public health practice.

(3) The total effect of project grant financing on the health problems of a state or region must be considered minimal compared to the efforts set forth through an ongoing service program with long term financial planning jointly supported through federal, state, and local resources, since project grants tend to seek the "unusual" rather than continually important problems affecting the public health. This concentration on high prevalence areas tends to ignore the fact that these same conditions exist to a significant degree in all segments of the population.

(4) Project grants require a disproportionately large share of administrative attention because of the peculiar and varied fiscal and other program management

requirements not customarily included in standard fiscal systems (for example, line item budget and reporting requirements, modification of encumbrance systems, etc.). Moreover, there is no common funding plan or administrative requirement among such grants.

(5) The project grant application seems to offer no long term solution to most public health problems since "eradication" is usually associated with a reduction in disease prevalence to a manageable proportion rather than complete eradication.

(6) Project grant administration by the Department of Health, Education, and Welfare involves significantly more direct access to administrative decision making within the state agency since grants are made for specific line items within a budget and for discrete program elements not necessarily thought to be of highest importance by the state agency. For example, some vaccine assistance grant applications were "packaged deals" composed by CDC.

(7) This "direct access" also extends to official and non-official local agencies and at time, without the knowledge or concurrence of the official state agency such as:

A. Emory University Community Nursing Service Project. Several years ago, Emory University School of Nursing became interested in a community nursing service project, prepared and submitted an application for grant and we learned the details only after copy had been returned from Bureau of State Services. There were severe emotional disturbances on our part objecting to certain phases of their proposal: for example, lack of medical referral and the completely inadequate relationships within the existing local health department.

B. The apparent prior commitment of the Children's Bureau to fund maternal and infant care projects at the state's two medical schools before either the state or local health departments were involved.

C. Current authority of the Children's Bureau to grant school and preschool health funds to medical schools and to hospitals related to medical schools without consent or involvement of the state or local health departments.

(8) Problems related to validation of matching federal funds are greatly compounded by direct grants to local units without prior state agency knowledge or consent. This extends to other than DHEW agencies. The problem has become so acute that special attention is being focused upon this by the Public Health Service and the Children's Bureau as evidenced by their joint memorandum dated December 13, 1965.

I hope this information will be helpful to you. We found that "case studies" would not be a very practical way to furnish you this material as this project would have taken longer than the preparation of these statements.

We appreciate very much the opportunity to work with you in this way.

Sincerely yours,

JOHN H. VENABLE, M.D., *Director.*

EXECUTIVE CHAMBERS,
Honolulu, September 13, 1965.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: This will reply to your letter of August 20, 1965, pertaining to a study into the organization, structure, and activities of the Department of Health, Education, and Welfare.

Obviously there has been great expansion in recent years in the programs of Health, Education and Welfare. It is our understanding that because of congressional demands for more stringent controls on federal expenditures, the Public Health Service and the Children's Bureau have tightened their controls in these areas. According to the Director of Health for Hawaii, they have demanded a clearer picture of programs and services financed with federal funds. This would involve, to some extent, the organization, structure, and operational

programs in the Department. However, these matters have all been worked out and we have maintained good working relationships with the federal agencies.

A problem area which has resulted from congressional action involves the condition that additional state funds are to be utilized in order that new federal funds be made available to the state. In a way, this penalizes the state that has a good ongoing program because it must show new monies expended over the previous year. In contrast, a state without a program in a specific area need only put up a small amount of money in order to obtain federal funds. Further, if a state with an established program experiences problems, such as delays in filling positions, the end result may be that it would appear that the state expenditure was reduced and on this basis federal funds would not be available.

All in all, I would say that we have been and are taking advantage of funds provided and that federal-state relationships in Health, Education and Welfare is good.

Warmest personal regards. May the Almighty be with you and yours always.

Sincerely,

JOHN A. BURNS, *Governor.*

STATE OF INDIANA,
OFFICE OF THE GOVERNOR,
Indianapolis, Ind., September 16, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Committee on Interstate and Foreign Commerce,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: In response to your request, I enclose some observations of the Indiana Health Commissioner, Dr. A. C. Offutt, on Indiana state agency relationships with the U.S. Department of Health, Education, and Welfare. (See attachment A.)

I commend Dr. Offutt's statement to your attention, particularly on the point of Federal programs which by-pass state government or which earmark funds in such a way that they cannot be completely responsive to needs within a state.

Sincerely,

ROGER D. BRANIGIN,
Governor of Indiana.

[Attachment A]

OBSERVATIONS OF A. C. OFFUTT, M.D., INDIANA STATE HEALTH COMMISSIONER, ON INDIANA STATE AGENCY RELATIONSHIPS WITH THE U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

In reply to the request of Honorable Paul G. Rogers, Chairman, Subcommittee on Investigations, for comments concerning state agencies' relationships with the Department of Health, Education, and Welfare, it will be necessary to direct our remarks, primarily, to relationships with the U.S. Public Health Service and the Children's Bureau. The major portion of our contacts are with these divisions of the D.H.E.W. This results from the fact that Indiana's public health program receives considerable financial support through these agencies.

Our contact with the Food and Drug Administration involves cooperation in the enforcement of federal food and drug laws and regulations and the exchange of information concerning problems in this area. Based upon our experience here in Indiana, this seems to be a beneficial and effective relationship. The few problems that do arise are easily resolved.

The Indiana State Board of Health has practically no contact with the National Institutes of Health since that agency places most of its research contracts or grants with colleges and universities or other research groups. The National Institutes of Health, in the last few years, have done a more effective job of informing state public health agencies of research findings than previously.

The Department of Mental Health maintains a close relationships with the National Institute of Mental Health, and these relationships are generally satisfactory.

Since a portion of Indiana's public health program is financed by federal funds made available through the U.S.P.H.S. and the Children's Bureau, we have more frequent and significant contacts with these two agencies than with others of the D.H.E.W. Where public money is involved, there must be accountability. Under these conditions, there is a greater chance for differences to arise than in those relationships where funds are not involved.

Over the years our dealings with both the Public Health Service and the Children's Bureau have been generally good. In those instances when difficulties have arisen and we have felt justified in criticizing certain actions of these two agencies, always there has been the question of whether or not our criticism should be directed toward the agencies or toward rules and regulations imposed upon them by those to whom they must answer.

We have stated that, in general, we have been satisfied with our relationships with the above-mentioned agencies, but no good purpose would be served by dwelling upon the point. It is felt that the interest of the Subcommittee will be best served if we express some of our concerns.

1. We question the desirability of the many "earmarked funds" that now exist, and the rate at which they are increasing. Such funds discourage flexibility and, in a sense, dictate state programs.

2. There appears to be a trend toward decreasing "general health funds" available to help support basic state programs and an increasing tendency to increase supports for special areas. Again, this decreases self-determination by the states.

3. Formula grant funds which also allow the state considerable freedom in determining the use of federal monies have suffered at the expense of the increased emphasis placed upon project funds. To qualify for project money, a state must conform to certain conditions that give little consideration to the circumstances that vary from state to state.

4. It is recognized that federal funds should be used primarily to demonstrate new programs, encourage their application, and to assist states in expanding programs to meet demonstrated needs. However, the health of the people is a responsibility shared by local, state, and federal government. The shared responsibility concept seems to be receiving less and less consideration by the nation's public health agencies.

5. We question the effect upon the image of official state agencies when federal public health programs are initiated that bypass the state and deal directly with local agencies and groups.

6. One of our great concerns is the manner in which public health responsibilities are being fractionated and dispersed among several agencies of state government. Action at the federal level has a significant effect upon this situation.

The above comments have been discussed with Stewart Ginsberg, M.D., Mental Health Commissioner, and reflect in general his opinions and reactions concerning his contacts with agencies of the Department of Health, Education, and Welfare.

STATE OF INDIANA,
OFFICE OF THE GOVERNOR,
Indianapolis, March 16, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health, Education, and Welfare Investigation, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you very much for your letter briefing me on the general response of the Governors in your subcommittee's study of programs of the Department of Health, Education and Welfare.

In line with your request, Dr. A. C. Offutt, Indiana state health commissioner, has enlarged upon his earlier comments which were submitted to you. The supplemental comments are enclosed. (See attachment A.)

We have inaugurated a system of screening U.S. grant requests of our State departments to assure ourselves that those which are submitted do not require assurances infringing upon the prerogatives of the State Legislature.

Sincerely,

ROGER D. BRANIGIN,
Governor of Indiana.

[Attachment A]

STATE OF INDIANA,
STATE BOARD OF HEALTH,
March 11, 1966.

Hon. ROGER D. BRANIGIN,
Governor, State of Indiana,
Indianapolis, Ind.

DEAR GOVERNOR BRANIGIN: As requested in a letter addressed to you by Hon. Paul Rogers, Chairman, Subcommittee on H.E.W. Investigation, we are enlarging upon the comments which you included in your letter of September 16, 1965, addressed to Congressman Rogers.

The original statements and the enlargement upon these statements follow:

"We question the desirability of the many earmarked funds that now exist and the rate at which they are increasing. Such funds discourage flexibility, and, in a sense, dictate state programs.

"There appears to be a trend toward decreasing general health funds available to help support basic state programs and an increasing tendency to increase support for special areas. Again, this decreases self-determination by the states."

Additional comments: The general health grant, which a few years ago represented the major portion of the federal government's financial aid to states in the field of health, allowed each state to assess its needs and determine what areas of health would be financed with federal funds. Of course, such funds were only allotted when a satisfactory plan was submitted and accountability assured. Matching requirements are more easily met for the general health funds than for the categorical grants, and personnel can be more efficiently utilized because wider ranges of assignment are possible without risk to audit exceptions.

The increase of categorical grants at the expense of the grants for general health places the small or average size state health department in a difficult position. Heart, Cancer, Chronic Illness, Tuberculosis, and several other such grants are not available unless matching funds exist and strict accounting provides evidence that both the matching and grant funds were expended in the designated category. Accountability is difficult to maintain unless personnel are given specialized assignments. This high degree of specialization is not economical or practical, especially in such related areas as Chronic Illness, Heart Disease, and Cancer.

Conditions of accountability in the categorical areas can be met by assignment of personnel to one special area, even though the program demands only fifty per cent of their time, providing they do not devote their unoccupied time to other activities. Theoretically, an audit exception is chanced if a motion picture projector is purchased with Cancer funds and used in a multiple program, even though projectors purchased with other funds are used in a program of cancer education.

"Formula grant funds . . . have suffered at the expense of the increased emphasis placed upon project funds. To qualify for project money, a state must conform to certain conditions that give little consideration to the circumstances that vary from state to state."

Additional comments: It does not seem necessary to explain the difference in the method of distributing formula grant funds and project funds. However, the field of Tuberculosis Control presents an example of a point that should be made. Tuberculosis Formula Grant Funds have been decreased in recent years, while the project funds have increased. To qualify for project funds, contrary to formula grant funds, a project request must be submitted to the Public Health Service. The design of such a request is time consuming and requires a special type of skill that is not usually available within the staff of the average state health department. Consequently, the larger departments or other agencies with "grants men" available are in a better position to take advantage of the project grant than a department such as ours. Project grant funds are assigned upon the decision of the grantor and upon the conceived merits of the project. For example, a request to fund a special tuberculosis project may be acceptable providing an amendment is made to provide free clinics as a part of the project. Such clinics would not be acceptable in some states, and, under these circumstances, such states could not take advantage of the project grants.

"The health of the people is a responsibility shared by local, state, and federal government. The shared responsibility concept seems to be receiving less and less consideration by the nation's (Federal) public health agencies."

Additional comments: The point made here is that health conditions existing in any community or state of the United States affect and should be a concern of the entire nation, even though the solution has to be applied locally. By decreasing the general health grants which provide flexibility, encourage initiative and the making of decisions at the state and local level, and increasing the categorical and project grants, the implication is made that the Federal government desires to determine the need and dictate the solution.

"We question the effect upon the image of official state agencies when federal public health programs are initiated that bypass the state and deal directly with local agencies and groups."

Additional comments: This does happen with the project grants, but perhaps better examples are the health components in such programs as Economic Opportunities, Migrant Labor, and some of the Manpower Development activities.

"One of our great concerns is the manner in which public health responsibilities are being fractionated and dispersed among several agencies of state government. Action at the federal level has a significant effect upon this situation."

Additional comments: This point seems to be rather obvious to members of Congress as evidenced by the investigation being made of the Department of Health, Education, and Welfare and legislation proposed for consideration during the present session. Examples of the point made are the health components of the Economic Opportunities program, the Elementary-Secondary Education Act, the recent amendments to the Social Security Act, Vocational Rehabilitation, and others.

It is hoped that the above comments provide the type of information that was requested.

Respectfully,

A. C. OFFUTT, M.D.,
State Health Commissioner, Indiana State Board of Health.

STATE OF IOWA,
OFFICE OF THE GOVERNOR,
Des Moines, Iowa, September 7, 1965.

Hon. PAUL G. ROGERS,
U.S. Representative,
Washington, D.C.

DEAR MR. ROGERS: Thank you for your recent communication concerning a study into the organizational structure of the Department of Health, Education, and Welfare.

In order to speed action on this matter, I have referred your correspondence to Arthur P. Long, M.D., Commissioner of the Department of Health, who will look into this situation and answer you directly. You should be hearing from him in the near future. (See attachment A.)

A copy of his letter to you will be sent to my office for review and will be retained in our files.

Very truly yours,

HAROLD E. HUGHES, *Governor.*

[Attachment A]

IOWA STATE DEPARTMENT OF HEALTH,
Des Moines, Iowa, September 9, 1965.

Hon. PAUL G. ROGERS,
U.S. Representative, Chairman, Subcommittee on HEW Investigation of the Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: This is in response to your letter of August 20 received by reference from The Honorable Harold E. Hughes, Governor of Iowa. In his reference, Governor Hughes requested that my comments and suggestions be given you directly. He will, of course, receive a copy of this communication.

For a period of some years, it has been my privilege to have worked quite closely with the Department of Health, Education and Welfare generally and with the Public Health Service more specifically. From this experience has arisen a real admiration for the contribution and work of the Department and particularly that of the specifically oriented health agencies as exemplified by the Public Health Service. At the same time, there has arisen some concern over the possible diffusion and fragmentation of health oriented efforts and activities resulting from the very broad and comprehensive nature and responsibilities of the Department of Health, Education and Welfare.

For some time, and particularly during the last few years, officials of state, local and academic health agencies and organizations have become somewhat confused, and perhaps to a certain extent thwarted, by having to communicate, plan and work with many separate and different agencies on health and medical matters. As a state health officer, it would appear to me that this confusion and what at least appears to be multiplication of effort and attention, might be avoided were there a single agency with which to deal. Accordingly, it is my recommendation that there be developed and organized a separate Department of Health to bring together the various agencies concerned primarily with health and environmental and other factors affecting health. Included in such a department should be a subdivision or bureau for over-all planning and very likely one for research and development. It is believed apparent that such a separate Department of Health should have appropriate regional offices from which could be provided to state and other local and academic health organizations, consultant services and advisory assistance in various programs and projects.

For Governor Hughes, it is my pleasure to extend the gratitude of the people of the State of Iowa generally and the Department of Health specifically for the opportunity to express an opinion and to provide recommendations in connection with this very important and, in fact, vital matter affecting the health and well-being of the people of the country.

Respectfully yours,

ARTHUR P. LONG, M.D., Dr. P.H.,
Commissioner of Public Health.

THE STATE OF KANSAS,
OFFICE OF THE GOVERNOR,
Topeka, Kans., August 27, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR PAUL: This is to acknowledge your letter of August 20 in which you invite the comments of the affected state agencies on their relationship with the Department of Health, Education and Welfare generally, as well as some related federal agencies.

I am transmitting your letter to the chairman of the Board of Social Welfare, Robert A. Anderson. This board has jurisdiction over the activities of HEW as they relate to the recipients of benefits under public assistance or the Kerr-Mills bill. I am further inviting comment from the president of the State Board of Health, Dr. Robert C. Polson. This board has general jurisdiction over public health matters in our state. I am asking that their views be transmitted to me to be forwarded to you with my own comments. Thank you for the opportunity to comment on the activities of HEW in our state.

I cannot help observing from the committee letterhead that you are the last of the Majority of the committee with whom I served as a member of the committee. That makes over a 50% turnover on your side of the chairman. I note that the percentage of turnover is about the same on the Republican side with Willard Curtin being the last Republican on the committee during my tenure.

I have heard a number of reports that Oren is soon to receive an appointment as federal judge in Arkansas and will be leaving Congress. I have not had this confirmed but have heard it with such frequency that I assume it to be true. His wisdom, experience and political acumen will be sorely missed by the committee as well as Congress generally.

I will look forward to seeing you on one of my return visits to Washington.

Yours very truly,

WM. H. AVERY, *Governor.*

COMMONWEALTH OF KENTUCKY,
OFFICE OF THE GOVERNOR,
Frankfort, Ky., August 30, 1966.

Hon. PAUL G. ROGERS,
Congressman and Chairman of Subcommittee on Health, Education, and Welfare, House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: This will acknowledge your August 20 letter concerning the various departments of state government having public health responsibilities.

This is a problem that we have recognized for many years. Attempts have been made in Kentucky State Government to coordinate the operations of these departments to the greatest possible extent; however, there continues to remain an overlapping of health programs, and we realize this is a field of endeavor that merits thorough study and broad recommendations to bring about effective coordination.

I am asking Mr. L. Felix Joyner, Commissioner of Finance, who has worked closely through the years with our health, education and welfare agencies, to obtain the views and recommendations of the state departments involved. (See attachment A.) You may wish to communicate directly with Mr. Joyner regarding this program.

You may be assured that Mr. Joyner and I, as well as all state agencies concerned, will cooperate in every way possible to assist in your study.

Sincerely,

EDWARD T. BREATHITT,
Governor.

COMMONWEALTH OF KENTUCKY,
DEPARTMENT OF FINANCE,
Frankfort, Ky., November 12, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROGERS: I am enclosing under cover of this letter, comments from five agencies of Kentucky State Government that have responded to your request for information concerning state reaction to the organization, structure, and activities of the Department of Health, Education, and Welfare. (See exhibits A–E.)

I shall not attempt to summarize these comments, but I do wish to note one important consensus. The Kentucky agencies are generally pleased with the working relationships between themselves and the various branches of HEW.

In carrying out the work of the subcommittee, I am hopeful you will find these comments of benefit.

Cordially,

L. FELIX JOYNER,
Commissioner, Department of Finance.

[EXHIBIT A]

COMMONWEALTH OF KENTUCKY,
DEPARTMENT OF MENTAL HEALTH,
Frankfort, Ky., November 5, 1965.

Hon. L. FELIX JOYNER,
Commissioner, Department of Finance,
New Capitol Annex, Frankfort, Ky.

DEAR MR. JOYNER: In reply to the letter from the Chairman of the Subcommittee of Health, Education and Welfare we forward the following comments with the understanding that it is very difficult for us to cover the broad scope of organization involved or to even comment specifically because of the overlap and interrelationship with the facets of Health, Education and Welfare.

The Department of Mental Health has maintained what we think is a fairly adequate relationship with the Department of Health, Education, and Welfare through the Regional Office. Most of our contact is through the Regional Office and we have had the best of cooperation and, usually, understanding and agreement from the Regional Office in total. However, we find that our programs do

involve more than one section or division of the Regional or National Offices. Communications have usually been very clear between divisions and related agencies of government in this state which also have the same regional overlap. We think maybe this has been facilitated by the fact that there is rapport with the Department of Health, Department of Economic Security and the Department of Education. As an example, as there will probably always be many agencies related to one specific program, such as mental retardation, rehabilitation, and community services in this state, interdepartmental committees, combined construction councils for health facilities, and personal contact with the other agencies have made our job easier. In a constructive way, services on the federal level are more fragmented than those of the state level.

Specific reference was made to the National Institutes of Health and the Food and Drug Administration in particular. Our relationship with the Food and Drug Administration is almost non-existent. Our relationship with the National Institute of Mental Health is quite broad. Most of our relationship between the National Institute of Mental Health are related to the Regional Office in Charlottesville and through the National Association of State Mental Health Directors. Programs funded through the NIMH are usually related to public health and welfare functions within the state and are coordinated adequately at this level.

In summarizing our thoughts we believe that it is necessary to have close cooperation and as little fragmentation as possible at the federal level in programs which are directly related to our responsibility in the state of Kentucky. It is very difficult to render care and treatment for the mentally retarded without working and trying to meet the total needs of the patient in developing an individual plan for the mentally retarded. In accomplishing this feat it is necessary to bring the other organizations of government into close cooperation for this common objective. Therefore, we think that the components of government which relate to this end should be as closely knit as possible. We hope that these brief comments will be helpful in your considerations.

Very truly yours,

DANIEL S. TUTTLE,
Deputy Commissioner.

[Exhibit B]

KENTUCKY DEPARTMENT OF CHILD WELFARE,
Frankfort, Ky., October 27, 1965.

Subject: Congressional Requests on Organization of the Department of Health, Education, and Welfare.

Mr. L. FELIX JOYNER,
Commissioner, Department of Finance,
Capitol Annex, Frankfort, Ky.

DEAR MR. JOYNER: In response to your request of October 19, 1965, relative to the letter from Congressman Rogers pertaining to a study by his subcommittee on the organization, structure, and activities of the Department of Health, Education, and Welfare, I am pleased to submit the following ideas.

It appears that the greatest aspect of the subcommittee's focus is toward health activities as they would affect the Department of Health, Education, and Welfare. In this regard, the Kentucky Department of Child Welfare would not, of course, be as involved as other departments of state government. Nevertheless, we are keenly interested and concerned in this matter in that our biennial expenditures for medical services for wards of our Department approach $200,000 ($200,000 per biennium). In meeting these expenditures, it becomes necessary for us to allocate these funds from our total budget, when we face severe unmet needs in other areas—foster care, for example.

It would certainly seem indicated that funds for the medical care of our wards would be available from a Federal health program, including medical expenses for unmarried mothers, corrective problems, the purchase of eyeglasses, the purchase of hearing aids, and payment for necessary dental services. We are, of course, able to secure medical service funds for those children who are on AFDC case rolls, but this is a relatively minor part of our total case load.

We also recognize a need for more prenatal clinics and well-child clinics in Kentucky in order to provide the necessary diagnostic services, as well as the above-mentioned treatment services. These clinics, of course, would normally be administered by the Department of Health, but would be of great assistance to our program, were they available.

It is possible that, under the new Medicare provisions of the Social Security Act, more medical services will be available to our wards. Further interpretation and clarification of this Act is necessary before we can rest assured that these necessary services will become available on July 1, 1966. In the meantime, however, we can say in general that there is a great need for additional aid for health services to our state wards, both in our institutions and those whom we serve through our local field offices.

Relative to the overall, organization of the Department of Health, Education, and Welfare, we are pleased to say that our working relationship with the Children's Bureau, including the regional office, is most positive, and we are pleased with their support and cooperation. (We should hasten to add also that our working relationship with the State Health Department is also most appreciated.)

The Congressman also requests any points of view that we may care to offer relative to the overall organizational area of the Department of Health, Education, and Welfare. In this regard, I would think the subcommittee would care to give major consideration to the structural organizational pattern that is established in the Commonwealth of Kentucky, directing their thoughts particularly to the advantages of having a distinct Department of Child Welfare. I refer to obvious advantages that not only pertain to state level of operation, but would also be analogous to conditions on a Federal level. This is a matter to which I have given considerable personal thought and attention for several years. It would appear to me that state departments of public assistance (known by several similar names throughout the country) which provide grants to adults might well confine themselves to being accounting agencies, determining eligibility and granting public assistance funds when necessary, but focusing their work, in a comparative sense, along the same lines that Social Security regional offices do—but keeping them on a state level.

The present U.S. Children's Bureau should then become a Department for Children and Youth, wherein the basic provisions for social services, etc., would be exercised. In this pattern, among other features, I would see all juvenile delinquency services currently within the offices of the National Institute of Mental Health, the Office of Juvenile Delinquency and Youth Services, and the U.S. Children's Bureau consolidated under the Department of Children and Youth.

I would be pleased to provide further clarification in regard to the above viewpoints; but for purposes of this report, perhaps it would be best to confine them at the moment to the above.

If you have questions in regard to any of the above points, I trust you will not hesitate to so advise.

Yours sincerely,

MAURICE A. HARMON,
Commissioner.

[Exhibit C]

COMMONWEALTH OF KENTUCKY,
DEPARTMENT OF HEALTH,
Frankfort, Ky.

Memorandum to: L. Felix Joyner, Commissioner, Department of Finance.
From: Russell E. Teague, M.D., Commissioner, Department of Health.
Subject: Congressional Requests on Organization of the Department of Health, Education, and Welfare.

This memorandum is in response to a letter of Congressman Paul G. Rogers to Governor Breathitt requesting comments and observations from state health agencies with respect to their relationship with the Department of Health, Education, and Welfare, the Regional Office, the Bureau of State Services, the National Institutes of Health, and the Food and Drug Administration. He would also like our comments on our relationship with the Children's Bureau, the Bureau of Family Services, which are located in the Welfare Agency of the Department of Health, Education, and Welfare, and which have considerable health functions, and also our relationship with the Social Security Administration in that Department, which now has considerable health functions.

As you know there has been a federal-state-local health partnership in operation since the first federal grants for health services started in 1925 with the passage of the Shepherd-Towner Act. This provided funds to states to operate

Maternal and Child Health programs and Crippled Children's programs, both administered through the Children's Bureau at the federal level and divided at the state level between the Department of Health, the Crippled Children's Commission, and the Department of Child Welfare. These programs have continued to expand and develop. The Health Department's relationship with the Children's Bureau has always been excellent.

During the War we administered, under contract with the Children's Bureau, the Emergency Mother and Infant Care Program (EMIC) for Military personnel. This was our first experience in direct medical care. From 1935 to 1938 the Bureau of State Services in the U.S. Public Health Service began to develop Grant and Aid Programs for specific disease control purposes. Such programs as Venereal Disease Control, Tuberculosis Control and Occupational Health were developed nationwide through the state and local health departments. Later general health grants were made available to actively support the basic health activities of state health departments. These funds could be used in all programs including Environmental Health, Health Education, Communicable Disease Control, Public Health Nursing, Dental Health, Laboratory, Local Health Departments, and other activities. All of these grants were made on a matching basis and tended to improve and develop state and local health department career staff personnel, and, of course, more effective programs.

During World War Two additional grants were created for new services—Heart Disease Control, Cancer Control, Chronic Disease and Aging, Water Pollution Control and others. Since the War these programs have been expanded and new categorical grants added including those for Dental Health and Air Pollution. Also, recently, project grant monies have been made available to attack special health problems. All of the above grants have been administered through the Regional Office of the Department of Health, Education, and Welfare by the Bureau of State Services of the Public Health Service.

The National Institutes of Health, although it maintains equal Bureau status with the Bureau of State Services in the Public Health Service has never worked through State Health agencies, but deals directly with researchers in medical schools and other institutions. It is unfortunate that the State Health Officer is not apprised of the grants made within his state by the National Institutes of Health. This tends to impair comprehensive planning.

The Food and Drug Administration is a separate agency in the Department of Health, Education, and Welfare, and has worked very well and in a cooperative manner through its district office in Cincinnati, with our Food and Drug program in the State Department of Health. There have been no grants from the Food and Drug Administration, but we are able to use general health funds from the Public Health Service to help develop our state program.

The Bureau of Family Services of the Welfare Agency in developing the Medical Care Program for Public Assistance recipients and aged under Kerr-Mills, has developed Medical Care programs throughout the country through the Social Welfare Agency of the states. Although this is a bill-paying operation in most states. However, in Kentucky, since 1960, the State Department of Health under contract of our Department of Economic Security has administered the medical aspects of this program in order to insure the quality of services purchased as well as the mechanism for improving the care administered in our hospitals, nursing homes, and services provided by other vendor groups. Our relationship with the Bureau of Family Services through the Regional Office of the Department of Health, Education, and Welfare, has been good, and we hope the State Health Department can be helpful in insuring quality care for welfare recipients. Recently we have been working with the Social Security Administration tooling up to contract with them to serve as their agent for the administration of Title XVIIII (Medicare) of the Social Security Amendment of 1965.

In working with all of these federal agencies we have consistently worked through the regional offices—Dr. Emil E. Palmquist of the Public Health Service, Dr. Madeleine E. Morcy of the Children's Bureau, Mr. George Narensky of the Bureau of Family Services, Mr. M. D. Dewberry o fthe Social Security Administration, and Mr. Edmund Baxter, Director of the Department of Health, Education, and Welfare, all of Charlottesville, Virginia, and Mr. T. C. Maraviglia, Director of the District Office, Food and Drug Administration, Cincinnati, Ohio.

In general our federal-state-local relationship in health programs have all been good, but we are concerned because of the serious fragmentation of health services at the federal level which has caused inefficiency in planning, communica-

tions and working together between the various federal agencies administering health programs within the Department of Health, Education, and Welfare. For instance, the lack of coordination of Public Health Service and Welfare Administration in planning and administering health programs. At state level, although our health services are fragmented between six or seven agencies we have been able to coordinate our activities to some degree. Over-all comprehensive planning and implementation of health programs is more difficult when the programs are administered by different agencies. At the local level (county and city) there is less fragmentation and more team work in administering public health programs.

It has been my privilege to serve on many advisory committees to program activities in the Bureau of State Services in the Public Health Service, and I am now currently serving on an Ad Hoc Advisory Committee to the Division of Medical Care of the Public Health Service, also an Advisory Committee on Medical Care to the Bureau of Family Services of the Welfare Agency, and on an Advisory Committee on Medical Standards to the Social Security Administration. The Association of State and Territorial Health Officers is also required by federal legislation to meet annually with the Surgeon General of the U.S. Public Health Service and the Chief of the Children's Bureau to advise regarding the health needs of the nation.

It is my opinion that all programs dealing with prevention and medical care, research, training, and health education should be better coordinated at the federal and state level. I am attaching hereto a listing of Grants and Aid Assistance Programs that the Kentucky State Department of Health receives through the Bureau of State Services of the Public Health Service and Children's Bureau of the Welfare Agency. Our funds for administration of the Welfare Medical Care Program comes through contract with the Kentucky Department of Economic Security. We anticipate funds directly from the Social Security Administration through the Regional Office of the Public Health Service for the administering of Title XVIII.

I trust this information will be helpful to Mr. Rogers. I am delighted that he is Chairman of this Subcommittee. I have had the privilege of appearing before Mr. Harris' Committee on Interstate and Foreign Commerce on many occasions of which Mr. Rogers is a member.

RUSSELL E. TEAGUE, M.D.,
Commissioner of Health.

Federal grant and special project funds, year 1965–66

Children's Bureau formula grants: Maternal and child health, Federal funds "A" and "B"	$654,641.00
MCH special projects:	
Child multiple handicap center	150,000.00
Maternity and infant care project	393,348.00
Public Health Service formula grants:	
General health	212,200.00
Chronically ill and aged	185,800.00
Radiological health	40,000.00
Federal tuberculosis	70,200.00
Federal cancer control	64,000.00
Heart disease, Federal	124,000.00
Dental health	10,000.00
Hospital administration	50,000.00
Water pollution control	86,500.00
Public Health Service special projects:	
Venereal disease casefinding project	57,002.00
Armed Forces medical rejectees project	84,826.00
Air pollution control program grant project	36,564.00
Kentucky Public Health hearing conservation program project	35,000.00
Migrant worker health project	9,849.89
Tuberculosis project	17,603.55
PHS vaccination assistance project	185,276.00
Department of Welfare: Medical care (contract with economic security), Federal share only	238,073.80
Grand total	2,704,884.24

[Exhibit D]

COMMONWEALTH OF KENTUCKY,
DEPARTMENT OF ECONOMIC SECURITY,
Frankfort, Ky., November 9, 1965.

Commissioner L. FELIX JOYNER,
Department of Finance,
Frankfort, Ky.

DEAR COMMISSIONER JOYNER: This is in answer to your memorandum of October 19, 1965, regarding a request from Congressman Paul G. Rogers. In reviewing the material as submitted by Mr. Rogers, it would seem that his primary interest is in the federal-state relationship between various state departments and the Department of Health, Education and Welfare in the area of public health.

The Department of Economic Security administers the Public Assistance Program, along with other allied programs, such as the Food Stamp Program and the Work Experience and Training Program under the Economic Opportunity Act. Therefore, our contact with the Department of Health, Education and Welfare is from the Welfare Administration rather than Public Health Service. Since we have no direct contact either with the United States Public Health Service or the National Institute of Health, we have no comment as to either the degree of efficient service or the necessity for the research services carried on by such agencies.

Our contact with the Welfare Administration portion of the Department of Health, Education and Welfare has been, in general, a satisfactory working relationship. There have been some policies in the Work Experience and Training Program and in the area of personnel administration which we have felt to be somewhat arbitrary. We have expressed ourselves freely as to our attitudes toward such regulations, but without any satisfactory changes on the part of the Washington agency. There have been times, however, when both the Washington agency and the regional office have shown grave concern regarding an emergency situation existing in our department and have done everything possible in helping to alleviate such a situation. The vastness of the operation of the Welfare Administration does cause considerable delay in program approval, but this can be understood since the many steps involved in administrative procedures are necessary in a large administrative agency of this type.

Our only recommendation in regards to any suggested changes in administrative process is that more consideration should be given to the state administrators in formulating nationwide policy. By such a joint working relationship, some of the policies would have more practical meaning than is possible under a Washington setup, which is so far removed from the field of operating programs on a local level.

Sincerely yours,

C. LESLIE DAWSON, *Commissioner.*

[Exhibit E]

COMMISSION FOR HANDICAPPED CHILDREN,
Louisville, Ky., October 28, 1965.

Mr. L. FELIX JOYNER,
Commissioner, Department of Finance,
Frankfort, Ky.

DEAR MR. JOYNER: Reference is made to your recent communication concerning Congressman Rogers' letter to Governor Breathitt on his subcommittee's work in the area of the Department of Health, Education, and Welfare.

The Commission for Handicapped Children's major contact with the Department of Health, Education, and Welfare is through the U.S. Children's Bureau, Welfare Administration. Our relationships with the central office in Washington and the regional office in Charlottesville, Virginia have been excellent.

During the past eight years that I have been associated with the Commission, I cannot think of one time when representatives of the regional and central offices of the Children's Bureau failed to provide us with assistance and consultation upon request. This cooperation and interest has been extended to all members of our staff in the various professions and disciplines.

Sincerely yours,

JAMES F. YONTS,
Administrative Director.

STATE OF LOUISIANA,
EXECUTIVE DEPARTMENT,
Baton Rouge, La., August 21, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for your letter of August 20, relative to the Interstate and Foreign Commerce Committee's study of the Department of Health, Education and Welfare.

I am happy to have your advice and counsel in this matter and I will give it my fullest scrutiny. However, at the time, I am not prepared to make any statement concerning the HEW Department.

By copy of this letter I am asking the Director of the Department of Health, Dr. T. N. Armistead, The Director of the Department of Public Welfare, Commissioner Garland Bonin, and the Director of the Department of Education, Mr. William Joseph Dodd to contact you with a view to giving specific answers to your inquiry. (See attachment A.)

I hope that we can be of some help to you.

With warmest personal regards, I am,

Sincerely yours,

JOHN J. MCKEITHEN, *Governor.*

[Attachment A]

LOUISIANA STATE BOARD OF HEALTH,
New Orleans, La., September 8, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: As you are aware, Governor McKeithen has asked that I contact you directly, giving my views on the Public Health Service, National Institutes of Health, Food and Drug Administration, etc. and their rapidly expanding programs of research and training, and how they fit in the overall public health functions of the Federal and State Government with particular focus on Health, Education, and Welfare.

Frankly, this has caused much concern to all of us in public health as well as those in organized medicine, and medical school administrators, as it has been becoming increasingly apparent that public health administration, as an essential service structure could well become lost in the top heavy and ever growing organizational set up. The subsidy to National Institutes of Health and other research has increased by leaps and bounds, whereas general health funds so badly needed to carry on our essential basic preventive services on a continuous and on-going basis just to hold the line in such services as VD control, TB control, Communicable Disease control, etc. have been gradually reduced. These must be carried on by such essential staff members as physicians, nurses, engineers, sanitarians, and clerks just to maintain a status quo health protection level in the population, or we will have a breakdown and reactivation of diseases that were well on the way to being controlled or even eliminated. (Notable recent examples are VD and TB).

Furthermore, these same state staffs must be maintained and increased both in numbers as well as through training to meet the ever growing new public health challenges such as Chronic Disease problems of aging, air and water pollution, accident control, etc., just to mention a few.

Therefore, serious consideration should be given to the setting up of a separate Health and Medical cabinet level agency in which all of the Federal health programs could be administered, and this will become increasingly imperative with the addition of new Federal health activities in the Medicare program. This consolidation should give serious consideration to the two major Federal Public Health agencies we now have, namely, the Public Health Service and Children's Bureau.

Obviously, the same could be said of both Education and Welfare in the present H.E.W. structure. Both of these programs are of sufficient magnitude to merit separate administrative structure as we are advocating for the Health Services.

From the state health administrative level we would also like to recommend the continuation and strengthening of the present Regional office structure through which H.E.W. operates at the present time. This is not only provides an excellent functional decentralized method of communicating with the various states but also will continue to maintain for the various Federal agencies responsible for health programs a closer and much more personalized method of transforming the services and programs to the states, *provided the staffing at the regional office level* continues to parallel the state agency personnel to cover the various categorical and specialized program areas.

Although from a standpoint of comparative budgets it might be termed a recommendation that Jonah swallow the whale, we feel that the National Institutes of Health should be a single division under the recommended *Department of Health*. It is essential that the National Institutes of Health engage in a large program of health research. In the past, however, N.I.H. has been establishing programs in states without any contact at all with state health officials. In many states these health officials have received no information on N.I.H. projects until months later when such projects were published.

In your letter to Governor McKeithen, you stated, "Federal health activities, of course, do not function in isolation from state and local programs: our study must take into account the federal-state relationship". To this we heartily agree. I would like to re-emphasize that in my opinion, the existing regional offices of the Public Health Service do most for the federal-state relationship and is by far the best feature of the present organizational structure.

I have recently had a similar inquiry from Dr. Floyd I. Hudson, Health Officer of the State of Delaware and President of the Association of State and Territorial Health Officers, so am sending him a copy of this letter to you.

I realize, of course, that the recommendations herein are of explosive magnitude in change of organizational structure, but I do appreciate the opportunity of giving you the view from the state level. I also hope that this will be of some value to you and your Committee.

With kindest regards, I am,

Yours sincerely,

T. N. ARMISTEAD, M.D.,
State Health Officer.

STATE OF MAINE,
OFFICE OF THE GOVERNOR,
Augusta, Maine, October 5, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: I have discussed with the several appropriate agencies in our State Government the matter of the interrelationships and working relationships between these State agencies and the various agencies and programs within the Federal Department of Health, Education, and Welfare.

I think there is a general recognition that the Department of Health, Education, and Welfare does have responsibilities for a tremendous range of activities, but I do not find that our State departments feel that they have unreasonable complications in their dealings with the Federal department. In general, the staff people in the Federal agency seem to consistently make every effort to have their working relationships with State agencies as simple and as fruitful as possible. There seems to be some feeling that some of the legislation under which the Federal agency works does not clearly set forth the responsibilities which the Feedral agency is to be expected to discharge and might advantageously at times more clearly assign responsibility to a specific administrative unit within the Federal agency.

Under present-day circumstances, it does not seem desirable to contemplate the administrative isolation of activities or responsibilities in the public health field for it is becoming clearer all the time that the interrelationships between responsibilities that might be labeled health, welfare, and education are interrelated to the point where division into categories is difficult and may even tend to minimize the effectiveness of programs by a lack of integration. It, therefore, seems to me that efforts should be directed towards developing and encouraging comprehensive and integrated activities by the Federal agency in relationship to the complex social problems of today.

Obviously, there are very serious administrative difficulties associated with the operation of a department such as the Department of Health, Education, and Welfare, but I do not think that the size of the department in and of itself in terms of its budgets necessarily creates insurmountable administrative problems. If the purposes, responsibilities, and basic mission of the department can be clearly defined, it seems to me that the administrative problems themselves can be resolved, and, furthermore, the advantages that might possibly be derived from the broad approach to problems which could be expected from an agency such as this are such as to make it worthwhile to resolve administrative problems without major changes in the general structure of the department itself.

Sincerely yours,

JOHN H. REED, *Governor.*

EXECUTIVE DEPARTMENT,
Annapolis, Md., September 29, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health, Education, and Welfare Investigation, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for your letter of August 20, 1965 concerning relationship between agencies in Maryland having public health responsibilities and relationships with the Department of Health, Education and Welfare Regional Offices, the Bureau of State Services, the National Institutes of Health, the Food and Drug Administration and the Children's Bureau. The relationships between the Maryland Department of Health and these Federal agencies are extensive and complex. I will attempt to relate to you the consensus of opinion which exists with respect to each of the component Federal agencies involved.

The relations between the Maryland Department of Health and the Region Three Office of the Public Health Service are extremely broad, covering almost every aspect of public health programs which are carried on in Maryland. Direct relationships with the staff of the Regional Office have been excellent and members of Public Health Services staff in Charlottesville are eager to help and give consultation freely and without reservation. I believe it is the consensus that their activities are somewhat limited, however, by the lack of specific Federal program objectives and a lack of realistic cooperation planning with the objectives of the State and local health components being taken into consideration. There has been, in the past and at present, a decided focus on Federal fund accountability rather than programs accomplishment. It has been difficult for the State Health Department to account for categorical funds under the policies established by the Public Health Service, administered through Region Three. If fiscal accountability could be altered to accounting for services rendered and results obtained it is our feeling that program needs and services would be considerably enhanced.

The Health Department also has extensive contacts with the Children's Bureau Office in Region Three. Some problems have existed in the statistical and reporting area where extensive revision of reporting requirements have been made without consideration of the practicality of such changes and without consultation with the State agency involved. Similar difficulties have been encountered with the Bureau of Family Services. We would suggest that new or amended reports required from the States be tested on a pilot basis not only from the point of view of the availability of data and the ease of collection, but also from the point of view of usefulness to both the State and the Department of Health Education and Welfare.

Relationships with Region Three, Public Health Service in the field of Environmental Health has been extremely satisfactory with relation to food control, sanitary engineering, occupational health, industrial hygiene and in radiation protection. Our relations with the Public Health Services with respect to housing hygiene have been satisfactory and courteous in every respect. Training courses, as conducted by the Public Health Service in various localities, have been excellent. The only suggestion offered is that these courses be conducted so that a final educational and training objective can be reached rather than having such education and training exist in a fragmented fashion.

The State Department of Health has also had relationships through its Division of Drug Control with the Federal Food and Drug Administration. I would suggest that the report of the study of the Food and Drug Administration by

an independent organization be examined very carefully and that a unified governmental approach to food and drug laws be adopted. In this area the Federal government should provide leadership, guidance and financial aid to State and local agencies to assist them in carrying out programs of drug control in their respective communities. So far there has been no such Federal financial support offered to assist States and local communities in drug control.

The Maryland Department of Health has also had numerous contacts with the National Office of Vital Statistics and no suggestion are offered for improvement of relationships. This Office has offered consultation and help freely and has consulted with State Bureaus of Vital Statistics prior to changing reporting or other procedures.

Extensive relationships exist with Region Three and the Central Public Health Services Office in Washington with the Hospital Construction Division of the Public Health Services who are responsible for carrying out the provisions of the Hill-Burton and related Hospital Acts. This program has been characterized by heartening cooperation between Federal and State officials and has resulted in satisfactory levels of new hospital construction in this State. Although Maryland has had a reduced volume of Federal dollars as compared with other States, this is one program which did involve extensive preplanning and continuous ongoing planning contacts with the State agency. The resulting program has been excellent.

These comments are offered in a spirit of constructive criticism where applicable to improve relationships between our State and the Federal offices. I would like to re-emphasize, that relationships with the Federal agencies of Health, Education and Welfare have been excellent in general, but I feel that there is room for improvement. If you have further questions after receiving this reply to your letter, please do not hesitate to call upon me.

With kindest personal regards, I am,

Sincerely yours,

J. MILLARD TAWES, *Governor.*

STATE OF MICHIGAN,
OFFICE OF THE GOVERNOR,
Lansing, Mich., September 27, 1965.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation, Committee on Interstate and Foreign Commerce, U.S. Congress, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: I have circulated your letter of August 20, 1965 to the appropriate state agency heads listed below, asking that they share their comments with you directly regarding relationships with the Department of Health, Education and Welfare. (See attachments A and B.)

My personal views on present programs and relationships are summarized in the following points:

1. *Policies.*—Policies of the Department of Health, Education & Welfare, both as stipulated by Congress and as reflected in rules and regulations developed by staff of the department, are in many instances too restrictive. This often impinges upon our capability to use funds and to carry out programs which are in the best interest of the state and localities. More flexible policies providing for state determination of basic action are essential to avoid waste and low yield programs.

2. *Operations.*—Proliferation of direct federal project areas has led to the development of large hierarchies of federal administrative personnel who are generally too far removed from community level problems to make effective decisions of the type for which they have been made responsible.

3. *Manpower.*—Current and anticipated expansion in several areas (such as home health services, heart disease, cancer, and stroke programs) seem at times oblivious to the realities of our critical manpower shortage in the various specialized fields. This shortage will grow more acute if projected federal research and development programs drain off manpower at the levels currently being projected.

4. *Planning.*—In many fields states have not been sufficiently involved in initial planning for major federal-state cooperative programs. An example is the current confusion over the delegation of administrative responsibilities for the medicare program, much of which could have been avoided if the states had

been involved and had been given an opportunity to participate more fully in the basic decision-making process. Our position is that there should be maximum opportunity for state and local decision making in HEW programs and minimum federal control.

Sincerely,

GEORGE ROMNEY.

Albert E. Heustis, M.D., Commissioner, Michigan Department of Health.
Robert A. Kimmich, M.D., Director, Department of Mental Health.
Mr. G. S. McIntyre, Director, Department of Agriculture.
Mr. Bernard Houston, Director, State Department of Social Welfare.
Mr. Alexander J. Kloster, Acting Director, Department of Education.

[Attachment A]

MICHIGAN DEPARTMENT OF HEALTH,
Lansing, Mich., October 4, 1965.

Hon. PAUL G. ROGERS,
Chairman of the Subcommittee on HEW Investigation,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: The Governor of Michigan has asked that I, among others in the state, respond to your request of August 20th.

This is indeed a most appropriate time to study the health activities of the federal government and I congratulate you and your colleagues on your foresight and interest. I, too, share your belief that federal health activity *should not* function in isolation.

My observations divide themselves as follows:

1. *Within the Federal Government itself.*—Either by administrative decision or by Congressional action we certainly have an array of federal organizations dealing with health and sickness without any single focus to bring together or resolve divergent views or overlapping practices or without any single focus to whom those of us with our multi-faceted problems affecting people who live in the states can turn. As new interests have been understood or dramatized, new programs have been initiated and frequently this has been done with too little thought to what already existed or how whatever existed and believed desirable could be tied into the new effort in a way not wasteful of either professional or dollar resources. As an outsider to the federal structure (but as a very interested outsider) it has always seemed that there could be much better coordination between the seemingly independent national institutes of health and the comparable "downtown" programs relating to disease areas. Again, as an interested outsider it has concerned me that apparently no one in the public health service has ever been given the tools to coordinate these wonderful research arms with the equally wonderful and needful programs to apply the research results to people where the people live. This fragmentation of responsibility results in different overall methods of working with the states in the different program areas and makes the total effort have less impact than would a more coordinated one.

2. *Between the federal government and the recipients of federally authorized programs.*—The federal government has many ways of dealing with the beneficiaries of its services. If federally financed programs are to have the greatest impact on the health of all of the people it would seem prudent that there would be a single state coordinating mechanism through which all health interests of the federal government which affect the people that live in states should flow. If it is found that the state coordinating mechanism is not adequate, it is my strong belief that it should be made so (by federal requirement if necessary) rather than being by-passed. In addition to coordinating those programs with a federal interest, this state coordinating mechanism should also have the responsibility to coordinate and to transmit to the federal government the health needs and the available factual data on the health problems of all of the health institutions and of all of the people that live in the state.

3. *Growing direct federal control.*—The trend toward the increasing of project grants for health services at the expense of formula grants for health services should be reversed. It is indeed true that project grants often produce a more

spectacular "flash fire" for a particular disease interest. But, unfortunately, too often this "flash fire" is just that. Human diseases do not exist apart from the human body. The intra-relationship of physical, mental, and emotional illness is now becoming more and more realized. What we need, therefore, is an attack which not only includes the special interest so necessary to get public attention and support but which also does not forget the rest of the body and the impact of the disease or special interest on the rest of the body, or vice-versa. While direct federal project grants by-passing any overall state coordinating body may well make federal administration simpler, I believe that our goal should be effectiveness and not simplicity in and of itself.

4. *The importance of planning.*—Preventive and disease control health services, where the people live are for the most part actually provided by generalized public health nurses and other local health department personnel covering general areas as opposed to the more specific areas of cancer, heart disease, etc. One nurse or other person visiting a family should have concern for all of the health problems in that family and not limit their concern for the heart problems of the aged grandmother. This individual or generalist should be able to be the main instrument by which all of our modern ways to prevent illness and to promote health are brought to bear upon whatever problems that family have. It is my impression that too often the people who are in the position of planning health services in the federal government have come from large teaching institutions and are somewhat remote from the whole array of health problems of the people to be served. Mechanisms should, therefore, be established that would involve the states in a more meaningful planning role of the development of national programs. In this way we can best utilize the mechanisms available for the delivery of health services and can plan to change those mechanisms to meet the changing needs of the "whole person" to be served.

Thank you very much for giving me this opportunity to share this thinking with you. I shall be glad to help in any additional way in which I am able.

Sincerely,

ALBERT E. HEUSTIS, M.D.,
State Health Commissioner.

[Attachment B]

STATE OF MICHIGAN,
DEPARTMENT OF MENTAL HEALTH,
Lansing, Mich., December 10, 1965.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on Health, Education, and Welfare Investigation,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building,
Washington, D.C.

DEAR MR. ROGERS: Governor Romney has forwarded your request to me for comments of State Government Departments' relationships to the U.S. Department of Health, Education, & Welfare. I will summarize some of my personal views and those of my staff with the following points.

Our experience in personal relations with individual Departments and with individual Institutes and personnel within these Institutes has been very good. We have been able to cooperatively formulate grants for many purposes and to carry out projects funded by these grants quite successfully. However, we do find that there is considerable overlap on the subjects of grants and that projects under the auspices of state departments of welfare, education, health and mental health frequently are not coordinated because of the lack of communication from the Federal levels on which agencies are carrying out particular segments of a program. This has been particularly true in the broad field of mental retardation with its broad ramifications on the health, welfare and education programs at the community and state levels. We have also questioned the Department's ruling on the restrictive use of Hill-Burton construction funds for psychiatric facilities in certain regions of this state which do not qualify for community mental health center construction funds under Public Law 88-164.

I appreciate the tremendous amount of legislation passed during the current congressional session which was devoted to the total health and welfare program of the Nation and the difficulties for implementing these many programs. The

delay in the preparation of rules and regulations for many of these programs is a detriment to state departments' implementation at the specific time when funds become available. Additional consultation from the state level would be helpful in problems involved in the expedient development of personnel, procedures and other details which are essential to carry these out.

I hope these comments are helpful in your study. I shall be most happy to contribute further details if this becomes necessary.

Sincerely,

ROBERT A. KIMMICH, M.D., *Director.*

STATE OF MINNESOTA,
EXECUTIVE OFFICE,
St. Paul, Minn., October 13, 1966.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: I am sorry for the delay in responding to your letter of August 20. Although I circulated the letter to the appropriate state agencies for their comments, there was very little response, which may indicate satisfaction with the present federal-state relationships.

Dr. David J. Vail, Medical Director, Department of Public Welfare, did respond and underlined a recurring source of antagonism when he referred to the "proliferation of programs, in tight little categories that create rather than solve problems at the state level." Dr. Vail has called to my attention his comments delivered at a meeting of the American Medical Association in March, 1965 (see attachment A), and the Surgeon General's Conference in January, 1964 (see attachment B) (copies enclosed), which he believes have relevance to your inquiry.

There is merit to Dr. Vail's remarks, but I also am cognizant of the difficulties which confront the Congress in shaping legislation to meet specific needs. The field of mental retardation is an interesting example. While public administration principles might seem to support a lumping together of all mental disorders for the purposes of providing publicly-supported programs and services, the fact is the the field of mental retardation has suffered from serious public neglect and needed very special and immediate attention. The only way to remedy the situation was to develop programs such as those embodied in Public Law 88–156 and Public Law 88–164, which specifically identified the field of mental retardation, and provided funds for comprehensive planning and needed services to combat it.

The fact that this new legislation caused a reshuffling at the state level and possibly encouraged what some might regard as unnecessary administrative "separatism" was regrettable, but the advantages which have accrued far outweight the disadvanages.

To my way of thinking, a more significant problem in the field of federal-state relationships is the seeming failure to fully utilize the office of the governor in the implementation of new federal programs.

Admittedly, there is evidence of a change in this regard. The recent enactment of the State Technical Services Act of 1965 is a good example in that it specifically assigns to each governor the sole responsibility for selecting the state agency to administer the program. I realize that this new legislation is under the jurisdiction of the Department of Commerce, and your inquiry deals with the Department of Health, Education and Welfare, but I am heartened by the apparent trend toward flexibility in allowing the governor to shape the direction of the program within his state.

As for the general question of public health-related problems of our state and the more effective coordination of federal and state efforts in these fields, I am asking Dr. Robert N. Barr, Secretary and Executive Officer, Department of Health, to write directly to you on this subject.

With kindest regards.

Yours very truly,

KARL ROLVAAG, *Governor.*

[Attachment A]

PROBLEMS IN IMPLEMENTING MENTAL HEALTH AND MENTAL RETARDATION PROGRAMS

(By David J. Vail, M.D.)

I have been asked to comment on problems with respect to the development of federally-sponsored programs on mental health and mental retardation. I am glad to do so. However, I fear that I am in danger of being type-cast as the chronic complainer. Though I have been critical of the NIMH and the Department of Health, Education, and Welfare, I believe responsibility for the problems is more widespread.

In the short time available I will briefly describe a few problems as I see them.

1. PAPERWORK AND CLUTTER

Speaking as the representative of the first state to submit a comprehensive community mental health centers construction plan, I can tell you that the amount of paperwork and busywork is unimaginable. The NIMH can take direct action to reduce this if they choose to. This problem is a very serious one, in my opinion; but easily solved.

2. CATEGORIES

This goes outside the NIMH and is a Departmental problem. Possibly it is a problem for the entire Executive Branch, and the Congress as well.

The humanitarian programs are necessary. But there is a problem in the administration of them. It appears that the biopsychosocial dysfunctions are broken down into tight little categories. Each category has its narrow objectives, receives its own batch of money and has a specialized staff assigned to shepherd the particular program. The result is rivalry and confusion. The state operators feel this keenly as multiple forces converge. Each category has its own State Plan. In the Minnesota Department of Public Welfare, for example, we write each year State Plans for Public Assistance, Rehabilitation of the Blind, Crippled Children's Services, Child Welfare, and Mental Health. Mental Health includes the regular Grant-in-Aid category; most recently the State Plan for Comprehensive Community Mental Health Centers Construction; and (luckily a one-shot deal) the so-called Comprehensive Plan to be completed this year. We can probably look forward to a Geriatric Care Plan if state hospital residents become eligible for OAA payments. Mental Retardation will have its own Plan, no doubt. The Minnesota Health Department has several categories of State Plans to contend with, including, of course, Hill-Burton. The Economic Opportunity Act has introduced an entirely new set of complexities.

I suspect that interest groups, such as the A.P.A., the N.A.M.H., the N.A.R.C., the A.P.W.A., the Child Welfare League, etc., have a great deal to do with the establishment and perpetuation of these categories.

3. CONFUSION

Now we enter an area for which the responsibility is borne not alone by the government departments but by citizens and professional groups. This is especially pertinent to the so-called "Comprehensive Community Mental Health Centers" model. Our studies in Minnesota suggest that the plan has many basic flaws.

There are interesting semantics in the phraseology of my assignment for this panel: "problems with respect to the development of federally-sponsored programs." New programs should solve problems, not create them. The fundamental question is, Are the new programs worth developing according to the present design?

4. THE MENTAL HEALTH—MENTAL RETARDATION SPLIT

The separation of mental health and mental retardation programs first appeared in the view of the state mental health authorities at the 1963 Conference of the Surgeon General. Our impression is that the split is now institutionalized and fixed in the bureaucratic structures of the Department of Health, Education, and Welfare, and the channels of communication and loyalty of that organization.

While this may be lamentable, I would remind this group that we in mental health and in the profession of psychiatry in particular have brought this on ourselves by neglecting the field of mental retardation for so long.

Mental Retardation needs its place in the sun. The chance to grow up away from the shadow of its big brother will not only be beneficial but essential. An eventual family reunion will be necessary. We feel that we will be able to accomplish this in Minnesota, as relationships are good and the government structures lend themselves to integration. Our worry is that pressures from the Department of Health, Education, and Welfare may delay or prevent this eventual reunion.

5. MONEY

There has been a great hoopla about restoring staffing funds to Title II of P.L. 88-164. I have been curious why there has not been similar pressure to provide funds for operating costs of community mental retardation centers. In terms of public accountability, one could show at least as much justification for mental retardation staffing as for the other.

Another problem in connection with money is that the existing proposal for staffing funds is for initiation only and phases out after 4¼ years. Without debating the merits or demerits of this concept, I must say that as a state program director I cannot be in the position of supporting or encouraging legislation at the federal level that is at some future time going to embarrass or further burden my own state legislature, to whom I am primarily accountable.

In summary, I find myself wistfully wishing for a House of Lords in Washington, with the power to delay legislation. I am convinced that another year or two in clarifying goals and objectives would do us all a world of good.

Q. You have referred to "basic flaws" in the existing design of the comprehensive centers program. Could you be more specific?

A. The essential job in our view is to clarify the *public* concept in mental health and mental retardation. We are talking about the proper allocation of public funds, under a public trust. This means that the public mandate must be spelled out.

1. First, we have defined two systems that merge into each other but are basically quite separate:

(1) The public mandate system, operated by government in order to prevent, control, and reduce problems that the community collectively define as problems.

(2) The voluntary market system, usually not operated by government but often subsidized by government. The market system makes available goods and services via open contracts between purveyors and customers, or recipients. Problems in this system are not defined by the public but immediately by the parties, privately or individually.

One flaw in the comprehensive community mental health centers concept is that it is not entirely clear in which system the comprehensive center belongs. It *appears* to belong in the voluntary market system. The next question is, Is the best investment of the federal mental health dollar at this time in further subsidy of the voluntary market system?

2. Second, we have tried to define targets of *public* concern.

Disordered behavior that causes public anguish is the broad order from which the classes are defined. The public will has allocated the accountability for one whole group of disordered behaviors—crime and delinquency—to correctional agencies. The public education and welfare systems have been allocated accountability for certain problems involving disordered or maladaptive behavior. The public mental health agencies have been assigned the problem of major mental disorder. Agreement on definition breaks down at this point: I use the term *major mental disorder* to mean those behaviors of excessive unreliability or weakness that require separation from home, and some measure of control and/or basic support. This definition includes mental retardation, problems of the senium, and the increasing influx of juvenile behavior problems that for legal purposes fall on the "mental illness" rather than "delinquency" side of the line.

The comprehensive center documents speak of "treating mental illness in the community" but do not spell out "mental illness" and more precisely. Thus the target is still blurry. This is the second flaw.

The public cannot afford to invest its hard-earned money into programs that do not first and foremost attack the serious problems about which the public is most concerned. We believe that the first priority of investment aimed at pre-

venting, controlling and reducing major mental disorder should not be in the market system but in the public mandate system: courts, probation offices; police and correctional systems; public schools; welfare departments; and public institutions operating under statutory authority and responsibility.

3. Third, we have tried to clarify authority and accountability. This is difficult to do. We are not aware of any real designation of accountability in connection with P.L. 88–164, other than internal accountability (i.e., for the mechanics of the operation). This is the third flaw.

Accountability, not service, is what we need more of. Continuity of responsibility, not continuity of care, should be the watchword. Our studies lead us more and more to the idea that what may be needed at the community level is a public mental health officer, with statutory authority and responsibility clearly spelled out; similar to the Mental Welfare Officer in Britain—a "duly authorized agent" as he is sometimes called.

4. The fourth flaw: a simple linguistic oversight. To plan, to prevent, to serve, are all transitive verbs. They have first and foremost direct objects: To plan *some thing*, to prevent *some thing*, to serve *some thing*. They have next indirect objects: to plan some thing for some *purpose*, to prevent something for some *purpose*, to serve some thing to *some one*. We have forgotten all this. These lovely verbs have been weakened to ordinary nouns that are treated like commodities—*planning, prevention, services*—that need have no objects but are treated as ends or good things in themselves.

5. The fifth flaw: a constricted model. The plan is for a hospital-like facility, staffed by professionals whom we now accredit in a limited number of fields. Is there room in the comprehensive community mental health program concept for the full use of nonaccredited professionals (i.e., professionals not accredited in the classic mental health fields), for volunteers, for so-called indigenous nonprofessionals? Is there room for experiments in transportation or communication? A day-care program as classically defined would not be feasible in our sparsely-populated northern regions. But a rapid-transit bus or railroad that brings families to the state hospital and funds or facilities to lodge them might be. Is there room for full use of the power that lies now dormant in the state mental hospital and other components of the public system? We believe further thought should be given to these questions.

[Attachment B]

DECEMBER 17, 1964.

To: Dr. Stanley Yolles, Acting Director, National Institute of Mental Health.
From: David J. Vail, M.D., Medical Director, Department of Public Welfare, State of Minnesota.
Comments on: *Mental Health Centers Construction: Program Regulations and State Plans* Presented at a panel discussion at the Annual Conference of the Surgeon General, United States Public Health Service, with the State and Territorial Mental Health Authorities, Washington, D.C., January 5–7, 1964.

It was very statesmanlike of Dr. Yolles to invite me to present my views as a state mental health program director on this panel on regulations and construction plans for comprehensive community mental health centers. He must be aware that I have been critical about the program in recent months. Here I will try to match his statesmanship by being as temperate and constructive as I can.

My main point is simply this: the regulations should be liberalized and the guidelines pruned back. The effect of the present system is an obstacle course not only for the state mental health authority but for the individual project applicant as well.

Minnesota seems to be the first state to have submitted a construction plan. On December 15, 1964, we posted to the United States Public Health Service regional office four sets of plans, two volumes per set. Section IV B, the Inventory, occupied one whole volume. We estimate that the two volumes total around 600 pages. We clocked the weight of a single two-volume set at *five pounds, twelve ounces*. Minnesota is a small state in population. We shudder to think of the poundage of the Plan from a state like Illinois or California.

The Inventory took many man-hours of work and compiling it strained our relationships with agencies whom we had to pester to provide the information. In my opinion it is busy work, with a questionable value. This attitude stems

from the effort of compiling only with the optional "short form". A compilation of the full information proposed for future years is frightening to think about.

I hope that this Conference will go on record *against* the requirement of taking the inventory, certainly in its present form.

The remainder of the Plan is unnecessarily voluminous. Section III, the general description of the state, is really a bit too much. Are we asked to do this because the Secretary wants the information (he has the Library of Congress at his disposal), or because it is somehow good for us to obtain it?

In all this information-gathering it would help us to know the purpose for it, and who is the beneficiary.

Section IV C, Survey of Need and Ranking of Areas produced interesting information for us, and thus we have no real complaints as we were motivated to proceed with research we wanted to do anyway. But the rationale is loose and somehow arrogant. "Need" is not self-evident, and we were required to break it down into four distinct categories. Furthermore, the structure of this part of the Plan is based on the implied promise that the comprehensive community mental health center program will do something to alleviate poverty, unemployment, crime, delinquency, and other social ills of our time. There is no evidence that it can keep such a promise.

The total effect, as I have said, is an obstacle course. Taken together with the endless confusion during the past two years, the plethora of committee meetings, the unpleasant job of staving off hungry hospital administrators and agency directors who see P.L. 88–164 as the golden road to expanded building programs, added to the normal duties of administering a state mental health program, the total experience has been demoralizing.

Why the effort to get the Minnesota plan written and submitted?

(1) In order to have a pattern laid out for the legislature, which goes into its biennial session now.

(2) As an intrapsychic defense maneuver of my own to reduce the ominous sense of oppression which I have experienced ever since the regulations first came out. Having submitted the plan, I feel some sense of relief. But the traumatic neurosis persists. While it may not be fair to blame this on the NIMH, still it is a factor in any of my present and future reactions.

I am troubled by the hidden assumption that all this work is somehow for our own good, to prepare us for the New Jerusalem offered by the comprehensive community mental health center concept as a solution to the public problems, which are the serious problems, of our society. I prefer proceeding as we are in Minnesota, to strengthen the problem-solving capabilities of the mental hospitals (which are and will always be indispensable) and force them into the mainstream of communty life, meanwhile developing the community participation and community problem-solving efforts of our existing community mental health centers, which now serve 90% of the state population, through consultation and out-patient services. I think there is a reasonably good consensus about the approach in our state. Our studies in Minnesota suggest that what may be needed to fill in program gaps at the community level are not new services but rather a new *function* of public mental health authority. The comprehensive community mental health center is feasible in our metropolitan areas (where we must finagle, however, to get around the 200,000 population limit) or possibly where distances to the state hospital are prohibitive, and our plan shows these possibilities. We have also established at the Rochester State Hospital, a comprehensive community mental health program which already includes under one roof, along with the regular state hospital program, the local community mental health center, a day hospital program, psychiatric emergency services, alcoholism counseling, and the local crippled children's services, with more public and private agencies expected to come in on the venture.

Generally, our attitude about the construction program in Minnesota could be described as pastoral; we will succor to our flock and suffer what we must to get them what they need.

About the possibility of staffing funds I am neutral. If the existing total of $2 million per annum of state and local community mental health funds in Minnesota could be matched by federal funds on a *sustained, indefinite* basis, then all well and good. But I dread the come-uppance four years hence when the federal funds phase out. Either the local programs would be ruined or the legislature would have to take from institutional programs to meet the bill, or both. This way lies disaster. I expect to do nothing official either to oppose or support passage of a staffing provisions bill. My gut response, however, is *enough already.*

There is not time to elaborate adequately on two points:

(1) *NIMH policy on state hospitals*

Whether from instant or not, the net resulting NIMH policy appears to be against the enhancement of state mental hospital programs as a hopelessly second-class operation and a write-off. This will be denied, and the Hospital Improvement Program (HIP) offered in evidence. The HIP is very welcome, and is being well administered. But it comes late in the day, as it were by way of consolation, and it is insufficient. And one must ask, What is the place of the HIP in the NIMH hierarchy? How well coordinated is it with other NIMH programs?

While there is nothing in the regulations specifically against state hospitals as construction sites, there is specific inclusion (Sec. 54.204(c)(2)), favoring the general hospital. So far there is no objective evidence that psychiatric care in a general hospital is superior across the board to other modes of psychiatric treatment, including the state hospital. Dehumanization can occur in private general hospitals as well as in state hospitals: it is just more expensive.

The relevance of this bias question is that the NIMH must be very careful, in evaluating state plans and individual projects, to be scrupulously fair in weighing plans for construction projects at state hospitals on their merits.

Perhaps the rules and regulations of another day need to be revised for current conditions, so that areas of mental hospital programs may be defined as community service. Surely the NIMH shares with us the recognition of the state hospital as a vital part of community life.

I propose that improvement of the public mental hospital should be the first concern of public mental health and not the last.

(2) *Manpower*

Wherever the comprehensive center is based it must rely on professional manpower supplies. If the comprehensive center is to be a vital part of the public service system, capable of contributing, as it purports, to the solution of problems as the *community* defines problems, we will need a different breed of mental health professionals. Existing training programs do not prepare staff for the hard realities of community demands, but only for the voluntary market system, based on the private practice model.

I suggest that the NIMH through its training branch, take the lead in requiring training centers, if they are to be eligible for federal training stipend grants, to produce more effective training in community service. A vast proportion of professional training (if we include the aggregate of federal and state agency support) is being supported by public money; but the public is getting too little in return. The continual production of workers with a private practitioner outlook is not serving the public interest, and the public has a right to expect more than this.

Finally, I would suggest that the NIMH work more closely with the state program directors and mental health authorities. I would strongly urge the formation of a formal policy advisory committee of state and territorial mental health authorities to meet regularly and frequently with the NIMH on these sensitive questions of federal and state relationships as they affect program development and implementation. Such an arangement would be of mutual benefit to the NIMH and the state programs. Without competent support at the state level any federally-sponsored program, no matter how glorious in its conception, is dead. Close communication and clear understanding between the federal and state levels would increase the chances of effective program accomplishment across the nation.

STATE OF MISSISSIPPI,
EXECUTIVE DEPARTMENT,
Jackson, Miss., August 31, 1965.

Hon. PAUL G. ROGERS,
Member of Congress,
Chairman, Subcommittee on HEW Investigation,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Mississippi will certainly provide all the information which might be helpful in your study into the organization, structure and activities of the Department of Health, Education, and Welfare.

Your recent letter is being circulated among the appropriate state agencies for comments on the subject. I feel confident that the information requested by you will be forthcoming in a timely manner. (See attachments A-D.)

Sincerely yours,

PAUL B. JOHNSON, *Governor.*

[Attachment A]

MISSISSIPPI COMMISSION ON HOSPITAL CARE,
Jackson, Miss., September 9, 1965.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR SIR: Governor Paul B. Johnson has requested that we, as an agency of Mississippi State Government having relationships with the Department of Health, Education, and Welfare, give you our comments regarding that Department and our relationships with it as requested in your recent letter addressed to him. I have no doubt you will be hearing also from other Mississippi agencies as the result of his request.

It will, perhaps, clarify matters if I first explain the function of this agency, and its relationship to the Department. The Mississippi Commission on Hospital Care has the responsibility of licensure of hospitals in this state and, also, is charged with administration of the program of construction of hospitals and related medical facilities as authorized in the Hill-Burton Act and succeeding legislation. It was created by the Mississippi legislature prior to passage of the Hill-Burton Act and is an independent state agency.

The states of Louisiana, Mississippi, Florida, North Carolina, Pennsylvania, and New Jersey have all lodged similar responsibilities in independent agencies. All the other states have placed this responsibility in their respective State Boards of Health. Our contacts and relations with the Department of Health, Education and Welfare have been largely with the Division of Hospital and Medical Facilities of the Public Health Service. Any comments we might make relate to that Division unless clearly indicated otherwise.

We could tell you, in complete honesty, that our relations with the Division of Hospitals and Medical Facilities over the past nineteen years have been most pleasant as well as profitable. Mississippi has benefited greatly from the program of construction of hospitals, and this benefit is not confined to the grants of funds which have made it possible. The technical assistance, the program guidance and advice have been of a value so great as to defy estimate. The forum which the annual Surgeon General's Conference has provided the state agencies to air their separate problems and exchange ideas has made possible a standard of excellence that no state could have attained alone and unaided.

Having said the foregoing, I should, perhaps, close this letter without further comment, but since you have asked for specifics to guide your committee in its deliberations, and since I have observed in recent years trends and attitudes in the Department that concern me, I feel that I would be remiss if I did not convey to you the bases for my concern.

May I say, at the outset, that I do not feel the Public Health Service was, in any way, improved by incorporating it into a non-homogeneous mass large enough to give Cabinet status. The rapid turnover of Secretaries, most of whom seem to consider the appointment as but a stepping stone to higher things, and all of whom seem impelled to make a reputation for themselves by instituting changes and initiating new programs, has resulted in a lack of direction and a dissipation of effort throughout the Department, even down to the lowest ranks. It has encouraged inter-departmental rivalries to the detriment of the Service and the people it should serve. It has contributed materially to the proliferation of departments noted by Congressman Harris in his statement. It has reduced a once proud service staffed by dedicated public servants to one peopled largely by time-serving and self-serving individuals who are looking forward to qualifying for as much retirement pay as possible while they are still sufficiently vigorous and active to find other employment more to their liking.

One undesirable by-product of this inter-department rivalry is increased difficulty of administration. When Hill-Burton was first instituted, responsibility and authority for approval of projects and plans, as well as reimbursements, was lodged in the regional offices resulting in prompt service which got

the program off to a quick start and with general satisfaction. When the Wolverton Amendments were passed in 1954, the Office of Vocational Rehabilitation was sufficiently strong to have written into the act a provision that applications for Rehabilitation Projects must be approved by the Surgeon General after review by O.V.R. This not only introduced delays, but the attitude first adopted by O.V.R. as to what constituted an approvable project posed additional difficulties with the result that construction of Rehabilitation Facilities got off to a very slow start and has not yet, 10 years later, attained the momentum and popularity of other categories. Now the National Institutes of Mental Health has retained similar, if not more strict, control over mental facilities and, apparently, an equally intransigent attitude. The Nurse Practices Act, enacted just one month subsequent to the Hill-Harris Act last year, removes not only control but administration of grants for construction of Schools of Nursing from the Division of Hospitals and Related Medical Facilities and lodges it with the Department of Nursing which has, no doubt, found it necessary to enlarge its staff by employing architects, engineers, accountants and administrative personnel to handle a program that, for 18 years, has been handled by the same state agencies that administer Hill-Burton grants for the other categories.

I feel some apprehension over the attitudes of some persons with considerable authority in the Public Health Service to use legislation to compel "reforms" that they consider desirable, but which I feel were clearly not the intent of Congress. As an example, at a meeting of the American Association for Hospital Planning less than two weeks ago, Dr. Paul Peterson, Deputy Chief of the Bureau of Community Health, P.H.S., asserted that only those hospitals which were accredited by the Joint Commission on Accreditation of Hospitals could qualify for care of persons over 65 under the recently enacted "Medicare" act. I gathered from his remarks that this is not provided in the act, but is rather a provision of the regulations contemplated by the Bureau of which he is a representative. Whatever the source of this requirement, if it is permitted to stand it will perpetrate a cruel hoax upon the old folks of this country who anticipate benefiting from this legislation. I think it safe to assert that considerably less than half of the hospitals in the United States are so accredited. Less than one-third of the licensed hospitals in Mississippi have been so accredited. I was seated next to Dr. Helen Knudsen of Minnesota when the remark was made. She told me only about 59% of Minnesota hospitals are accredited.

The Joint Commission on Accreditation of Hospitals is a fine organization. Its Director is Dr. John D. Porterfield III, former Director of the Ohio State Department of Health, and he has served both as Assistant Surgeon General and Deputy Surgeon General of the U.S. Public Health Service. It is a voluntary organization that takes pride in the fact that it is so. They will not inspect a hospital for accreditation except upon invitation of that hospital. I should think they would resent any compulsion by outside forces upon a hospital to seek accreditation since the use of force would dim the luster of their award. But, whatever the attitude of the Joint Commission toward the use of such compulsion, I cannot believe that Congress intended "Medicare" to have the effect of greatly reducing the already inadequate supply of hospital beds available to beneficiaries under the act.

And, I feel certain that it has come to your attention that the Department has interpreted the Civil Rights Act of 1964, not as forbidding discrimination on account of race, but as requiring the forced integration of hospitals and other facilities. In spite of Sec. 623 of Public Law 88–443 which became effective on August 18, 1964, and which prohibits any federal employee from exercising "any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title.", federal officials of the Department of Health, Education and Welfare have been and are asserting their right and obligation to fix personnel policies, hiring practices, medical staff eligibility, staffing arrangements, and even bed assignments in hospitals, citing as their authority Public Law 88–352 which became effective on July 2, 1964. Here, again, I feel the intent of Congress is clear. There can be no discrimination in federally assisted hospitals on account of race, but I question that DHEW has the mandate to supervise the most minute details of hospital administration.

Yours most sincerely,

FOSTER L. FOWLER,
Executive Director.

[Attachment B]

MISSISSIPPI STATE MEDICAL ASSOCIATION,
Jackson, Miss., September 15, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigations,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Your letter of August 20 to the Honorable Paul B. Johnson, Governor of the State of Mississippi, has been referred to this office. We are grateful for the opportunity to reply to the question posed in your correspondence.

First, however, may I express my deep and sincere appreciation to you and your colleagues on the Special Subcommittee on Investigations of the Committee on Interstate and Foreign Commerce for your study into the organization, structure, and activities of the Department of Health, Education, and Welfare. I am sure this study will benefit all concerned with the public's health.

In your letter of August 20, you made a statement which I believe is most important in viewing the federal government's increasing role in health care activities. You state that: "Federal health activities, of course, do not function in isolation from state and local programs . . ." I would invite your committee's attention to the effect of these activities on state and local health programs.

There is a pattern which is increasingly apparent in all federal health activities as these activities interact with state and local health activities. May I direct your attention to two specific programs and examples in this regard, beginning with the research grant program to medical schools administered by the National Institutes of Health.

NIH Research Grants to Medical Schools.—I am sure the legislative history of all state medical schools shows that these institutions were established to meet local and/or regional health needs. Through 1963, the latest year for which complete data are available, 51 per cent of total medical school expenditures were provided by the federal government compared to 27 per cent in 1957 and 46 per cent in 1961, a growth in the federal share of 188 per cent in six years.

How well a medical school can be oriented to local needs when a major and growing portion of its budget consists of research grants for federally selected projects should be apparent to all. It should also be apparent to those who would point out that the state institution has a "choice" of accepting or rejecting these grants that this choice is a superficial one. It is impossible for any state to compete with the largesse of the federal government in attracting health resources. And, especially is this situation felt in those states with low per capita incomes.

Community Health Centers Construction and Staffing.—Another example of the same problem encountered in the interaction of federal, state, and local health activities can be seen in the new community health program. Certainly no one would deny the fact that mental illness is one of the pressing medical problems of our times. However, I am sure that within the individual states there are different medical problems of as great or greater import. What effect will a federally sponsored community health center and staffing act have on solutions to these state and local public health problems?

I believe the most important effect results from the fact that there is a limit to health resources. Staffing of these new centers with physicians and allied professional personnel possessing training necessary to accomplish the community health program's purposes can be achieved only at the expense and detriment of existing and planned state and local health activities.

In summary, it is our experience that the increasing role of the federal government in health care activities is removing the opportunity for state and local selection of priority health activities. We suggest that this situation is worthy of extensive investigation by your committee and we assure you of our cooperation in this regard.

Thank you again for the opportunity of presenting this information to your committee. Best regards.

Sincerely,

EVERETT CRAWFORD, M.D.,
President.

[Attachment C]

BOARD OF TRUSTEES OF MENTAL INSTITUTIONS,
Jackson, Miss., September 10, 1965.

HON. PAUL G. ROGERS,
Member of Congress, Chairman, Subcommittee on HEW Investigation, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Your letter of August 20, 1965, addressed to Governor Paul B. Johnson, with reference to your subcommittee's investigation of the organization, structure, and activities of the Department of Health, Education, and Welfare, has been forwarded to our office with the request that we, along with other agencies, give you the benefit of our observations.

The Board of Trustees of Mental Institutions in Mississippi has jurisdiction over the mental hospitals and the schools for the mentally retarded. Through our many years of association with HEW we have witnessed the enormous growth of the department and have, at times, been disturbed over its inclusiveness, even though we have never been disappointed at the services it has rendered to us as an agency of the State of Mississippi. We would not be justified in making any direct criticisms of the department, however, the following observations are made in an effort to be constructive:

In many instances, in this and other states, we have seen evidences of the tendency of the Department of Health, Education, and Welfare to appropriate all programs in public health as well as in allied fields which carried Federal support funds along with them. Although many state departments of health were originally organized to carry out preventive functions largely, they went into treatment and research as soon as Federal support funds became available. In some instances, only token work was done in these fields in order to secure funds for use in traditional programs. A comparison of state expenditures for specific programs with Federal allocations would reveal these variations.

The whole procedure for applying for grants seems to be unwieldy. The process of determining available Federal assistance, the writing up of projects, and the many man hours spent in interaction between the states and HEW are exhaustive and time consuming. Lack of coordination at both the state and Federal level often results in wasted time and overlapping interests and functions. A better system would be the centralization of authority in Washington and at the state level. A fraction of the time and money now spent by the myriad agencies would easily finance a bureau of grants or some such agency at both the state and Federal level. It might also result in a better equity of implementation of those programs which Congress seems to have thought worthy of support.

I hope that these observations will be of some value to your committee.

Yours very truly,

SETH HUDSPETH, *Executive Secretary.*

[Attachment D]

STATE OF MISSISSIPPI,
DEPARTMENT OF PUBLIC WELFARE,
Jackson, Miss., September 24, 1965.

HON. PAUL G. ROGERS,
Member of Congress, Chairman, Subcommittee on HEW Investigation, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Your letter of August 20, 1965, to Honorable Paul B. Johnson, Governor of the State of Mississippi, concerning the study of the organization, structure and activities of the Department of Health, Education, and Welfare has been referred to this Department for review.

We have given careful evaluation of the purpose of the study noting that emphasis is placed on the general field of public health with some review of health activities which cut across the various subdivisions of the Department of Health, Education, and Welfare.

The Mississippi Department of Public Welfare works in full cooperation with the Mississippi State Board of Public Health. However, the Welfare Department's responsibility for services are primarily in the area of public assistance to needy individuals and casework services to them, and a plan of referral to appropriate service agencies when our Department cannot aid them.

The regulations of the Welfare Department are in accord with State and Federal approved plans.

The Department of Health, Education, and Welfare, Regional Office, Mr. Robert W. Brown, Acting Regional Director, Atlanta, Georgia, is the Federal liaison between the Mississippi Department of Public Welfare and United States Commissioner of Public Welfare, Dr. Ellen Winston, Department of Health, Education and Welfare, Washington, D.C. We feel that we have excellent coordination between our Agency and the Department of Health, Education and Welfare.

Because the emphasis of the study is in the field of public health, I am confident that Dr. A. L. Gray, Director, State Board of Public Health, Jackson, Mississippi, will give you specific information which will be helpful to you.

With best wishes, I am,

Sincerely yours,

EVELYN GANDY, *Commissioner.*

EXECUTIVE OFFICE,
Jefferson City, Mo., October 25, 1965.

Mr. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Rayburn House Office Building,
Washington, D.C.

DEAR MR. ROGERS: On August 20, 1965, you asked for the benefit of our views and those of our public health officials concerning possible organization problems within the Department of HEW.

We have contacted each of the state agencies that would be concerned. We now have their answes and are able to pass their comments on to you.

Dr. George Ulett, the Director of the Division of Mental Diseases, merely states that his relationship with the Public Health Service has been most satisfactory and that he particularly appreciates the close working relationship with the Regional Office.

The doctors of our Division of Health have made the following comments: (1) That the restrictions on the use of categorical grants are many times too strict and impractical; (2) that the state plans necessary for the use of these categorical grants are too detailed and require too much specialization for the practical application of these funds since local conditions vary considerably; (3) that the appropriations made to the Department of Health, Education, and Welfare for grants to the states are normally made late in the session and because of this that the practical use of these monies becomes very difficult; (4) that the magnitude of categorical, research and other grants makes it difficult for state health departments to know what other agencies are receiving grants and funds for health purposes. This, of course, is due to the great number of programs that exist and the ever increasing numbers of new programs. Cities and local communities deal directly with the Public Health Service and many times it is not known how these programs could or should be coordinated with statewide programs.

I have passed on to you the comments by these department heads. I may add that I would agree personally with the general thoughts that much can be done in better coordination of existing programs, the timeliness of the appropriations, and in general the return of tax revenues to state and local government.

We hope that these comments have been useful to you and thank you for requesting them of us.

Sincerely yours,

WARREN E. HEARNES, *Governor.*

THE STATE OF NEVADA,
EXECUTIVE CHAMBER,
Carson City, Nev., September 10, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Congress of the United States,
Committee on Interstate and Foreign Commerce,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: This letter is in response to your request to comment on the relationship of the Nevada agencies with public health responsibilities and the Department of Health, Education, and Welfare in general.

We have had no difficulty with the Department of Health, Education, and Welfare. We have enjoyed a pleasant, helpful and efficient working relationship. The complex problems of public health today do not permit a small state as Nevada to employ the many specialists required of this complex environment. Without the cooperative services and understanding of the Regional Office, the Taft Engineering Center, Communicable Diseases Center and others, we just could not exist.

As an example of the cooperation we get, I might mention the recent plague epizootic at Lake Tahoe. At the first signs of plague infection, specialists from the Plague Center in Region IX were in contact with and participated in surveys at Lake Tahoe. The last time we had an epizootic of this kind was about 1939 and we do not have specialists for this specialty. It is provided by Public Health Service.

In the field of industrial health, the Salt Lake Field Office provided a complete technical survey, consultation and field study of an arsenic exposure at Getchell Mine. We could not have done this alone. There are many examples of this kind in our Nevada relationship with Public Health Service.

There have been complaints and criticisms of the Indian health program. We would recognize that Public Health Service only recently got into the Indian health program and very possibly this health program is only a part of the Indian problem in general.

In the area of Food and Drug, they provide an excellent service to us. The relationships are close. We would expect the study of the Food and Drug Division to recognize the recently completed study of State and Local Food and Drug Programs financed by Food and Drug and that some means be taken to provide funds for their cooperation with state agencies. Some means could well be provided to finance educational leaves to ease the problems of staffing these programs with competent personnel.

In Nevada the milk program is under the State Health Department. Nevada was one of the first states to require milk to come from Bangs-free herds—all milk to be pasteurized. This program was initiated after consultation and continuing guidance of the Public Health Service Regional Offices. All meat is inspected in Nevada and this is a state program in cooperation with the Department of Agriculture.

I would be very pleased to elaborate on any of these comments and to provide other information.

Cordially,

GRANT SAWYER, *Governor.*

STATE OF NEW HAMPSHIRE,
Concord, N.H., September 16, 1695.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR MR. ROGERS: In response to your inquiry of August 20. I am pleased to enclose copies of letters on the subject from our Director of Public Health and the Executive Secretary of the New Hampshire Water Pollution regarding their relations with federal agencies in the health and welfare field. (See attachments A and B.)

I would add I have had occasion to seek the help of the Regional Office of Health, Education and Welfare in Boston with reference to certain problems which have arisen in our State Department of Health and Welfare and I have found the Regional Office to be completely cooperative in every way.

Sincerely,

JOHN W. KING, *Governor.*

[Attachment A]

STATE OF NEW HAMPSHIRE

INTERDEPARTMENT COMMUNICATION

Date: September 10, 1965.
From: Mary M. Atchison, M.D., Director, Division of Public Health.
Subject: Your Memo 1924.
To: Governor John W. King, State House.

DEAR GOVERNOR KING: In response to your request for information sought by Senator Paul G. Rogers, Chairman of a Congressional Subcommittee on HEW investigation, I present our reactions as they apply only to the Division of Public

Health. In his inquiry, apparently they are investigating the relationships that exist between State and Federal Agencies.

The agency of HEW that is of concern to us are the United States Public Health Service (including the National Institutes of Health, the Food and Drug Administration, and the United States Children's Bureau). All of these Federal Agencies operate through regional offices—the Children's Bureau regional office is more remote, namely in New York City and possess fewer personnel, while the United States Public Health Service regional office and the Food and Drug Administration office is in Boston. This Division of Public Health can truthfully testify that the relationships with these federal agencies have been and are currently most favorable. Members of the staff in the Division of Public Health will concur with this opinion.

The other federal agency which is involved in the over-all problems in the area of public health is the Water Pollution Commission which I believe now has been separated federally into a separate governmental agency, as it has in this State recently, as you are aware.

I might comment only to the point that with the advent of Medicare, there will be a great need to solve future problems with the assistance of the regional office concerned with the new programs that are inevitable.

Sincerely,

MARY M. ATCHISON, M.D., *Director.*

[Attachment B]

NEW HAMPSHIRE WATER POLLUTION COMMISSION,
Concord, N.H., September 8, 1965.

Hon. JOHN W. KING,
Governor of New Hampshire,
Concord, N.H.

DEAR GOVERNOR KING: This is in response to your request for comment in connection with Representative Paul G. Roger's (Florida) inquiry regarding the Department of Health, Education and Welfare activities in New Hampshire.

For several years prior to 1956, but more intensively since that time, the Water Pollution Commission has worked closely with the Department's Division of Water Supply and Pollution Control. Congress established a pollution control grant program in 1956 and this, coupled with the state aid system adopted in 1959, has produced a marked increase in the number of treatment plants being built from year to year. Obviously, under these circumstances we have had to maintain frequent contact with counterpart officials at the Federal level and have found them to be a group of competent, dedicated professionals. There has been an atmosphere of genuine cooperation between us and we would hope that whatever changes Congress may decide to make in the Federal law, it will include provisions for these qualified people to remain in charge of administrative and technical aspects of the program.

The one area in which there has been some disagreement has to do with the enforcement phase of the program. Our view is that the states have the primary responsibility to exercise control and that Federal enforcement should be the last resort. On occasion, it has appeared to us that Federal proceedings were initiated before state and interstate agencies had had a reasonable opportunity to solve pollution problems at the lower level of government. Similarly, there has been little or no advance notice when federal enforcement action was contemplated. Clearly, there are and will continue to be situations when intervention is necessary, but again, we are of the opinion that this approach should be reserved for those instances where there is an inability or demonstrated lack of willingness on the part of state and interstate authorities to take appropriate action. One solution which has been suggested which seems to have merit would involve a policy of calling a pre-conference meeting betwen the various state, interstate and Federal officials involved. This, of course, would provide a forum for discussion and possible resolution of problems without the necessity for formal conference proceedings under the Federal Act.

Intimately related to any compliance schedules adopted under the Federal enforcement procedures is the question of the availability of grant funds. As you know, Congress is now appropriating at the rate of 100 million dollars per year with New Hampshire's share being approximately one million dollars annually. Presumably Congress will increase the level of appropriations to 200

million dollars per year and the New Hampshire share would then be in the vicinity of two million dollars annually. In either case only a certain number of projects can be underway at a given time if all are to receive adequate assistance. Hence, it is our contention that communities cannot be expected to undertake construction of pollution control projects unless they are assured of their share of Federal and State grant funds. We further believe a realistic enforcement schedule will duly recognize this premise. This concept has not been accepted by Federal enforcement authorities and we sincerely wish it would receive their serious consideration. Unless and until Federal appropriations are in keeping with a highly accelerated schedule, there will be considerable difficulty in convincing communities to act more promptly than they are now doing.

New Hampshire, with your support, has now embarked on a 40% aid program and it is apparent that the Federal Government should also review the extent of assistance which it offers to municipalities faced with this costly program. The "Public Works and Economic Development Act of 1965" and the "Housing and Urban Development Act of 1965" when funded promise improvement in the situation. However, as was pointed out by former secretary of HEW, Celebrezze, the formula (particularly where separation of combined sewers is required) should be broadened to something approaching the highway assistance program if the type of acceleration desired is to be obtained.

Admittedly I have digressed from the subject of organizational structure alone but these other considerations are basic and compelling if we are to view the total picture. In substance, it has been our experience that the present organization is providing all of the technical and associated services needed by the states but we are persuaded that the financial contribution is less than adequate if the objective of cleaner waters is to be reached within the next decade or two.

I hope these observations will be of some value and assistance to you in preparing a reply to Representative Rogers, Chairman, Sub-Committee on HEW investigation.

Very truly yours,

WILLIAM A. HEALY,
Executive Director.

STATE OF NEW JERSEY,
OFFICE OF THE GOVERNOR,
Trenton, N.J., October 29, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health, Education, and Welfare Investigation, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for your consideration in asking me to submit my views and those of principal public health officials in this State concerning the public health related problems that might exist and, as you ask, particularly our views with respect to the organization of the Department of Health, Education and Welfare, primarily as it affects public health.

Let me say strongly at the outset that the State of New Jersey and the Department of Health of this State have enjoyed and benefited from an excellent relationship over many years with the Public Health Service including the National Institutes of Health, and the Food and Drug Administration.

The work of the study group on the Mission and Organization of the Public Health Service which was completed in 1960 was a significant step forward. The study group recommended changes, many of which we understand are now administratively operative. These significant changes in organization appear to have brought about an organization with the flexibility and adaptability necessary to cope with the very complex, changing and dynamic modern public health problems. They are indeed increasing in their complexity and changing at an alarming rate.

We are all aware that organization of itself cannot insure efficiency and that organization structure exists for the primary purpose that all essential activities are carried out. Effective organizational structure must be geared to the dynamics of our present society and it must be tempered by the basic determinant that it must never be permitted to grow so elaborate as to hinder work accomplishment. We believe that the new organization of the Public Health Service as developed since 1960 provides the organizational structure necessary for effective leadership in the field of public health at the federal level. It has the

flexibility and adaptability to deal effectively with the complex problems of modern day public health.

However, the tremendous expansion of public health programs and activities with the accompanying administrative problems and inevitable difficulties which accompany growth and change brings us to the suggestion that your Committee might consider the work size and administrative problems that would appear to be incumbent on any Department as large and complex as the Department of Health, Education and Welfare. It would seem that the problems normally assigned to each one of the three principal parts of the total Department have grown and changed manifold and perhaps much more than any other Department of government in the last several years. It would also appear that problems, changes and responsibilities for each of these three principal areas are not likely to diminish but are more likely to continue to increase in the next succeeding several years.

Public health has changed markedly since the passage of the Social Security Act in 1936, which established the federal-state partnership in public health. At that time formula grants were made available to support the state's basic public health program which was at that time relatively simple consisting principally of limited environmental health services, communicable disease control and services relating to maternal and child health. Knowledge and technique have expanded significantly over the years. Along with this expansion, new complexities have arisen in modern day public health because of the new problems of urbanization, of population expansion and of changed ways of financing health services through this federal-state relationship. The present pattern of federal financial participation in the cost of public health services seems incompatible with sound planning necessary to meet present day health needs and with logical and accountable methods of administration.

We agree thoroughly with the Association of State and Territorial Health Officers suggestion that there is a need to provide for grants to states which would enable each state to conduct comprehensive community health studies in order to develop meaningful statewide health plans. Serious deficiencies presently exist in many of our community health activities. Duplication, overlapping and gaps arise, in large part, from a somewhat haphazard development of programs and agencies which development can often be traced to the proliferation by the federal authorities of the project grant concept. There would appear to be need to review more thoroughly the federal fiscal concepts, currently effective and being proposed now as they relate to the allocation of federal funds to the states and to the matching requirements of the states.

Our greatest single problem with respect to grants received from the federal public health service has been the marked deterioration of the emphasis on categorical or formula grants and the inordinate emphasis being placed by federal authorities on project grants. Formula grants permit flexibility in state operation. They permit the federal support monies to be used in a manner judged most necessary by the state commissioner in accordance with the total program plan of the Governor. Formula grants are not designed as short term grants and they cause fewer administrative problems such as recruitment, return of equipment to the federal government, etc. Project grants on the other hand are looked at as shorter term grants and do cause administrative and program problems. The basic problem that must be considered is one of achieving a better balance between categorical or formula grants and project grants. Categorical or formula grants need to be increased to provide necessary greater flexibility and dependability of basic support. Project grants should be continued for appropriate experimentation, demonstration and stimulation of new programs but through fewer but broader systems and categories.

It is highly important and it is in the national interest that the federal government assume a share of the cost of supporting the full range of health services as properly identified and as indicated in approved state health plans.

We have heard much lately of suggested changes in public health grant legislation to be effective July 1, 1967. We are concerned that these suggested changes may ignore the realities of health needs of today.

The proposed elimination of the basic general health formula grant destroys the very basic concept of the federal-state cost sharing to meet the basic health needs of local communities. It takes away from the state flexibility and basic support.

We are also concerned with proposed new mechanics for allotting certain public health funds to the states. The fundamental concept of need as measured in per capita wealth was true and necessary in 1935 but it has little or no connection with health problems today. The big needs and worst health indices are in the big cities. This fact seems to be completely ignored in the proposals that we have heard about. We wonder if density of population or percentage of urban areas should not be factors to be considered in any allocation formula. Better still would be factors measuring major health problems such as infant mortality or tuberculosis morbidity. To ignore these factors would seem to ignore the reality of health in this country today. In our judgment, the rural areas are not now the areas of most urgent health needs as was true in 1935. Almost all of today's indices of health needs point to urban areas and old cities. Currently proposed formula mechanics indicate that the so-called "richer states" will be dealt with even more severely, much more so than in any past basic public health service equalization concept or practice. There appears to be no credit given to those states who, with their own funds, have initiated and supported better and necessary public health services.

We are likewise concerned with the proposed variable matching requirements which again relate to the per capita wealth concept. Currently, we in New Jersey are required to match on a one to one basis. The proposed newer variable matching requirements would appear to require New Jersey in certain instances to provide two matching dollars for each federal public health dollar received. From the point of view of equity, New Jersey would do very poorly indeed since it would get the least allocation to start with and would have to match at the maximum amount. Variable matching can create serious problems for New Jersey particularly since our bigger cities are undergoing radical population changes bringing serious shifting and concentration of public health problems, with an accompanying increasing inability to pay for necessary and basic services.

These fiscal concepts currently proposed go beyond those which were established and were necessary during the depression years. They do not seem to face current health needs. The necessary concept of truly sharing by the federal and state governments the cost and needs of basic modern public health services appears to have been voided.

In conclusion, let me strongly emphasize that the State of New Jersey has enjoyed for the past several years and continues to enjoy and benefit from excellent relationships with the Public Health Service and the Food and Drug Administration, both at the Washington and at the Regional Office levels. Federal Regional Office people in New York City are able, available and effective. We believe there is a strong need for the continuance of such offices in the public health service organization.

I appreciate the opportunity given me to offer suggestions that we deem relevant to your study. We offer constructively.

Sincerely yours,

RICHARD J. HUGHES, *Governor.*

STATE OF NEW YORK,
EXECUTIVE CHAMBER,
Albany, N.Y., September 17, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for your letter of August twentieth detailing the activities of the Special Subcommittee on Investigations of the Committee on Interstate and Foreign Commerce conducting a study into the general organization, structure and activities of the Department of Health, Education, and Welfare.

In accordance with your letter I have asked the appropriate agencies of state government to address themselves to the problems mentioned in your letter and for them to forward whatever comments they may have on this subject directly to you. (See attachment A.)

With best wishes,

Sincerely,

NELSON A. ROCKEFELLER, *Governor.*

[Attachment A]

STATE OF NEW YORK,
DEPARTMENT OF HEALTH,
Albany, N.Y., October 15, 1965.

Hon. PAUL ROGERS,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Governor Rockefeller has asked me to comment on the relationship of our Department with the Department of Health, Education and Welfare.

Let me preface my comments by noting that our day to day working relationships with the Public Health Service and the Children's Bureau, the two arms of HEW with which we have constant contact, are excellent. We are continually impressed by the competency and cooperation of their staff and their willingness to work with us to meet the ever changing challenges of public need. Such problems as we encounter in our relationship are engendered by problems of policy and direction generated by the over-all character of public health activities.

As you know, the growing presence of Federal government in the public health field is a fairly recent development. The public health movement sprang originally from local responses to local health conditions. We had assumed that the state's primacy in public health was guaranteed by the Constitution. Article X, for example, reserves to the states all those powers not delegated to the Federal government. In 1911 the Supreme Court in discussing this provision said that among the powers remaining with the state are the powers to guard public morals, the public safety—and the public health.

But the Federal government has now assumed the authority, for example, to intervene at will within the states on matters of water and air pollution. Congress has delegated authority to Federal agencies to deal directly with local government and even private agencies in health related matters. The Community Health Services Program and the Antipoverty Program are two examples—one of which bears directly and the other indirectly on public health.

Those of us on the state level are not blind to the forces that have thrust the Federal government more deeply into public health. To a degree this has occurred, we admit, because some states have not acted forcefully—particularly in meeting the staggering burden of metropolitan problems.

But often this dilemma can be traced to the fact that the Federal government dominates the most yielding tax fields. State and local governments have been hard put to finance their services as their expenditures have skyrocketed from $26 billion to $64 billion in 11 years.

The Federal response, at least to the state's financial plight, has been to proliferate the grants-in-aid system. Categorical grants have burgeoned into a multiheaded Hydra that typifies the current disarray of grant assistance. Too often these grants are launched with immature enthusiasm which fades as fast as it flourished, leaving the states holding the pieces.

Every health officer has his horrible example of Federally instigated programs disfigured by a capricious Congressional cutback of funds. Or else we scramble feverishly to spend Federal largesse suddenly dumped in our laps.

Some months ago I testified before a Senate subcommittee on a bill amending the Federal immunization assistance program. This bill offers a microcosmic view of much that is wrong with the grant system. Among its provisions, the bill added measles to the vaccination program and slightly modified the age of children eligible. I urged the subcommittee to report the bill favorably. But at the same time I seriously questioned some of the underlying assumptions of the Federal program. If Washington wants to help states lift the level of immunity this is fine. But to dictate conditions down to the last detail stifles state initiative.

I objected strenuously to overcentralized control which absorbs our energies in paperwork designed to assure Federal auditors that no vaccine has found its way into ineligible children.

In New York State, on the other hand, if our localities decided to launch a new immunization program or any other reasonable health service, we'll provide 50 to 75 per cent state aid. And we dont' have to amend our Public Health Law to do so—because our law allows us to aid localities on a flexible, intelligent basis.

Another example is the program which emerged from the report of the President's Commission on Heart, Cancer and Stroke. Essentially this program calls for Federal grants to develop multipurpose regional complexes consisting of

medical schools, teaching hospitals and treatment centers tied into community diagnostic and treatment facilities.

Once again here is a generally laudable idea. But it was introduced with little attention to the complex machinery of health services already operating in the Nation. Soon after the program was announced the *New York Times* had this to say:

"The present mix of public and private medical facilities and services is already fantastically complex, and the vast scope of the Johnson program will make it more complicated still." This is a fair appraisal in my view.

The first imperative to any study looking toward reorganization of Federal health activities in relation to the states and localities is to derive a working philosophy that outlines the health responsibility at each of the three tiers of American government. A simple but workable philosophy is that each level of government should be allowed to do what it is capable of doing for itself. When a community's capacity or responsibility to deal with a health problem is exceeded, then it's time for the state to enter the scene. When the dimensions of a health problem surpass the state's competence we have a natural function for the Federal government.

Within this philosophical framework I see the Federal government functioning properly in four areas.

First, Federal agencies should do the health job that cuts across State borders—such as controlling interstate commerce in food and drugs and protecting one state from abuse or encroachment by another.

Second, the Federal government should set minimum nationwide public health standards. These standards would set a health base beneath which no American need live. But they would leave each state free to strive for higher health goals for its people.

Third, the Federal government should provide technical aid and leadership to states which seek this help. This assistance should be designed to encourage initiative and creativity.

Fourth, as long as the Federal government continues to be the top revenue raiser, it should continue to aid the states financially. In dispensing this aid I recommend that the Federal government require of each state a comprehensive health plan before providing Federal assistance. This plan would help Washington determine whether a state was addressing itself squarely to its problems or whether perhaps the state might need Federal guidance. All Federal grants for health whether awarded to official or private agencies should be at least reviewed by the state to determine how they fit within the state plan. Once its plan is approved and Federal funds awarded, the state should be allowed maximum freedom in moving from plan to action.

I know that many able minds are wrestling with the problem of providing Federal aid in ways that nourish creative vitality in state government. Last fall a plan was proposed which called for returning a share of the Federal government's brimming tax revenues to the states in largely unfettered block grants. The President was reported first as enthusiastic over the idea, but later the proposal seems to have been shelved. I hope the President will warm once again to this eminently sensible proposal.

I also value the constitutional interpretation of public health as a power reserved to the states. I see this not so much as a state right, but as a state responsibiliy in four broad sectors:

First, to set, administer and enforce the public health laws;

Second, to lead the way through research, technical services to communities, training and by creating new programs to meet new health challenges;

Third, to aid by giving financial support for community health services;

And finally, to provide care by offering direct health services which localities cannot provide such as state hospitals, and also to provide local-type services where no local health agency exists.

I also accept the traditional position given the local health agency as the point where services are delivered.

Let me say, perhaps immodestly, that there is much in the relations between New York State and its communities that the Federal government might emulate in its dealings with the states. Our liberal state aid formula, for example, respects the intelligence and spurs the initiative of our local people.

Our State Health Department also continues vigorous and venturesome. The proof lies in the recent enactment of Governor Rockefeller's Pure Waters Program, passage of his recommended legislation implementing the Folsom Report, our air quality standards, PKU testing, medical audit, expanded rehabilitation

for children, our growing rehabilitation network, x-ray and laboratory licensing and the new bureaus of heart and chronic respiratory diseases, to list a few that stand out. In Albany our laboratories continue the research tradition that unmasked the Coxsackie virus and developed cardiolipin and Nystatin. In Roswell Park the work in tissue culture and virology are but the most heralded of several paths we pursue towards cancer's cause and cure.

What we ask the Federal government to do is recognize the value of creative state government as we continue these efforts. But New York is tarred to a degree by the same brush that paints state government generally as an outmoded device doomed to the museum of political science. The dilemma of an energetic state such as ours was recently described by an astute political reporter.

He referred to Governor Rockefeller's efforts to get a fairer share of Federal aid for our new water pollution program. This program, incidentally, offers an excellent opportunity for a true Federal partnership, since under it costs would be shared 30 per cent each by Federal and state government and 40 per cent by localities.

"The problem," this observer noted, "is that New York is asking to move much faster than most of the other states are willing to do. The pace of Federal cooperation in such things is not based on that of the initiator but on that of some informal consensus or average." New York, in other words, may be a step ahead of the nation, but it is simply out of step as far as Federal aid is concerned.

My criticism of Federal, state, local relationships is not based on a hollow attachment to the Federalism of a former time.

We need a vigorous and growing Federal health program with a sense of direction, not an over-active octopus throwing its tentacles in all directions simultaneously.

But over-centralization, particularly when administered by multiple competing agencies, wastes critical manpower just as the demands for that manpower are growing.

In state and local public health agencies shortages of 20 to 50 per cent of certain professional skills plague us.

Yet we are confronted with Federal encroachment that threatens more bureaucracy, more duplication and more fragmented health programs absorbing personnel in Federal paperwork positions, while state and local agencies lack trained professionals to perform actual health services.

While an affluent society can perhaps afford inefficient application of labor in many areas, we cannot do so in the area of health.

We are all drawing on the same pool of manpower, and that pool is already unable to fill the demand.

From an organizational standpoint there is imperative need to consolidate Federal health agencies into a single department. This is necessary in order to give effective assistance to the Executive and Congress in formulating a consistent National health policy and to effect efficient administration.

Of the existing agencies, the Public Health Service is the logical choice for delegation of the responsibilities in health now carried by the other agencies of Health, Education, and Welfare. It is to be emphasized that medical research and control of environmental pollution are essential parts of public health protection. The Public Health Service has demonstrated its competence through many decades. With vigorous leadership from Doctor Stewart and adequate support from the Executive and Congress, the Public Health Service could lead the country's health effort in a most exemplary fashion.

Sincerely yours,

HOLLIS S. INGRAHAM, M.D.,
Commissioner of Health.

STATE OF NORTH CAROLINA,
GOVERNOR'S OFFICE,
Raleigh, N.C., August 27, 1965.

Hon. PAUL G. ROGERS,
U.S. Congress,
Washington, D.C.

DEAR CONGRESSMAN: Thank you for your letter concerning the study being conducted on the organization, structure and activities of the Department of Health, Education, and Welfare. I appreciate having this information, and I will be happy to cooperate in anyway possible.

I am taking this matter up with several State officials for their opinions.
With best wishes, I am,
Sincerely,

DAN MOORE, *Governor.*

STATE OF OHIO,
OFFICE OF THE GOVERNOR,
Columbus, Ohio, August 31, 1965.

Hon. PAUL G. ROGERS,
Member of Congress,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: I appreciate your recent letter informing me of the formation of a Special Subcommittee on Investigations of the House Committee on Interstate and Foreign Commerce for purposes of conducting a study of the Department of Health, Education and Welfare.

In accordance with your request, I am forwarding copies of your letter and the enclosed statement by the Honorable Oren Harris, Chairman of the Committee, to Dr. E. E. Holt, Superintendent of the Department of Education, Dr. Emmett Arnold, Director of the Department of Health and Mr. Denver White, Director of the Department of Public Welfare, for their information.

With kindest regards,
Sincerely,

JAMES A. RHODES, *Governor.*

THE UNIVERSITY OF OKLAHOMA MEDICAL CENTER,
Oklahoma City, Okla., August 31, 1965.

Hon. PAUL G. ROGERS,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: The Honorable Henry Bellmon, Governor of the State of Oklahoma, has asked that I respond to your letter of August 20, 1965, in which you requested comments on the organization, structure, and activities of the Department of Health, Education, and Welfare.

I am delighted to see that your Special Sub–Committee is going to study the myriad problems relating to the unprecedented growth in the Department of H.E.W. I shall address my remarks, primarily to the public health programs. In the first draft of this letter I found I had written thirteen pages that never really touched the core of the fundamental problem. I have thrown them away and will, as succinctly as possible, outline what I feel is the heart of the matter.

A. "FORCES" THAT HAVE GENERATED THE "DRIVE" FOR THE ESTABLISHMENT OF NEW HEALTH PROGRAMS

(1) A burgeoning population, (2) a changing social economy, (3) a shortage and maldistribution of health science personnel, (4) an explosion of technical knowledge, (5) evolvement of health science and health needs as political instruments attractive to a knowledgeable and demanding public.

B. RESPONSES TO "FORCES" GENERATING NEW HEALTH PROGRAMS

(1) An explosion of government sponsored health programs that represent "fragments" of a total need without adequately relating them to overall need. The programs have evolved in response to group pressures. Although well meaning, these pressures have presented components of emotion, bias, politics, and opportunism.

C. RESULT

(1) The development of a confused "disorganization", with programs divided and sub-divided among competing bureaus and agencies at both national and state levels. (2) A serious schism between organized American medicine, public agencies, and academic centers—all vital to health science and health services, hence, the loss of effectively coordinated efforts essential to any successful national health program. (3) Serious imbalances in health programs; e.g. research emphasis (though superbly excellent in itself) is now out of balance with

health education. Another example, mental health programs, set up in areas that have inadequate accessibility to the basic medical services, etc. (4) An increasing dilution of an already diluted and maldistributed health science personnel manpower pool. Our new programs attack one problem and create new ones.

D. WHAT NEEDS TO BE DONE

(*1*) *Return to fundamentals*

Health services are "people", very special people with special education, training, and skills. The very essence of any health program is the availability of appropriately trained personnel. To launch new programs without a primary consideration of the impact on overall personnel needs is irresponsible and dangerous.

(*2*) *Develop a long range master plan*

One that defines national goals, organization structure, realistically evaluates fiscal and manpower resources available, as well as, those that must be developed and based on the *overall needs* of our people rather than a response to isolated crisis and pressures.

Comment.—It is almost inconceivable that an intelligent national leadership could sponsor the proliferation of newly sponsored health programs without recognizing the dangerous impact that is made on an already inadequate health science manpower pool. These people must be produced and their genesis is primarily dependent on our academic medical centers (The University Medical School-Health Science Complex). The Medical Centers, in turn, have not faced up to their medical social responsibility; i.e., to develop programs of manpower production based on society's needs, rather than geared to whatever money for sponsored programs happens to be available.

In summary, there has been no coordinated health planning based on total needs, and no recognition of the basic requirement for all medical sciences, i.e., the production of the numbers and kinds of health personnel required to meet the needs.

It is important that planning not become rigid and unilateral. We need a blue chip national health planning commission that incorporates the best minds of organized medicine (including the A.M.A.) the organized allied health services (nursing, etc.), the Public Health Service and the American Medical Colleges. Representatives from these groups should drop their "union" interests in the national interest and they should initiate a long master plan that will be based on surveys of what we have, what we do not have, and finally, what we need, region by region. Before any new major health program is activated there should be assurance that the necessary and appropriate manpower is going to be produced and available, without depleting other needed health services. Basic to all of this is the immediate need to support the production (education and training) of health science personnel in a manner that is realistic.

If we continue to ignore these fundamentals we will have chaotic, inadequate, and low quality health programs across the board. No one wants this, I am sure.

Thank you for the opportunity to discuss this vital question. Medical school "Deans" must become involved and concerned, for the future of medical-health-education is at stake, as is the future manpower pool of medical health science personnel.

Sincerely yours,

JAMES L. DENNIS, M.D.,
Director and Dean.

STATE OF OKLAHOMA,
VOCATIONAL REHABILITATION DIVISION,
STATE BOARD FOR VOCATIONAL EDUCATION,
Oklahoma City, Okla., September 1, 1965.

Hon. HENRY BELLMON,
Governor, State Capitol,
Oklahoma City, Okla.

DEAR GOVERNOR BELLMON: We have had an opportunity to study the letter you received from Congressman Paul G. Rogers, Chairman of the Subcommittee on Health, Education, and Welfare Investigation, regarding the relationship of this Agency with the Department of Health, Education, and Welfare, and the HEW

Regional Offices, the Bureau of State Services, the National Institutes of Health, and the Food and Drug Administration.

Our relationship with these Agencies has been excellent. We have had the very best of cooperation from the Department of Health, Education, and Welfare, and the HEW Regional Offices. We have very little or no business with the other agencies.

Sincerely yours,

LOWELL E. GREEN,
Director, Vocational Rehabilitation Division.

STATE OF OKLAHOMA,
DEPARTMENT OF MENTAL HEALTH,
Oklahoma City, Okla., September 10, 1965.

Re your letter of August 20, 1965, to Governor Henry Bellmon.

Hon. PAUL G. ROGERS,
Congress of the United States,
House of Representatives,
Subcommittee on HEW Investigation,
Washington, D.C.

DEAR MR. ROGERS: During the past two years this Department has received a total of seven Federal Grants in order to institute hospital improvement programs, in-service training for personnel within the hospital and a project designed to test the effectiveness of a structured community aftercare program. These grants have allowed this Department to structure demonstration programs in such areas as resocialization of the chronic schizophrenic patient, the geriatric patient and community aftercare. There can be no doubt that they have allowed us to begin new programs at our hospitals and in our communities that might not have been possible otherwise.

Our relationship with the National Institutes of Health, both at the national level and through the regional offices, has been excellent. Professional consultation has been of the highest caliber and their primary concern has been to make certain that programs are carried out and monies spent in accordance with the outlines of the approved projects.

Sincerely yours,

ALBERT J. GLASS, *Director.*

OFFICE OF THE GOVERNOR,
STATE CAPITOL,
Salem, Oreg., October 14, 1965.

Hon. PAUL G. ROGERS,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: In the course of the review by your Subcommittee on HEW Investigation, you requested comments from me about the federal-state relationships in the sphere of health activities. I, in turn, have asked for the comments of the state agencies most immediately affected.

I am forwarding herewith copies of each of the replies. (See attachments A–H.) They seem to be fair and objective and in accord with my own observations.

Sincerely,

MARK O. HATFIELD, *Governor.*

[Attachment A]

STATE OF OREGON,
STATE PUBLIC WELFARE COMMISSION,
Salem, Oreg., September 14, 1965.

Mr. FREEMAN HOLMER,
Director, Department of Finance and Administration,
Salem, Oreg.

DEAR MR. HOLMER: The following are our comments on the Public Health Service of the Department of Health, Education, and Welfare:

"We believe that Public Health Service should take more leadership in requiring certain minimum standards for the services provided by state and local

health departments, comparable to the standards set by the Welfare Administration of the HEW for welfare programs of the states.

"Federal requirements should include provision of immunizations for all low-income families, sanitation enforcement, and population control as part of the basic public health program for all counties in all states. Services beyond this minimum program could well include provision of dental services and drugs for those who cannot afford to obtain them from private sources.

"We believe that present public health programs place too much emphasis on remedial care and not enough on prevention. We believe the Public Health Service should work closely with the Welfare Administration on a Federal level in order to facilitate closer cooperation between public welfare and public health on state levels with a broad diagnostic program freely available to the entire low-income population. Many disabling diseases might be caught and treated before becoming so severe that the patient becomes unemployable and has to turn to public welfare for support."

Our agency has virtually no direct contact with public health officials at the Federal level. We therefore are not in a position to comment on the functioning of the Federal Health Service other than in terms of the leadership we believe is needed to make state programs more effective.

Sincerely,

ANDREW F. JURAS, *Administrator.*

[Attachment B]

OREGON MENTAL HEALTH DIVISION

SEPTEMBER 23, 1965.

Memorandum to: Mr. Freeman Holmer, Director, Department of Finance and Administration.
From: J. H. Treleaven, M.D., Administrator.
Subject: Congressional Study of Federal Organization.

I am replying to your letter of September 7 concerning the Congressional Study of Federal Organization.

Our relationship with the Regional Office of the Department of Health, Education, and Welfare is excellent. The consultants serving Oregon, either on a regular basis or for specific projects, have always been most helpful and competent. Our experience is primarily with the National Institute of Mental Health Section, although we have had some contact with the Chronic Diseases Division of the U.S. Public Health Service, and the Hospital and Facilities Construction Section.

We do note, however, a fragmentation of program responsibility, both in the regional and national offices of the Department of Health, Education, and Welfare. This seems to be posing increasing problems as federal activity in health and welfare programs has greatly increased. An example is to be found in the federal mental retardation program. Part of our program is administered through the Children's Bureau, part through the Chronic Diseases Division, and part through the Hospital and Facilities Construction Section. As a consequence, it is difficult for us to coordinate our state program. Each of the federal funds programs is set up independently by the Board of Health, the Crippled Children's Division, and the Welfare Commission. At times, their philosophies behind these programs seem to be in some contradiction, or there is lack of coordination.

Another problem arises from the tendency of each component of the Department of Health, Education, and Welfare to establish its own rules, regulations, policies, procedures, forms, manuals, etc., governing the submission and administration of grants. This results in increasing complexity in the state agency's management of its grants program.

There appears to be an increasing tendency on the part of some federal agencies to direct service programs through federal grants, reducing state autonomy and decision-making with regard to program content and program operation at the local level. The most clear-cut example of this, in my mind, is the Community Mental Health Clinic grant program under P.L. 88-164. Here we see the National Institute of Mental Health attempting to promote, through construction and staffing grants, a concept of mental health service which is yet untried and unproven and which, in spite of its apparent theoretical promise, might be quite

impractical for many areas of the nation such as our state. This concept has tied up most of the federal agency energies and funds in the mental health field.

It is my firm opinion that a much more successful utilization of this money could be obtained by simply increasing the grants to states for general mental health services and letting each state devise that program which is more appropriate to its population distribution, professional resources, and mental health needs.

[Attachment C]

OREGON STATE SYSTEM OF HIGHER EDUCATION,
OFFICE OF THE CHANCELLOR,
Eugene, Oreg., October 2, 1965.

Mr. FREEMAN HOLMER,
Director, Department of Finance and Administration,
State Capitol Building,
Salem, Oreg.

DEAR FREEMAN: This letter is in response to yours of September 7, 1965, in which you asked for comments in response to a recent request for information from the Congressional Committee on Interstate and Foreign Commerce. The information you requested is concerned with relationships of the institutions in the Oregon State System of Higher Education with the U.S. Department of Health, Education and Welfare, particularly with those divisions of HEW concerned with public health. I have requested that each of the institutions in the State System which has frequent relationships with HEW provide a report of relationships with the different agencies of HEW, particularly those concerned with public health.

I believe the most useful report which I can provide is to furnish you with the replies received from the institutions. Accordingly, I am enclosing the comments which I have received from the University of Oregon, Oregon State University, and the University of Oregon Medical School. These three institutions have the greatest volume of contract projects with HEW agencies.

In general, I believe you will note from the enclosed reports from the institutions that their relationships with HEW agencies are satisfactory and that they have had a high degree of cooperation from those agencies. You will note also that there is some dissatisfaction resulting from the fact that the federal government's fiscal year and the dates upon which federal funds become available do not fit satisfactorily with the academic year of the higher education institutions; also that in some instances there appears to be a need for better arrangements between some of the individual HEW agencies where our institutions have projects and programs which cross the lines of two or more of the HEW agencies. A few other difficulties have been encountered as indicated in the attached institutional reports. Some of these difficulties seem to arise from general federal policies in financing and overseeing projects rather than with the individual agencies of the HEW.

My conclusion is that over-all our relationships with the various divisions of HEW have been satisfactory and most helpful to the carrying out of many important programs in teaching and research. If you have questions, I shall be most happy to discuss them with you.

Cordially yours,

R. E. LIEUALLEN, *Chancellor.*

[Attachment D]

UNIVERSITY OF OREGON,
Eugene, Oreg., September 29, 1965.

Memorandum for Chancellor Lieuallen:

I am responding to your letter of September 16 in which you ask for the comments of the University concerning our relationships with the agencies of the U.S. Department of Health, Education, and Welfare.

I asked Dean Alpert to solicit views from the various offices and departments of the University having the closest relationships with the Department. He and Jerry Kieffer have drafted the attached memorandum which I think is responsive to your request.

If I can be of further help, please let me know.

ARTHUR S. FLEMMING, *President.*

UNIVERSITY RELATIONSHIPS WITH THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Set forth is a summarization of views from members of our faculty and staff concerning University relationships with the various agencies of Health, Education, and Welfare. The following general comments seem appropriate.

(1) Overall, the University appears to have very broad and extensive relationships with the Department. In addition to a variety of advisory roles which members of our faculty perform for the Department and its agencies, the University is participating in an extensive and growing volume of grants and contracts. Heaviest involvement has been with the Office of Education in its many programs. In addition, the Public Health Service and, in particular, the National Institutes of Health, have provided members of our faculty with extensive resources. We also have a long history of experience with contracts and grants with the Vocational Rehabilitation Administration. Some of our Chemistry staff have had occasional relationships with the Food and Drug Administration. Finally, the University has been given extensive help by the Office of Education and by the Public Health Service in the development of academic structures, laboratories, and in their proper equipment.

(2) There is a striking amount of agreement among our faculty and staff that the University enjoys a very cordial and constructive relationship with the Department and its various agencies. Even where suggestions and criticisms were offered, they were directed mostly at broad practices and requirements of the Federal Government rather than at specific difficulties with the agencies staffs and their particular practices and procedures. Our staff comments included frequent references to the helpful, efficient, and competent performance of duty by those Health, Education, and Welfare personnel with whom they had dealt. They were particularly pleased with the refreshing amount of openmindedness, understanding, and flexibility found among such personnel.

(3) Our staff is highly impressed by the soundness of the procedures used in making grants and contracts, fellowships and so forth. The screening procedures, the advisory systems, and site visits have all been conducted with considerable efficiency and fairness.

(4) The most common problems experienced by our staff relate to the lack of synchronization between what might be called Federal Government's budget cycle and the University's academic year. The problem is simply that the academic year and the Federal fiscal year are not harmonious. Federal agencies run out of grant and contract money toward the end of the spring and are left in a state of near indecision or inaction well into the late summer. This means that firm commitments cannot be given on contracts and grants. The University programs cannot proceed with recruiting and with equipment purchases until the fall since most academic staff who might be brought into work on such grants and contracts are not available until the following June. Staff already in residence cannot be easily moved about at that late date, grant and contract work often is effectively delayed, graduate assistants cannot be given firm offers, and work cannot be soundly programmed.

Another line of complaint which also is not directed at Health, Education, and Welfare but to Federal policies in general relates to the need for a more liberal patent policy. Some of the staff feel that the Government's "take all" patent policy has seriously reduced productive collaboration between the University scientists and industry. Staff members urge a less restrictive patent policy which would allow discoveries in the field of health to be handled on the basis as discoveries made under government-supported research in other areas such as rockets, atomic energy, agriculture, etc.

(5) Some of the HEW agencies, for internal reasons not entirely clear to our staff, seem to have difficulty expediting the formal approval of contracts. Even though informal HEW staff approval is given to contracts, formal contract approval has been delayed as much as 60 to 90 days. Moreover, under federal regulations, formal actions under contracts cannot proceed until the contractors have exchanged formal agreements. This means that authority does not exist in advance of such an exchange to buy equipment and make firm hiring commitments. Suggestions have been made that the Federal Government adopt some kind of interim letter of intent which would free the recipient of the contract to make certain commitments pending the final approval of contracts where the broad terms are in general agreement between the parties.

(6) Although most of the broad program relationships between University staff and the agencies of HEW have been with the headquarters offices of these

agencies in Washington, a growing amount of contact is evident with the Federal field offices. Field office staffs have been helpful in supplying program information, identifying persons in Washington who could clear up the problems, and in forwarding back to Washington policy problems or other obstacles needing resolution.

We have noted that HEW's Regional offices have experienced some difficulties in keeping fully staffed because of extensive reorganizations, particularly in the U.S. Office of Education headquarters. We assume this to be a temporary problem which will be resolved in the course of the next year.

Relationships with the HEW Regional office and with its director have been exceptionally good. A most friendly and cooperative relationship has been maintained with the Regional Director over the past years.

JAROLD A. KIEFFER,
Assistant to the President.
HARRY ALPERT,
Dean of Faculties.

[Attachment E]

UNIVERSITY OF OREGON MEDICAL SCHOOL,
OFFICE OF THE ASSOCIATE DEAN FOR BUSINESS AFFAIRS,
Portland, Oreg., September 24, 1965.

Chancellor R. E. LIEUALLEN,
State System of Higher Education,
Eugene, Oreg.

DEAR CHANCELLOR LIEUALLEN: In Dean Baird's absence I am replying to your letter of September 16 relative to the request from Governor Hatfield concerning our relationships with agencies of the U.S. Department of Health, Education and Welfare.

As you may know, the agency of HEW with which we have any major contact is the National Institutes of Health. The bulk of our grants for research and training is made by this agency. We also have a few grants from the Bureau of State Services. Our relationship with both of these agencies is that of an applicant for grant funds. This requires a rather close relationship with the particular institute involved in the administration of grant funds which are received.

We have been impressed by the system which the NIH uses in considering applications and making awards, and in our opinion their policies, rules and regulations with respect to grants are adequate, fair and reasonable. For example, the procedures involving NIH grants are less restrictive and burdensome than those required by other governmental agencies with which we have contractual research projects such as the Army and Navy grants. In our dealings with the various officials of the NIH we have found that they have always been receptive to suggestions and have been willing to provide adequate time for the discussion and consideration of problems presented to them. We do not believe that any undue control is exercised by them in the administration of grant funds.

Other than the two agencies listed, the NIH and Bureau of State Services, the Medical School has had no dealings with other agencies of HEW.

Very truly yours,

W. A. ZIMMERMAN,
Associate Dean for Business Affairs.

NOTE.—The National Institutes of Health referred to above is a division of the Public Health Service of HEW.

[Attachment F]

OREGON STATE UNIVERSITY,
OFFICE OF THE PRESIDENT,
Corvallis, Oreg., September 24, 1965.

Chancellor R. E. LIEUALLEN,
State System of Higher Education,
Eugene, Oreg.

DEAR CHANCELLOR LIEUALLEN: Transmitted herewith are comments from Oregon State University regarding our relationships with divisions of the U.S. Department of Health, Education, and Welfare.

A. NEW REGIONAL OFFICES

Relationships with the Regional Office primarily concern acquisition of Surplus Property. Procedures and requirements of the Regional Office have posed no major problems. Annual visitations are made by representatives of the Regional Office. Opportunity is thus afforded to maintain a close working relationship and better understanding.

B. BUREAU OF STATE SERVICES

Oregon State University has received several research and training grants through the Bureau of State Services. These grants have been in both the environmental health areas and the community health areas.

There appears to be a conflict between the programs of the National Institutes of Health and the Bureau of State Services programs. It appears the Public Health Service should make an effort to coordinate the program of the Bureau of State Services with the various National Institutes of Health programs. The Bureau of State Services is reluctant to accept applications dealing with water pollution or air pollution problems since the National Institutes dealing with these problems also have programs in this area. The Bureau of State Services programs involve environmental science; however, it is impossible at the University level to clearly separate programs dealing with air and water resources from other environmental problems, since water and air are obviously a part of our environment. Recently Oregon State University submitted a comprehensive proposal dealing with environmental engineering. Since the program proposed is about 40 percent in the water pollution area, the Bureau of State Services suggested that the application be withdrawn to avoid complications with other divisions. To summarize, it would appear that effort should be made by the Public Health Service to have its various divisions support the appropriate portion of worthwhile proposals.

The discussion of administration of these grants follows under the National Institutes of Health. Administration problems are similar for all Public Health Service grants.

C. NATIONAL INSTITUTES OF HEALTH

Oregon State University has received substantial research support from divisions of the National Institutes of Health. These grants have had a beneficial effect in strengthening our graduate instructional and research programs.

The review procedure by a study section of institutional proposals seems to be the fairest and most objective method used by any Federal grant agency. The only shortcoming is that of time factor. It may be as long as seven months after submission before the investigator is advised of the status of his grant.

Oregon State University relationship with regard to administration of grants has been excellent. To date no problems have developed. We do believe, however, that the National Institutes of Health's administration procedures could be simplified in both the areas of construction and research grants. The institutions need more flexibility in expenditure of funds. The matter of equipment and travel requirements can best be determined by the institutions themselves. Present procedures of the National Institutes of Health require prior approval before travel funds can be increased, and when purchases of equipment involve a cost of over one thousand dollars.

D. FOOD AND DRUG ADMINISTRATION

Oregon State University has one contract on a cost reimbursement basis with the Food and Drug Administration. This contract resulted from a proposal which was solicited by the Food and Drug Administration for a specialized study. Our relationship with this organization has been very satisfactory from the standpoint of review of proposal and administration of contract.

E. OTHER AGENCIES OF HEW

Oregon State University has not been directly involved with other programs of other agencies of HEW.

Sincerely,

M. POPOVICH,
Dean of Administration.

[Attachment G]

OREGON STATE BOARD OF HEALTH

When we consider the relationships of the Oregon State Board of Health with the U.S. Department of Health, Education and Welfare, it is apparent that changes in direction should be considered. This may be summarized by an opinion that considerable benefit would accrue by dividing the Department of Health, Education and Welfare, creating thereby a Federal Department of Health. Such a Department could combine the many splintered health functions now scattered throughout other Federal agencies. This action could be of substantial benefit to Oregon and other states, since the efficiency of having only one Federal agency to deal with in matters pertaining to health is immediately apparent.

We further believe that such a centralized health agency could achieve more effective coordination and planning on both the Federal and state level. Grants-in-aid methods and research projects would improve under the more unified direction and evaluation.

At present there appears to be an increasing trend to bypass state agencies. We observe Federal agencies allocating projects directly to local governmental and voluntary agencies without full consideration of other and similar state activities in the same areas of interest. This can and does result in confusing local situations in which local resources are not effectively utilized.

Relationships with the Children's Bureau and the Public Health Service have been close and satisfactory, except in those areas where the state agency has been bypassed, and in the field of Water Pollution Control.

The Public Health Service has had increasing responsibilities for enforcement in the area of Water Pollution Control in the last four years. This has resulted in what may be termed an attitude of competition with state authorities. Instead of assisting states in carrying out enforcement programs, the tendency is to suppress or supplant the state program. This may be justified in states without effective intent or abilities, but in states having operating programs for abatement of pollution, their efforts should have whole-hearted Federal support and cooperation. Such an increase in cooperation and coordinated programs would achieve greater progress in abatement programs. Surely the interest in the drinking water supplies of the nation exists completely in the field of the health sciences.

[Attachment H]

STATE OF OREGON, INTEROFFICE MEMO

OCTOBER 12, 1965.

To: Mr. Freeman Holmer, Director, Department of Finance and Administration.
From: Willard Bear, Assistant Superintendent, State Department of Education.
Subject: Congressional Study of Federal Organization.

Doctor Minear has referred to me your request for comments pertaining to Paul Rogers' study of HEW. I have discussed the contents of Mr. Rogers' letter with other division heads of this Department and find no basis for comment inasmuch as we have little direct contact with the public health service of HEW.

COMMONWEALTH OF PENNSYLVANIA,
GOVERNOR'S OFFICE,
Harrisburg, Pa., September 1, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
U.S. House of Representatives,
Washington, D.C.

DEAR PAUL: I am much interested in the study of the Department of Health, Education, and Welfare, which your special Subcommittee is undertaking, and can assure you that we will do everything possible to cooperate.

Because several of our departments and other agencies are closely related to the activities of the Department of Health, Education, and Welfare, I believe that we could best provide the information you want from them by coordinating their replies through our Council for Human Services. This is an interdepartmental Council created early in this Administration to better co-

ordinate the activities of all State agencies involved in rendering direct services to people. Its membership is made up of the agency heads, and its Chairman is Secretary Arlin Adams of the Department of Public Welfare.

I am referring your letter to Secretary Adams, suggesting that he employ the staff and facilities of the Council to make available to you as promptly as possible the information and comments you have requested. (See attachment A.) Should it then seem appropriate, I will supplement these with my personal observations.

Let me wish you every success in the carrying out of this study, which I feel certain will be of interest and benefit to all of us who work with and are affected by the Department of Health, Education and Welfare.

Most sincerely,

WILLIAM W. SCRANTON, *Governor.*

[Attachment A]

OCTOBER 14, 1965.

Subject: Reply to Congressman Rogers Concerning Health Activities in the Department of Health, Education, and Welfare.

To: Hon. William W. Scranton, Governor.

From: C. L. Wilbar, Jr., M.D., Secretary of Health.

Secretary Adams has sent me a copy of the letter written to you by Congressman Paul G. Rogers, Chairman of the Subcommittee on HEW Investigation, in which he asks you for comments concerning the administration of the health aspects of the Department of Health, Education, and Welfare and their relationship with the states. Mr. Rogers suggested that you would want to hear from your "appropriate state agencies" particularly as to what these agencies feel regarding their relationship with HEW, especially the Regional Offices, the Bureau of State Services, the National Institutes of Health and the Food and Drug Administration.

As you are well aware, there has been a tremendous acceleration of federal expenditures, mainly through the HEW department, for health purposes since the end of World War II. Probably the largest increase has been expenditures for the National Institutes of Health which has risen from a very small appropriation to the expenditure of nearly a billion dollars a year. However, there have been great increases also in money spent in the Bureau of State Services and in the Food and Drug Administration. Also in recent years there has been a major tendency to appropriate large sums of money for newer health projects administered in entirely new channels. The most recent example is the bill on heart, cancer and stroke, which appropriates $50 million the first year, $90 million the second year and $200 million the third year for regional cooperative enterprises. This came directly on the heels of major changes in the Social Security Act in connection with health care for the elderly and others.

The tendency to continuously splinter health administration, such as removal of water pollution activities from the Public Health Service and even set up new agencies outside of HEW to administer health aspects of federal law such as the Office of Economic Opportunity and the Appalichia Office, has made planning, coordination and thoroughness of administration in the public health areas precarious.

There has also been a considerable tendency to use project grants rather than program grants to state and local communities and to have such grants go directly from the federal government to a local agency which may or may not be a governmental agency, with little or no coordination or planning on the part of the states. This trend has helped to channel more funds into the urban areas, which is probably needed, particularly in some states, but has led to a very haphazard type of planning and has caused a spotty meeting of some of the major health problems.

In my opinion, the Regional Offices of the Department of HEW have valiantly attempted to be helpful to state and local communities. However, they are understaffed and too, are overwhelmed by the tendency to splinter administration at the federal level and to break down grant money into a multitude of individual relatively small projects. Thus, the Regional Offices have become, to a large degree, channeling devices and program reviewers with little time for aid in planning and organizing health departments.

The National Institutes of Health have such a large number of requests for grants that they must have many reviewing committees consisting of persons

who are not employees of the Public Health Service, but serve on a part-time basis. Most of these reviewing committees are made up of university-oriented and clinical or basic science-oriented persons. Consequently, non-university organizations, such as hospitals or health departments, have been given little attention as far as research grants are concerned and the badly needed applied and methodology type of research receives little attention from the National Institutes of Health. This is research concerned with obtaining popular application of the findings of clinical and basic scientific research. The very size of the appropriation along with its multiphased activities has tended to separate the National Institutes of Health from the rest of the Public Health Service. I believe this is unfortunate and a closer guidance by persons with a more comprehensive viewpoint of health needs, resources and management is highly desirable.

While the Food and Drug Administration has been friendly to the states, it has tended to make determinations on a national basis without much mutual planning and discussion with state counterparts. Much of the activities in this field needs to be federally determined, in my opinion. Nevertheless, determination of needs and carrying out of determined standards administratively in the field of drug, devices and cosmetics control are largely done, in this state as in a number of others, by state government. Thus, intimate mutual planning is very necessary.

The Bureau of State Services has, over the years, shown a sympathetic understanding of state needs and problems with a desire to work cooperatively with state health departments and other state agencies administering health programs. The staff of this Bureau has been definitely limited compared with the staff of the National Institutes of Health. In this regard, it must be kept in mind that in spite of the growing magnitude of federal funds in the health field, it is still true that much more health activities are administered by state and local government than by the federal government. State governments now employ about seven and a half million employees compared with two and a half million federal employees.

There has been a tendency for more and more federal aid toward training qualified health people and to some extent toward helping to recruit people into the health sciences. In spite of this aid, the ratio of qualified professional health people to population continues to decrease. Consequently, federal funds, investigation and consultation in this area of training of health manpower is one of the greatest areas needing acceleration in my opinion.

In regard to specific reorganization, I cannot help but feel that the health field has become a large, complex and popular it should have a separate department in the United States Government. Most of the nations of the world have separate departments of health as have all but a few of the states of this country. At least, it would seem advisable to have all the health functions of the federal government incorporated into a major branch of the Public Health Service under a Deputy Secretary of Health, Education, and Welfare. The preventive aspects and treatment aspects of health need to be closely intertwined. The health of the body and mind can hardly be separated. Any one aspect of health is apt to effect all other aspects. Such a coordinated federal unit could and should, I believe, work closely and cooperatively in planning with the states and major local jurisdictions and agree on a coordinated and more effective federal spending pattern in the health field.

COMMONWEALTH OF PUERTO RICO,
OFFICE OF THE GOVERNOR,
La Fortaleza, San Juan, P.R., November 10, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Congress of the United States,
Washington, D.C.

DEAR REPRESENTATIVE ROGERS: I have given instructions to the Secretary of Health, Dr. Guillermo Arbona, so that he be in charge of submitting to you all the pertinent information related to the study about the Department of Health, Education and Welfare that your Subcommittee is conducting. (See attachment A.)

We will gladly give all our cooperation for the best outcome of this important study that is being done under your direction.

Sincerely yours,

ROBERTO SÁNCHEZ VILELLA.

[Attachment A]

COMMONWEALTH OF PUERTO RICO,
DEPARTMENT OF HEALTH,
San Juan, P.R., March 18, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation, House of Representatives, Congress of the United States, Washington, D.C.

DEAR CONGRESSMAN ROGERS: I am glad to include information asked by you to the Office of the Governor of Puerto Rico on relations between the federal agencies dealing with health matters in the Commonwealth of Puerto Rico and the Department of Health, Education and Welfare.

Sincerely,

FRANCISCO BERIÓ, M.D.,
Acting Secretary of Health.

Enclosure: Memorandum from the Secretary of Health to the Honorable Governor of Puerto Rico.

MARCH 9, 1966.

Memorandum to: The Governor.
From: Secretary of Health.
Subject: Relationships with the Department of Health, Education, and Welfare.

The Department of Health of the Commonwealth of Puerto Rico has relationships with several agencies within the Department of Health, Education, and Welfare. These relationships have to do with the administration of grant-in-aid funds, with consultantship services provide by the Department of Health, Education, and Welfare, and actual direct assistance under special circumstances.

The organizational units of the Department of Health, Education, and Welfare with which we have the closer relationships are:

1. The Public Health Service

Bureau of State Services.—We receive grant-in-aid funds for the following purposes: general health services, venereal disease control, tuberculosis control, heart disease control, cancer control, dental health, radiological health, water pollution, air pollution, hospital construction (Hill-Burton), mental retardation.

2. National Institutes of Health

Mental Health and grants for special research projects.

3. Welfare Administration

Grants for Public Assistance, Child Welfare, Child Health, and Title V of the Economic Opportunity Act.

Our experience with officers of these units within the Department of Health, Education, and Welfare have been extremely satisfactory. They have always been interested in helping us in every way possible. Thanks to these relationships we have been able to profit from grants in aid and research funds as well as from the technical and professional advice always available.

We feel that federally available assistance in consultation as well as funding can be greatly simplified and also that federal aid to the states can be more effective. Federal aid in most instances is earmarked for categorical purposes and regulations made so as to assure utilization for the very specific purpose that the law determines. There is no recognition to the fact that different jurisdictions, states, territories, and the Commonwealth of Puerto Rico are in different stages of development in health and welfare services and have different problems. Standards are incorporated in laws or regulations that may be relatively easy for the wealthier and more developed States to implement yet very difficult for other jurisdictions because of the scarcity of trained personnel and matching funds. They constitute a stimulus for the development of programs that although needed do not have a high priority in our plans. For example, we need to develop home health services. In our situation, however, home health care services do not have a high priority. We are still trying hard to develop ambulatory health center services, but there being federal funds available we probably will engage in the development of a home health care program. We could use the same monies much more profitably in health center service development, but can't. This is true in general, of other Health and Welfare grants.

I feel very strongly that assistance channeled from the Federal Government to the States through the Department of Health, Education, and Welfare could be much more effective if the assistance were made for general health and

welfare purposes rather than for specific or categoric purposes. I realize one of the intentions of the Federal Government is to have similar services available geographically. That, however, is very difficult. For instance, our average monthly payments in public assistance does not reach $11.50 a fraction of what it is in most States.

I feel that the federal aid could be much more effective if it were dependent on a jurisdiction plan designed on the basis of needs, and resources with priorities clearly identified. In this way a jurisdiction whose main problems are cardiovascular disease, cancer, and mental health would receive most of the assistance in developing these programs, while a jurisdiction where maternal and child health and communicable disease control are the main problems would receive most of the assistance in these areas.

The amount of the assistance to the jurisdictions would be determined as at present, in terms of population, per capita income, and some special factors as size of the problems, danger to other jurisdictions, etc.

GUILLERMO ARBONA, M.D.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
EXECUTIVE CHAMBER,
Providence, R.I., September 15, 1965.

Hon PAUL G. ROGERS,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for your letter regarding the study of your committee into the organization, structure and activities of the Department of Health, Education and Welfare.

I am pleased to enclose the comments of our Department Directors who have dealings with the Department of Health, Education and Welfare. (See attachments A–G.)

I hope these comments will be helpful to you and your committee.

Sincerely,

JOHN H. CHAFEE, *Governor.*

[Attachment A]

STATE OF RHODE ISLAND, INTERDEPARTMENTAL COMMUNICATION, SEPTEMBER 1, 1965

To: Mrs. Charlotte Gleeson.
Department: Executive.
From: Mr. Frederick C. Lees, Director.
Department: Natural Resources.
Subject: Comments concerning Department's relationship with the Federal Department of Health, Education, and Welfare.

The only direct contact the Department of Natural Resources has with the Federal Department of Health, Education and Welfare is in the field of policing of the taking and distribution of shellfish. Our relationship with the Regional Office, in Boston, has been extremely cooperative and the reports of HEW concerning our policing program have been excellent. The Department has made occasional suggestions on improvement of our methods for the taking of samples, etc., which we have accepted and followed.

Just recently a number of our Conservation Officers actively participated in a forum sponsored by HEW to improve the policing procedures of other states.

We receive information concerning Pesticide residue in foods and medicated feed for poultry and livestock from the Food and Drug Administration.

[Attachment B]

STATE OF RHODE ISLAND INTERDEPARTMENTAL COMMUNICATION, SEPTEMBER 2, 1965

To: Mrs. C. M. Gleeson.
Department: Executive.
From: Mr. Augustine W. Riccio, Director.
Department: Social Welfare.
Subject: Letter of August 20, 1965, to Governor Chafee from Paul G. Rogers, Chairman, Subcommittee on HEW Investigation.

With regard to the above request, letter attached, please be advised that our contacts with the Department of Health, Education, and Welfare are largely limited to the Welfare Administration. We have no contact with the Bureau of

State Services, the National Institutes of Health, and the Food and Drug Administration.

We do have contact with the Department of Health, Education, and Welfare Regional Offices of the Bureau of Family Services. Dr. Cannon's Department would be the Department that is mainly involved.

AUGUSTINE W. RICCO, *Director.*

[Attachment C]

STATE OF RHODE ISLAND, INTERDEPARTMENTAL COMMUNICATION

SEPTEMBER 7, 1965.

To: Mrs. C. M. Gleeson, Chief Clerk.
Department: Governor's Office.
From: Mr. John J. Hall, Director.
Department: Labor.
Subject: Comments on the letters from the House of Representatives to Governor Chafee regarding the Department of Health, Education, and Welfare.

I have checked with the chiefs of our various divisions and find that we do not have any direct contact with the Department of Health, Education and Welfare. While many of our activities border on the subjects handled by this Department we generally work through the State Departments of Health, Social Welfare and Education.

Most of our direct contacts with the federal government are with the U.S. Department of Labor.

[Attachment D]

STATE OF RHODE ISLAND, INTERDEPARTMENTAL COMMUNICATION

SEPTEMBER 8, 1965.

To: Mrs. C. M. Gleeson.
Department: Executive.
From: Frank A. Carter, Jr., Director.
Department: Employment Security.

This is in reply to your memorandum of August 30, asking for my comments on the request of Congressman Paul Rogers.

Over the years, the Department of Employment Security has had very few contacts with the Department of Health, Education and Welfare, none of which relate to Public Health responsibilities or the Food and Drug Administration.

Only recently, in order to carry out the mandates of the Manpower Development and Training Act, it has been necessary for this Department to consult with officials of the Regional Office of the Vocational Education Division of the Department of Health, Education and Welfare. In this regard, we have found the representatives of that Agency to be cooperative in assisting both this Agency and the State Department of Education in their joint responsibilities in achieving the objectives of the program.

Several years ago this Department cooperated with the United States Public Health Service in providing that Agency with data from the Temporary Disability Insurance records. This work was done on a contract basis and did not involve a great deal of close contact with individuals of the Federal Agency.

Because of these limited experiences with the Department of Health, Education and Welfare, I do not believe that we can make any substantive comment concerning the study of the organization, structure, and activities of that Federal Agency which obviously does not come within the purview of this Department.

[Attachment E]

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
DEPARTMENT OF EDUCATION,
Providence, R.I., September 8, 1965.

Mrs. CHARLOTTE M. GLEESON,
Chief Clerk, Office of the Governor,
State House, Providence, R.I.

DEAR MRS. GLEESON: On August 31 I received a communication from you requesting comment on a letter which Governor Chafee had received from Representative Paul G. Rogers of Florida.

I referred the letter to my Coordinator of School Health Programs, Leo J. Conley, Jr., for reply. Mr. Conley, on our staff since June, is public health trained and is the logical one to reply to such a request. His comments are attached. (See exhibit 1.)

Sincerely,

WILLIAM P. ROBINSON, Jr.,
Commissioner of Education.

[Exhibit 1]

COMMENTS OF COORDINATOR OF SCHOOL HEALTH PROGRAMS, RHODE ISLAND DEPARTMENT OF EDUCATION, RE 8/20/65 LETTER FROM CONGRESSMAN PAUL G. ROGERS TO GOVERNOR JOHN H. CHAFEE

"It is becoming increasingly evident that the possession of certain basic knowledge about health is essential if each individual is to take prompt advantage of the advances of medical science, protect himself against the hazards of medical quackery, and achieve for himself, his family, and his community an optimal level of health. Fundamental to the acquisition of such knowledge is a sound program of health instruction in the nation's schools since it is during childhood and adolescence that the process of acquiring correct health information and the development of proper health attitudes and practices must begin." [1] An obvious corollary to this statement is that the development of methods of health protection and the provision of services to ensure such protection are of considerably less consequence if the citizenry has not been schooled to avail itself of these safeguards.

If we are to have "a sound program of health instruction in the nation's schools" then a persistently high quality of leadership in this particular area must be had at the federal level within the Department of Health, Education and Welfare. Because of lack of such leadership, in this writer's opinion, American schools have not progressed far along the road of guiding their students toward "an optimal level of health." Health and safety misconceptions among our school children are alarming.[2, 3] Health defects among youngsters are numerous and varied.[4] A current review of a study of those recently registered for Selective Service shows that 11.3% of those examined were disqualified for medical reasons only.[5] Foremost of the implications of these facts and figures is that American education has not fulfilled one of its major and long-held objectives: [6] that of assisting the student, to the degree possible, to achieve improved physical and mental health.

Why have we not progressed more rapidly toward this goal? The reasons are legion and range far beyond the indictment of lack of effective national leadership. This writer's opinions concerning these reasons are shared by others.[7] Health education courses in teacher-training institutions are neither plentiful nor are they wholeheartedly recommended to the teacher-to-be as valuable adjuncts for the necessary fulfillment of his task. Health instruction has never had the status, say, of the "3 R's." [8] In the main, inadequate time segments are provided for health teaching, per se, in the elementary and secondary schools.[9] Too often health is correlated with science or physical education [10] and suffers to the point of extinction. Too often physical education is considered *TO BE* health education. Boiled down, the objective of improved health teaching in the nation's schools is given only lip service, and that but occasionally.

In light of all this, the following observations seem pertinent.

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[1] Herman E. Hillebow, M.D., and Granville W. Larimore, M.D., *School Health Education Study 1961–1963* (a summary report; New York City: Samuel Bronfman Foundation), Forward.

[2] Irwin, Cornacchia, Staton, *Health in Elementary Schools* (Saint Louis: The C. V. Mosby Company, 1962), pp. 146–153.

[3] Samuel Bronfman Foundation, *School Health Education Study 1961–1963*, A Summary Report, pp. 6–7.

[4] William B. Ragan, *Modern Elementary Curriculum*, (revised ed.; New York: Holt, Rinehart and Winston, Inc., 1964) p. 329.

[5] Dr. Arthur Lesser, *Health of Children of School Age*, (Washington: U.S. Government Printing Office, 1964), pp. 8–9.

[6] Bureau of Education, *Report of Commission on Reorganization of Secondary Education*, No. 35, pp. 11–16.

[7] Samuel Bronfman Foundation, *op. cit.*, p. 11.

[8] *Ibid.*, p. 11.

[9] *Ibid.*

[10] *Ibid.*

As health education of the elementary pupil is best accomplished by the child's own teacher rather than by a specialist,[11] it would seem appropriate to provide for the *adequate* training of *all* elementary teachers in this area in both teacher-training institutions and in in-service training courses.

The writer concurs with Ragan [12] who, it should be pointed out, is a curriculum expert and not a health specialist, but who recommends that, at the elementary level, as much time be devoted to health as to any other curricular area.

Many state laws provide for instruction in physiology, hygiene, alcoholic liquors, etc. If recourse must be made to legislation, far better it would be to have clear and strong legislation providing for overall health instruction or health education for all grades than to prescribe for particular content.

Health instruction at the junior high and high school levels should be taught by persons adequately trained in school health education.

All major sized school systems should employ supervisors in school health education just as they should in all other major content areas. Such persons, with proper credentials and special certification, would assist in curricular development within the school systems. Smaller communities should jointly purchase the services of such an administrative specialist on an area-wide basis.

Strong leadership by the Department of Health, Education and Welfare, particularly through more joint efforts by the Office of Education and the Public Health Service, (as in the School Health Education Study), would surely advance these means toward an optimal level of health." Others could be devised. Undergraduate scholarships could be provided. Loans and grants-in-aid could be offered in quantity. Recruitment into the field should be encouraged for, if the need for physicians and nurses is distressing, the lack of teachers qualified to teach health and of supervisors to asist them is even more acute. Until such trained persons are in our classrooms in adequate numbers, the efforts of researchers, physicians, and public health authorities in the preventive field is certain to be dampened for the simple reason, as stated previously, that the public at large is not as disposed to accept the results of such efforts as it would be if it were trained to avail itself of these safeguards.

Health instruction of the public must begin in kindergarten and continue through all grades. Until such opportunities are adequate and extensive, health education will nurture itself on fallow minds. And the nation's health will suffer sorely.

On Congressman Rogers' inquiry into the relationship between the Rhode Island Department of Education and the Department of Health, Education and Welfare, it has been good during my brief period of employment (since June, 1965) here. Several Public Health Service personnel on loan to the Rhode Island State Department of Health have offered their assistance to this Coordinator. Replies to letters written by him to Health, Education and Welfare offices in Washington have, for the most part, been prompt, pointed and courteous. To date there has been no contact with Health, Education and Welfare's regional office, the Bureau of State Services, the National Institutes of Health nor the Food and Drug Administration.

[Attachment F]

STATE OF RHODE ISLAND INTERDEPARTMENTAL COMMUNICATION

SEPTEMBER 15, 1965.

To: Mrs. C. M. Gleeson, Governor's Office.
Department: Executive Chambers.
From: Joseph E. Cannon, M.D., M.P.H., Director.
Department: Health.
Subject: Congressional investigation of the organization structure and activities of the Department of Health, Education, and Welfare.

In reference to the letter received from Paul G. Rogers, Chairman, Subcommitte on HEW Investigation, I would strongly recommend that serious consideration be given to the establishment of a separate Department of Health in the Federal Government. A number of Federal Governmental Agencies have, over

[11] Irwin, *op. cit.*, pp. 158–159.
[12] Ragan, *op. cit.*, p. 338.

the years, been assigned segments of health and medical programs. State agencies and the public are confused and handicapped by having to deal with too many different agencies on health and medical matters. I might summarize some of these thoughts as follows:

A. DISPERSION OF ORGANIZATIONAL RESPONSIBILITY FOR HEALTH SERVICES WITHIN DHEW CREATES SERIOUS PROBLEMS OF COORDIATION AND FEDERAL-STATE RELATIONSHIPS

Major health service responsibilities are widely dispersed throughout the DHEW. In addition to the Public Health Service, the following operating agencies of the Department administer substantial medical programs:

1. Children's Bureau—maternal and child health and crippled children's services.
2. Vocational Rehabilitation Agency—medical rehabilitation Agency—medical rehabilitation and training programs.
3. Food and Drug Administration—health protection services related to food and drugs.
4. Welfare Administration—indigent medical care through the Kerr-Mills program.
5. Social Security Administration—health insurance programs through recently enacted medical care legislation.

All of these have overlapping areas of responsibility which make adequate coordination and planning impossible to achieve. The Public Health Service is the only one of these operating agencies whose responsibilities are confined to health and which deals with health programs on an across-the-board basis. Some reorganization is essential which would combine these health functions under a single organization and effective medical leadership in order to assure comprehensive planning, adequate coordination, and effective administration of these programs.

B. NEED FOR EMPHASIS ON DEVELOPMENT AND SUPPORT OF HEALTH SERVICES

The development and support of health service programs has lagged in relationship to the development and support of research. The urgent need for a greatly expanded nationwide attention to the needs and opportunities for comprehensive health service planning and development is evidenced by:

1. The lag in application of research findings.
2. The urbanization of the population.
3. The increase in the chronic diseases.
4. The increase in population, particularly older persons and children.
5. The proliferation of organizational responsibility for health services both at the national and State and local levels.

C. MAJOR ATTENTION NEEDS TO BE GIVEN TO DEVELOPING AND SUPPORTING THE HEALTH LEADERSHIP RESOURCES OF STATE AND LOCAL GOVERNMENTS

During recent years the capabilities of State and local governments to provide effective leadership in planning, coordinating, and conducting essential health service programs has declined at a time when it is more and more important to have strong leadership at these levels to help achieve national health goals. Federal assistance, comparable in its magnitude to that provided the universities of the Nation for research, is urgently needed if the Federal government is to have the kind of assistance at the State and local level which it needs for effective operation of national programs.

I am not alone in my beliefs, as evidenced by the following attachments: Exhibit 1, exhibit 2, exhibit 3.

In the Wooldridge Report, a recommendation was made that the National Institutes of Health be separated from the Public Health Service. It is the feeling of most, if not all of the State Health Officers, that this would be a serious mistake and that the National Institutes of Health should be a single division under the Department of Health. The Medical Care Section of the American Public Health Association, a knowledgeable group of Medical Care and Public Health Administrators, have taken this position, as well.

It may also be of interest to note that the General Accounting Office of the Federal government, in its review of health programs in the District of Co-

lumbia in February of 1964 stated "We believe that the dispersion of health and medical activities to several different departments does not make for efficient, effective, and economical planning and execution of health and medical programs." I strongly believe that this is a sound philosophy in relation to a separate department of health at the Federal level, with responsibilities as indicated above.

[Exhibit No. 1]

AMERICAN MEDICAL ASSOCIATION

To: Ben Freedman, M.D.; John S. Neil, M.D.; John B. Hall, Jr., M.D.; Henry A. Holle, M.D.; Berwyn F. Mattison, M.D.; John D. Porterfield III, M.D.; Myron Wegman, M.D.; Alfred L. Frechette, M.D.; Franklin D. Yoder, M.D.
From: Charles C. Edwards, M.D.
Date: June 1, 1965.

At the meeting of the Council on Medical Service of the American Medical Association with representatives of American Public Health Association, Association of State and Territorial Health Officers, and American Association of Public Health Physicians the following statement was adopted:

"JOINT STATEMENT OF THE AMA, ASTHO, AAPHP, AND APHA

"ADOPTED APRIL 24, 1965

"Without respect to individual organizational positions on the substantive content of H.R. 6675, the American Medical Association, the Association of State and Territorial Health Officers, the American Association of Public Health Physicians, and the American Public Health Association are in unanimous agreement in urging that the health care portions of the program envisioned by H.R. 6675, when and if enacted, utilize the administrative and medical competence to be found in state health departments. It is stressed that this is to be a medical care program rather than a welfare program and requires competent medical direction. The coordination of, and prime responsibility for, the program in each state, whatever agencies be empowered to carry out specific portions of the program, may properly be placed in the state health department."

For your information, the Board of Trustees of the American Medical Association approved this point statement. The statement was subsequently incorporated in testimony that Donovan F. Ward, MD, President of the American Medical Association, presented to the Senate Finance Committee on May 11, 1965.

[Exhibit No. 2]

On February 23, 1965 at Bal Harbour, Florida, the AFL-CIO Executive Council issued a statement with accompanying background paper on President Johnson's Health Message. The statement urged the enactment of legislation proposed by the President including (1) long-term, low-interest loans for comprehensive medical care plans, (2) initial staffing grants for community mental health centers, (3) increased grants and scholarships to train physicians, dentists, nurses and medical technicians, (4) establishment of regional medical complexes, (5) extension of the MCH and CC programs, "and (6) improved standards of medical care for needy persons".

One section of the background paper is especially pertinent to quality of health and medical care. The entire section is quoted.

"5. CHILD HEALTH AND EXPANSION OF PUBLIC ASSISTANCE MEDICAL CARE

"The emphasis the President has placed on increased and improved health services to children is most timely. Project grants to provide concentrated and comprehensive medical care services to children in low-income areas, and the proposed increase in funds to be made available to Crippled Children and Maternal and Child Health programs are sorely needed, and eminently appropriate. There is every reason to believe that they will be used effectively to provide high-quality health services to the nation's children—preventing unnecessary disability, undue suffering and premature death, and demonstrating new ways that medical services can be better organized and delivered.

"Improved standards of medical care under public assistance were also proposed by the President and are incorporated in H.R. 3699. These proposals, among other things, would result in substantial improvements in the present medical assistance to the aged programs under Kerr-Mills, thus making them meaningful supplements to the basic insurance protection contemplated in H.R. 1–S. 1 (King-Anderson). With the release of funds resulting from adoption of King-Anderson, such improvements become a practice possibility.

"There is, however, reason to fear that the proposed extension of medical care to new groups of individuals, and especially to children, on a needs basis might be carried out with the same notable lack of assurance of quality care that has generally characterized welfare medicine in the past. The Maternal and Child Health and Crippled Children programs have demonstrated how welfare funds can be used to provide high-quality medical care. In the development of new programs, or the extension of existing programs to new categories of beneficiaries, the utmost care must be exercised to make certain that the medical care provided meet high standards of quality, and that administration of the program be the responsibility of those agencies that give evidence of being able to assure that these funds will be spent for high-quality care."

[Exhibit No. 3]

A Policy Statement of the New York Academy of Medicine on the Role of Government Tax Funds in Problems of Health Care

In the light of present knowledge and informed opinion the Trustees and Council of The New York Academy of Medicine believe that:

1. In the United States today a serious gap exists between the state of health of significant numbers of people and that state of health which would be attainable if the best of present-day medical knowledge were more universally available and more fully utilized by the people of this country.

2. A major goal of our democratic society must be that all people have the assurance of equal opportunity to obtain a high quality of comprehensive health care.

3. The attainment of the goal of equal access to a high quality of comprehensive health care requires that governmental and voluntary agencies must work together:

first, to identify the reasons such services are not more universally available to people; and, then,

second, to take whatever actions are necessary to make them more widely available.

4. The steps taken to improve the accessibility of health care must always take into account the importance of using the nation's resources in the most effective and economical manner consistent with the enhancement of individual dignity and high standards of care.

5. It is both legitimate and essential that Federal, state, and local legislative and executive agencies be concerned that the goal of high-quality comprehensive health care for all our people is reached to the fullest extent possible, and that this concern requires, at appropriate levels of government, such functions as the following:

(*a*) establishment of priorities for new as well as existing governmental health-care programs;

(*b*) allocation of the funds needed to achieve these priorities;

(*c*) implementation of such measures as are required to assure universal access to health care;

(*d*) introduction of such effective controls as may be needed to assure a high quality of care, economically provided;

(*e*) support of demonstration and research efforts to improve the effectiveness and efficiency of health-care programs;

(*f*) consultation with appropriate professional groups and agencies in the exercise of its policy-making and administrative functions.

6. Whenever Federal, state, or local tax funds are allocated for health-care purposes, an appropriate governmental agency must be fully accountable for achievement of the purposes for which the funds were made available—including the establishment and maintenance of standards of performance and the administrative procedures required for economical use of funds.

7. The varying fiscal capacities and efforts of the several states have resulted in an uneven and inadequate level of many of those health services that are re-

quired in the national interest. When the nation as a whole suffers from such varying levels of essential health services, the resources of the Federal government must be utilized for establishing and maintaining standards of service, as well as for an equitable basis of financing throughout the nation.

8. The availability of health services, as a matter of human right, should be based on health need alone, not on a test of ability to pay. The full attainment of this goal requires the broadest possible participation in the systems of financing health services, if individual dignity and self-dependency are to be enhanced.

9. When federal and/or state and local tax funds are available for purchase of health care, whether for public assistance, social security or other categories of public program beneficiaries, it is the official health agencies, and the official health agencies alone, to which should be delegated responsibility for the administration of such funds. The official health agency is the only unit of government that can coordinate all governmental health programs and combine public responsibility and accountability and the other functions of public administration with the professional skills, concern, and consultation required for setting standards and for continuous evaluation of program quality and overall effectiveness.

Initiated by Committee on Special Studies, Harry Becker, Executive Secretary
Approved by Council and Trustees.
May 26, 1965.

[Attachment G]

STATE OF RHODE ISLAND, INTERDEPARTMENTAL COMMUNICATION

SEPTEMBER 15, 1965.

To: Mrs. C. M. Gleeson.
Department: Executive, Office of Governor.
From: Mr. Joseph H. O'Donnell, Director.
Department: Administration.
Subject: Ref. to letter (8–20–65) to Governor from Paul G. Rogers, Chairman, Subcommittee on HEW Investigation with attached statement of Hon. Oren Harris (D-Ark.)

The following represent concerns of the Rhode Island Department of Administration relating to HEW programs and procedures—and those of other federal departments as well.

1. The program people in HEW apparently feel strongly constrained to deal only with program personnel in health, education and welfare at the state level. This is mostly understandable, particularly under the "one agency" principle. However it is particularly recommended that in the instances of (a) increases in grants, (b) the introduction of new grant programs, and (c) especially in project grants, that the state's central agency for fiscal management (i.e. budgeting and/or accounting) be informed by the HEW program people as to what is transpiring e.g. in at least the manner that such state central staff agencies are kept apprised of developments in educational television channel allocations, etc.

A rather remarkable current illustration of neglect on the part of HEW to consider the role of state finance managers is in the handling of Public Law 89–97. Apparently HEW has had separate meetings with state health program personnel, with state welfare program personnel, with Blue Cross and Blue Shield officials, with medical association people (and perhaps with AHA officials?). State fiscal officials are noticeably missing (uninvited?) from this listing although extensive *state* funds are involved and it is on the matters of state funds that Governors ordinarily depend primarily on the knowledge and advice of their budget directors.

As a matter of cross-illustration, the situation is very like omitting the federal Bureau of the Budget out of considerations on expenditure programs of HEW, Defense, Interior, etc.

2. The concurrent audit program of the federal Bureau of Public Roads should receive the highest commendation. The concepts involved should be extended in every possible area of federal-state relations. The Bureau of the Budget and the National Association of State Budget Officers are cooperating in this kind of development. This is fine, but it should be pressed very hard at the federal among the program people.

3. While conceding the existence of stimulating grants and "seed money", the fact remains that federal aids are progressively becoming so fragmented through endless project grants that there is a serious question as to whether the expenditure of such funds approach maximum benefit. So-called "bread and butter" programs seem to be losing ground—and federal funds—to a seemingly endless stream of minor project grants. Rhetorically, it may well be asked whether or not some (many? most?) project grants involve (a) "research" into matters long ago conclusively and definitely "researched", and (b) proving the obvious and incontrovertible. Moreover, while projects are receiving prime attention at the federal level and heavy pressure upon the states to accept such, they are also drawing away prime talent (which is everywhere limited) from existing and basic programs.

SOUTH DAKOTA,
STATE DEPARTMENT OF HEALTH,
Pierre, S. Dak., September 23, 1965.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR REPRESENTATIVE ROGERS: Governor Nils Boe has asked me to reply to your letter of August 20 concerning the relationship of state agencies with the Department of Health, Education and Welfare.

I am happy to report that, during almost 30 years of my affiliation with our State Health Department, our relationship with federal health agencies has been both pleasant and profitable. Representatives of the regional office of HEW have been especially helpful in furnishing us with consultation and assistance in program development. Federal control has been kept to a minimum consistent with the legal obligations of the agencies concerned. This has permitted the development of programs adapted to the specific needs and circumstances existing in the State.

Sincerely yours,

G. J. VAN HEUVELEN, M.D.,
State Health Officer.

TENNESSEE EXECUTIVE CHAMBER,
Nashville, Tenn., August 26, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives, Washington, D.C.

DEAR MR. ROGERS: I am in receipt of your recent letter concerning the study being conducted by the special subcommittee into the organizational structure and activities of the Department of Health, Education and Welfare.

I am asking appropriate departments of State government to comment regarding your request and we shall be happy to transmit this information to you as soon as possible.

Sincerely yours,

FRANK G. CLEMENT, *Governor.*

COMMONWEALTH OF VIRGINIA,
GOVERNOR'S OFFICE,
Richmond, Va., September 21, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives, Washington, D.C.

DEAR MR. ROGERS: I am enclosing comments from the Virginia Commissioner of Health, Commissioner of Mental Hygiene and Hospitals, and the Director of the Department of Welfare and Institutions in response to your invitation of August twentieth.

I call your attention particularly to the statement by Dr. Mack I. Shanholtz, State Health Commissioner, and the supporting comments by Dr. Hiram W. Davis, the Mental Health Commissioner.

My experience during the past four years as Governor leads me to heartily endorse the principal theme they emphasize—centering a responsibility so that channels of communication and execution are clearly designed.

We are glad to have this opportunity of presenting our views to the subcommittee.

With kind regards, I am,

Sincerely yours,

ALBERTIS S. HARRISON, Jr.,
Governor.

[Attachment A]

COMMONWEALTH OF VIRGINIA,
DEPARTMENT OF HEALTH,
Richmond, Va., September 15, 1965.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: It is indeed encouraging to be asked to comment on reorganization of the Department of Health, Education, and Welfare, and particularly the Public Health Service. Some of us who have basic and special training and experience in the health sciences and who live at the "point of delivery" of health services have often wondered why we are seldom consulted. We realize, of course, that the Congress is subjected to many influences emanating from the personal feelings and ambitions of the public as well as from organized pressure groups. At time, however, new health programs and policies seem to have been developed in response to these expressions of personal or political interest rather than from expressed state needs. As a result, we no whave a hodepodge of health programs and projects administered by various agencies which is becoming chaotic and impossible of sensible, efficient, and economic administration on the state level.

In any reorganization effort certain basic principles should be kept continuously in mind. One important principle is that if a special health function is to be undertaken, the responsibility should be given to *one* agency to serve the whole community needing the health service and not, as is presently done, to several agencies for different segments of the community. Furthermore, the agency given the responsibility should be the one most competent to carry out health services; it's staff should be educated, trained, and experienced in the health field.

With these principles in mind, HEW could best be reorganized by placing all educational services in the Office of Education, all welfare services in the Welfare Administration, and all health services in the Public Health Service.

This would abolish such agencies as the Children's Bureau, which has responsibility for both welfare and health services to children. No state has a counterpart of the Children's Bureau, since in the states the welfare aspects of this program are administered by the welfare departments, and, in nearly all, the health aspects by the health departments. Likewise, Vocational Rehabilitation is composed of education (training) and health (physical restoration), and the Food and Drug Administration is essentially a health service with food (sanitation and food protection) and drug (health protection).

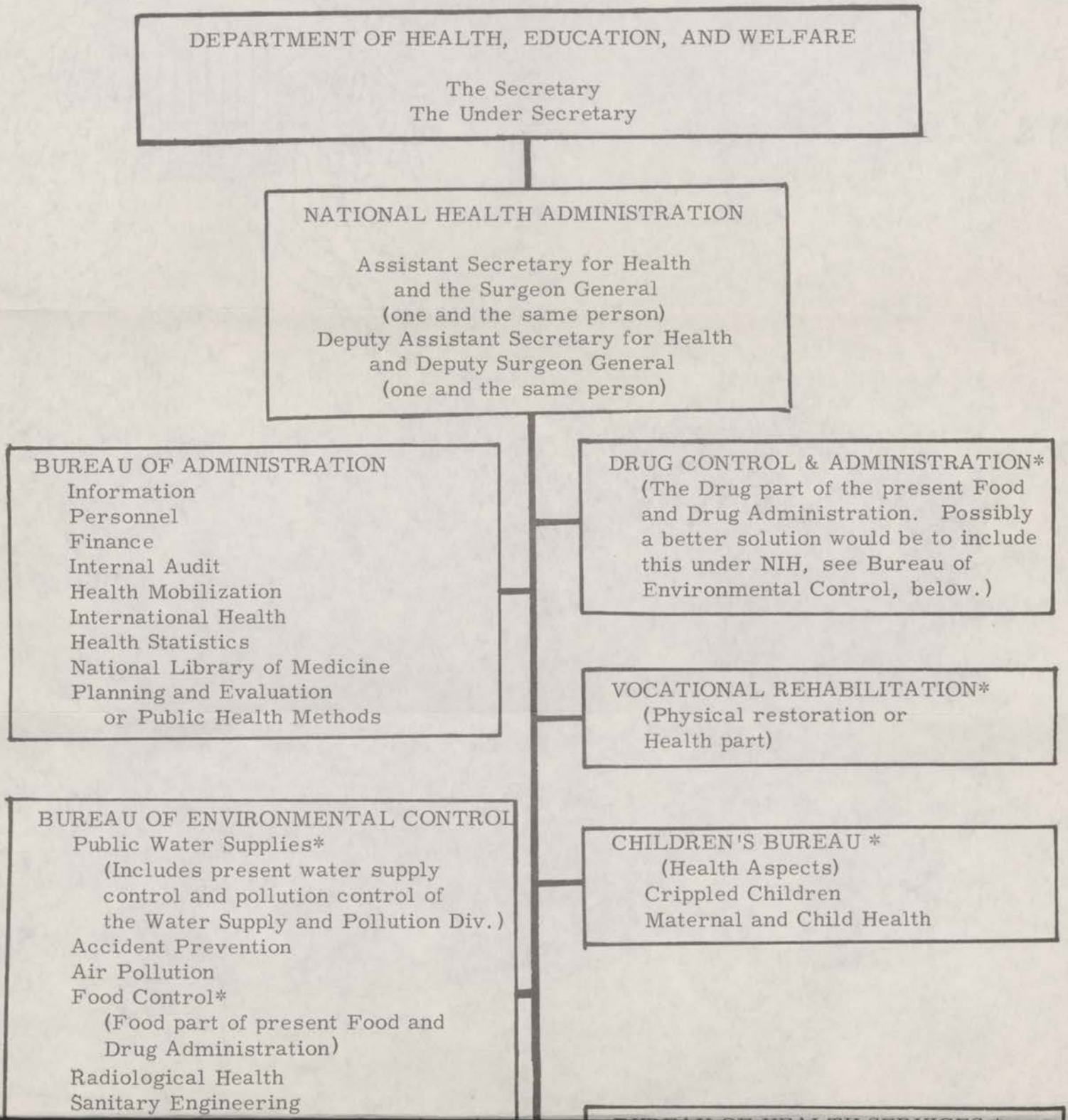
Please let's not think in terms of further fragmentation of health services but, rather, in terms of consolidation. It is better to have one good health agency than several sub-agencies. It is easier to strengthen the one we have than to create new ones. At the point of delivery in the states, we prefer to deal with one Federal agency. Our communications will be greatly improved if we can deal with the one which speaks our language.

A proposed reorganization chart is enclosed. (See exhibit 1.) In this connection I would like to emphasize two recommendations. First, we should have a single national health agency to work through the health authority in the states to meet the health and medical care needs of the public. The director of the Federal agency should also be the Assistant Secretary for Health in the Department of Health, Education, and Welfare.

Second, the National Institutes of Health should not only remain under the national health agency but it, too, should operate in closer cooperation with the state health departments to insure the practical application of newer knowl-

EXHIBIT 1

PROPOSED REORGANIZATION OF THE U.S. PUBLIC HEALTH SERVICE BY MACK I. SHANHOLTZ, M.D. VIRGINIA STATE HEALTH COMMISSIONER September 15, 1965



(Present Environmental Engineering and food protection)

BUREAU OF RESEARCH INSTITUTES

Institutes:

- Environmental Health Sciences*
  (To include Taft Center in Cincinnati, Ohio, and the new center to be built in North Carolina, etc.)
- Allergy and Infectious Diseases
- Arthritis and Metabolic Diseases
- Cancer
- Communicable Diseases*
  (To include CDC at Atlanta, Georgia, along with Quarantine Division of Bureau of Medical Services)
- Child Health and Human Development
- Dental Health
- General Medical Sciences
- Heart
- Mental Health
- Neurological Diseases and Blindness
- Clinical Center

Divisions:

- Health Professions Training Programs*
  (Scholarships, loans, including those now administered by NIH and CDC)
- Biological & Drug Standards and Control
- Drug Control*
  (Drug part of present Food and Drug Administration)
- Research Grants
- Research Facilities and Resources
- Research Services
- Geriatrics and Chronic Diseases*
  (Would replace present Division of Chronic Diseases in the Bureau of State Services. Under this re-organization, the Cancer Institute would operate the cancer program, the Health Institute, the heart program, etc.)

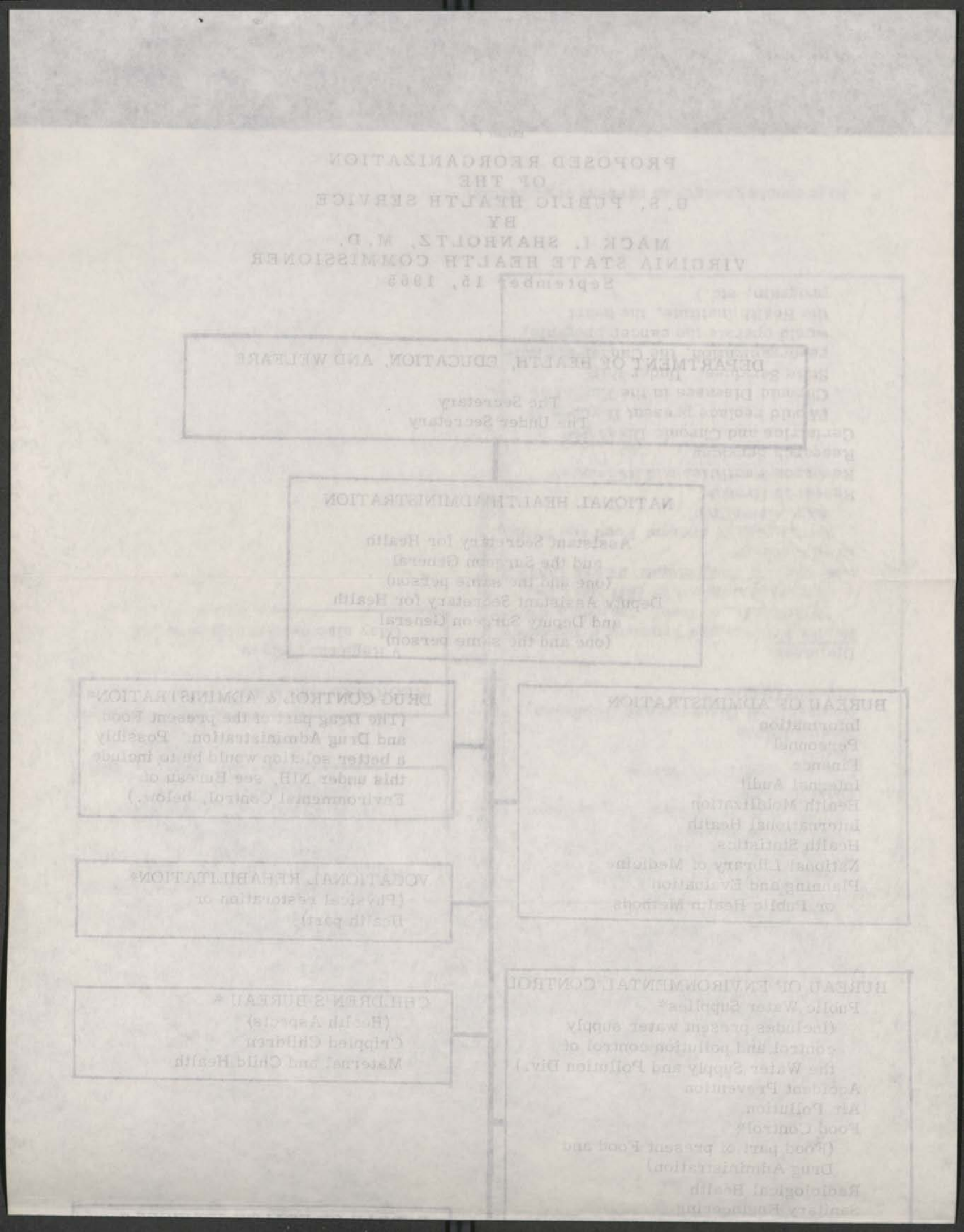
BUREAU OF HEALTH SERVICES *
(Instead of having them in separate bureaus, this could also include Vocational Rehabilitation (health part), Crippled Children, and Maternal and Child Health.)

- Social Security Administration*
  - Title XVIII
  - Title XIX
- Nursing
- Hospital & Medical Facilities (Hill-Burton)
- Indian Health
- Occupational Health
- Public Health Service Hospitals and Clinics
- Health Services for:
  - U. S. Coast Guard
  - U. S. Bureau of Prisons
  - U. S. Bureau of Employment Compensation

REGIONAL OFFICES

9 Regional Offices
(May also need reorganization)

* - Represents changes in present organization



edge made available through research for the better health of our people. This could be accomplished in part by allowing the various Institutes to administer the service programs of the special diseases with which they are concerned.

One further thought, after reorganization the new national health agency should establish a policy, which is lacking at present, for dealing with the official state health agency. It should provide within this policy basic financial support for state health programs as well as for developmental or special grants.

I hope these thoughts will be of some value to you. If you should have any further questions, please do not hesitate to call on me.

Sincerely,

MACK I. SHANHOLTZ, M.D.
State Health Commissioner.

[Attachment B]

COMMONWEALTH OF VIRGINIA,
DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS,
Richmond, Va., September 20, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building,
Washington, D.C.

DEAR MR. ROGERS: Your letter of August 20, 1965 concerning the reorganization of HEW addressed to the Honorable A. S. Harrision, Jr., Governor of Virginia, was forwarded to me as well as to other department heads for comment.

Dr. Mack I. Shanholtz, Virginia State Health Commissioner, has written you a detailed letter with attached chart for the proposed reorganization of the Public Health Service. In the pursuit of brevity and in order to conserve your valuable reading time, I endorse and support the letter and chart submitted by Dr. Shanholtz. He and I have discussed the subject of HEW many times over the past years and I concur in his presentation to you.

I would like to add that we of the state government medical services are extremely interested in the many programs administered by HEW. I particularly wish that we could play a more active role in the development of the rules and regulations to guide new programs before they become official. This has been a repeated request to HEW through our official organization but to date we have not effected a satisfactory solution. Maybe your committee could bring about our inclusion in these new programs before they become official.

Sincerely,

HIRAM W. DAVIS, M.D.,
Commissioner.

[Attachment C]

COMMONWEALTH OF VIRGINIA,
DEPARTMENT OF WELFARE AND INSTITUTIONS,
Richmond, Va., September 14, 1965.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation,
House of Representatives,
Washington, D.C.

DEAR MR. ROGERS: The Virginia Department of Welfare and Institutions receives substantial funds through the Welfare Administration of the Department of Health, Education, and Welfare for assistance in the purchase of medical care for recipients under four categories of assistance programs. The categories are: Old age assistance, medical assistance for the aged, aid to the permanently and totally disabled, aid to dependent children.

Payments made directly to the providers of such care totaled $6,895,047 during the fiscal year ended June 30, 1965. A table showing expenditures for categories and types of care is attached. (See exhibit 1.)

In addition to the vendor payments referred to in the preceding paragraph, it is estimated that $1,344,000 was included in money payments to recipients of old age assistance, aid to the permanently and totally disabled, and aid to dependent

children for medical care such as physicians' services, drugs, nursing services in the home, laboratory services, etc. All payments under medical assistance for the aged were to the providers of services or supplies.

This Department does not have any direct working relationship with the Public Health Service.

Sincerely,

W. L. PAINTER, *Director.*

[Exhibit 1]

Virginia Department of Welfare and Institutions, total expenditures for medical vendor payments by category and apportionment of funds for the period July 1964–June 1965

	Total expenditures	Apportionment of funds		
		Federal	State	Local
Old-age assistance:				
Hospitalization	$886,157	$675,270	$109,896	$100,991
Nursing home care	2,073,876	1,687,192	263,579	123,105
	2,960,033	2,362,462	373,475	224,096
Medical assistance for the aged:				
Hospitalization	1,731,295			
Nursing home care	72,593			
Other	504,897			
	2,308,785	1,471,144	493,731	343,910
Aid to the permanently and totally disabled:				
Hospitalization	504,340	329,604	102,166	72,570
Nursing home care	559,413	382,875	117,396	59,142
	1,063,753	712,479	219,562	131,712
Aid to dependent children: Hospitalization	562,476	368,957	120,945	72,574
Grand total	6,895,047	4,915,042	1,207,713	772,292
Total hospitalization	3,684,268			
Total nursing home care	2,705,882			
Total other	504,897			

THE STATE OF WYOMING,
DEPARTMENT OF PUBLIC HEALTH,
Cheyenne, Wyo., September 21, 1965.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Your letter dated August 19, 1965, was referred to me by Governor Hansen for a direct reply.

I read your letter with great interest and share your concern about the rapid growth of the Department of Health, Education and Welfare and the administrative problems which this growth has created. It is evident that the recognition of existing health needs as well as the discovery of new needs requires a hard look at the organization, and the administrative structure responsible for the maintenance and promotion of the health of the people in our country.

We are concerned about the organization of the Department of Health, Education and Welfare and its Federal-State relationship as it pertains to the administration of health services.

The American tradition calls for the well-being of the individual citizen as the ultimate goal of our efforts. To accomplish this we have to provide adequate services for the care and the prevention of illness and disability of each citizen. One of the most powerful assets of any nation is the health of its people. A high level of physical and mental health assures the people a sound basis on which to develop their potentials as individual citizens, and to increase the potential of the nation.

Even though we do not see health as an end in itself, it is certainly sufficiently important to be considered as a separate and distinct endeavor of state and national government. This consideration I share with many of my fellow state health officers. We feel that on the federal level a better coordination and promotion of health services could be accomplished by the creation of a *separate department of health* which would replace that division of the health services and health administration which is now part of the Department of Health, Education and Welfare.

There is no question in my mind about the necessity of better coordination of the efforts now expended in the many areas of health. The gap between research and implementation is growing rapidly. Most of the knowledge made available by research cannot be implemented because of the lack of administrative tools and coordination of services. One cannot help but be concerned about the separation—on administrative level—between the U.S. Public Health Service, National Institutes of Health, Social Security Administration and its health activities, and other agencies now becoming involved in certain health programs.

Another area of much concern is the continuing separation of mental health from the total health field. This regrettable separation in many states has already led to the creation of separate agencies to administer mental health programs. These agencies generally are serving the needs of a clinical operation in an institutional setting, and that procedure overlooks the vital *public health approach* to mental health problems. There is a growing awareness that too much emphasis in mental health is on the illness of the individual and neglects to examine the pathology of the society in which the individual operates. Although the symptoms of mental illness are often more easily detectable in individuals, the true source of illness and disability may often be determined through the sociological structure of the community.

If we are serious about our intention to provide care and protection for every individual, we must establish certain principles to accomplish this enormous task. A basic criteria is one that although clinical care of individual patients will always be necessary, a significant improvement can only be accomplished with a concisive public health approach. The coordination of clinical services and prevention of disease and disability under a public health model is of utmost importance. Experience has shown us that in order to accomplish an observable improvement in the health status of the population, it is necessary to teach the individual to accept and be responsible for personal and family health practices. In other words the creation of a nation of sheep would not only be against our principles but would also fail to accomplish a significant improvement in the health status of our citizens. To avoid *that*, it is imperative that we should watch for over-centralization of health programs. Federal *leadership* is undoubtedly desirable to achieve involvement of state and local departments to bring health practices closer to the people. Although we should move in a united manner for the improvement of total health, stronger emphasis should be placed on local involvement, and recognition of local needs and local problems. The health needs and health resources in the rural states are vastly different from those in large metropolitan areas. Over-generalization in the field of health can create nothing but failure in responding adequately to the specific health needs of certain regions.

As pointed out before, a much closer coordination and balance should be obtained between research and implementation in health. This leads to the conclusion that a separate department of health should be created on the federal level, coordinating all the efforts now expended in the field of health, providing aggressive and imaginative leadership to the states and local governments. In addition to this, a regional organization of the department ought to be instituted. More authority should be given the regional offices, so that would be a faster service to state and local health units in time of need. This in turn would make it possible for the states and local health departments to assume a more independent and responsible role. Such would seem to lead to an overall improvement of the health of our people.

Sincerely yours,

ROBERT ALBERTS, M.D.

APPENDIX II

FORM LETTER OF APRIL 4, 1966, REQUESTING VIEWS OF STATE GOVERNORS RE FEDERAL-STATE-LOCAL RELATIONSHIP IN PUBLIC HEALTH MATTERS, AND REPLIES THERETO

APRIL 4, 1966.

Hon. ——— ———,
Governor of ———.

DEAR GOVERNOR ———: As you know from my letter of last August, our Special Subcommittee has been engaged in a study of the organizational structure of the Department of Health, Education, and Welfare with reference to the health programs administered by the various agencies within the Department. The Governors of all fifty States were contacted and asked to give their comments and recommendations on the present Federal-State-local relationship in matters of public health. We were most gratified by the response. The volume and high quality of the correspondence indicate a deep interest in the subject matter of our study.

The initial phases of our study having been completed, the Subcommittee will hold public hearings this month. A background statement on these hearings is enclosed for your information. The initial subject to be taken up will be current problems in the Federal-State-local relationship in public health matters.

As Governor of your State, your views on this subject in relation to the public health problems of your State would be of vital interest to our study. On behalf of myself and the Subcommittee, I hereby extend an invitation to you to appear at our hearings and give us the benefit of your views. If circumstances preclude your appearance at our hearings, I would deeply appreciate your submitting a written statement so that an official viewpoint from your State might be included in the records of our hearings.

Since we are in the process of scheduling witnesses, I would very much appreciate your letting me know at your earliest convenience whether you will be able to appear.

With kindest personal regards, I am,

Sincerely yours,

PAUL G. ROGERS,
Chairman, Special Subcommitee on HEW Investigation.

STATE OF ALABAMA,
GOVERNOR'S OFFICE,
Montgomery, Ala., April 25, 1966.

Hon. PAUL G. ROGERS,
Chairman, Special Subcommittee on HEW Investigation,
House of Representatives,
Washington, D.C.

DEAR MR. ROGERS: As Governor of the State of Alabama, I want to thank you for this opportunity to offer a further statement for inclusion in the record of your committee hearings concerning the structure of the Department of Health, Education, and Welfare.

Modern health programs are changing to keep pace with an expanding wealth of new knowledge and technological advance. Local health service programs face the problems of surveillance over communicable disease problems which no longer constitute major threats but continue to demand attention which will prevent their resurgence. At the same time, they must gain proficiency in new methods to control new disease and disability entities.

At the service level, research assumes a secondary role and is generally restricted to new methods of administering preventative programs more effectively and efficiently. Research of a more basic nature is encouraged at Federal levels.

There has appeared to be a growing divergence of effort between the Federal support funds and local operational programs of direct service to individuals comprising the community.

In discussing this with our State Health Department, I find them concerned with trying to maintain a balance between the basic service programs for which there is little interest at either the State or Federal levels because maintenance efforts are frequently vague and vary widely even in neighboring localities. For example, the rural efforts to secure adequate immunity levels in the children entering the population each year is a continuing educational and promotional problem compared with a similar effort in an urbanized area a short distance away geographically.

In the States, we feel less need for a multiplicity of highly specialized fragmented programs dealing with single diseases or problems than for some encouragement in maintaining a solid foundation of basic local health services which can appropriately and efficiently utilize advanced programs and refined techniques when indicated.

In the South we have been blessed with an abundance of resources and are pleased with an improving economy. Changes are necessary to meet new needs of a growing population and a shift from a rural to an urban State. Highly trained health professionals seem to be decreasing in comparison to need, while new demands for quantity and quality service are exploding from all levels of government.

I note in the Medicare legislation some confusion between agencies of State government about overlapping of certain areas of authority and multiple Federal agencies with which each may have almost parallel efforts. This leads to confusion and problems of communication at all levels.

It appears that separate Federal Departments of Health, Education, and Welfare could be utilized to functionally serve their State and local service counterparts.

We urge more latitude be given the States by allowing greater flexibility in spending of Federal grant money, particularly for basic health services. I have viewed with alarm the continuing decline in general health grants. I urge that your committee recommend the States be given more flexibility in the use of their share of allocated Federal funds as long as this money is used to meet problems which the States feel most urgent.

The strict adherence to the long-established rule of the Federal-State-Local channels is strongly urged. This is most important in Health which by constitutional omission remains the responsibility of the State. Deviation from this channel, or by-passing the State level, often leads to serious misunderstandings, poor coordination and disrupted or confused planning to meet the needs of the communities.

Federal support in a lump sum could be adequately supervised by the State as a part of the available revenues for a specific category of service. In State appropriations we must consider other sources and sometimes I am confident we are not aware of varying restrictions between sources that prevent proper utilization from the taxpayers' viewpoint.

Thank you for your consideration of these requests.

With kind regards, I am,

Sincerely yours,

GEORGE C. WALLACE, *Governor.*

STATE OF CALIFORNIA,
GOVERNOR'S OFFICE,
Sacramento, Calif., April 14, 1966.

HON. PAUL G. ROGERS,
Chairman, Special Subcommittee on HEW,
Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

MY DEAR CONGRESSMAN: Thank you for the opportunity of commenting on the public health activities of the Department of Health, Education and Welfare, as a part of your study into the organizational structure and activities of the Department of Health, Education and Welfare.

The rapid growth and dispersion of health activities in the Department during recent years has created certain problems for us in California, as in other states.

In one sense we are glad to have these problems because they reflect the development of needed public services. However, we want to minimize the difficulties in order to achieve the greatest efficiency in the programs established by Congress.

Two problems in our public health work in California may be particularly pertinent to your present study.

One is the placement of new health programs in a variety of federal agencies, departments and units of departments. The resources of these new programs then come to the states in multiple and sometimes overlapping, if not conflicting, channels. For example, a health officer seeking to establish better health services for a community of seasonal agricultural workers' families finds that funds are available not only through the program in the Public Health Service for seasonal agricultural workers but also another unit of the Public Health Service offering a Vaccination Assistance Program, project grants from the Office of Economic Opportunity, resources of Title IX of PL 89-97 under the welfare administrations—and many others. While it is helpful to have many resources, when these are bound by differing limitations and administered by agencies with differing points of view, the health officer does encounter difficulties.

The solution to this general problem may be for the Congress to establish a much stronger central health direction for the medical aspects of programs. It would seem appropriate to establish this in the principal health agency of the federal government, the Public Health Service.

The second general problem is tendency on the part of the federal personnel in new programs, in their eagerness to initiate activities, to deal directly with local communities. While it is understandable that in states with weak state health agencies federal program people may want to get on with the job, bypassing of the state health agencies is not a good long term solution. In states like California, with strong health agencies, this tendency of federal program people confuses lines of communications, diffuses responsibility and does not permit maximum effectiveness. I believe it is essential for us to build strong state agencies to handle efficiently the health programs established by the Congress. Perhaps the outstanding example of how to do this is the Hill-Harris Hospital Construction and Planning Program.

One approach towards solving this problem lies in H.R. 13197. This would support a strong federal-state partnership in health matters by granting federal aid to the states for proper planning and development of a comprehensive health program.

It is my understanding that Dr. Hienrich Blum, Director of the Contra Costa County Health Department will appear before your committee to discuss some of the problems faced by the State of California and local communities in the administration of public health needs. I am sure that he can convey to you some of the above matters personally.

I hope that these comments may be of assistance to you.

Sincerely,

EDMUND G. BROWN, *Governor.*

STATE OF CONNECTICUT,
EXECUTIVE CHAMBERS,
Hartford, Conn., April 15, 1966.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR REPRESENTATIVE ROGERS: As indicated in my letter of April 4th I am forwarding to you my views concerning the study of organizational structure in the Health, Education and Welfare Department.

Some of the following observations may be pertinent to your study:

1. The health services function of the Children's Bureau might be made one of the major divisions within the Public Health Service with the same kinds of activities being largely continued.

2. The State Hospital and Medical Facilities Construction Agency, which in Connecticut's case is the State Health Department, possibly should receive notices of grants made for nursing school, medical school, medical research and health profession training construction projects.

3. Public Health Service representatives perhaps could work closely with State Health Departments in responding to inquiries about project grants for various community health services from local governmental or voluntary health agencies. Communication with the State Health Departments might also precede any stimulation of requests from community health or voluntary health agencies.

4. The various health categorical grants might better be combined into perhaps not more than three or four categories. Possibly a general categorical grouping of Health Improvement for Chronically Ill; Preventable Disease Control and Environmental Health might be used to consolidate various individual grant programs now operating. There might be more substantial general grants made to provide a firm base for broad public health activities.

5. In states, like Connecticut, where there is an Office of Mental Retardation, Children's Bureau and other mental retardation grants might be administered by that division, with professional consultation from the Maternal and Child Health Unit, rather than the other way around as present regulations require.

6. Plans could be made for closer coordination of health and medical care programs which are currently separately administered under the Welfare Administration and the Public Health Service. As programs develop and expand under Title XIX, comprehensive quality care with emphasis on prevention and rehabilitation could thus be given medically indigent persons eligible for these programs.

Improved coordination between the National Institutes of Health research programs and the Bureau of State Services, at Federal level, might also be possible so that benefits of these operations could be made more readily available to operating programs in the various states.

I hope these comments will be of some interest to you.

Sincerely,

JOHN DEMPSEY, *Governor.*

STATE OF DELAWARE,
EXECUTIVE DEPARTMENT,
Dover, Del., April 28, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health, Education, and Welfare Investigation, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: Thank you very much for your recent letters and the study being conducted by your Subcommittee on the organizational structure and programs of the Department of Health, Education and Welfare. I apologize for not having answered your letters before this time; however, because of a recent illness I was not able to respond promptly.

I have asked Dr. Floyd I. Hudson, Executive Secretary of the Delaware State Board of Health, to prepare an elaboration on his comments contained in his memorandum of September 13, 1965. For your information and study, I have enclosed a copy of Dr. Hudson's comments as you requested in your letter of February 14, 1966. I certainly hope his remarks will be of benefit to you in achieving the goals of your Subcommittee.

Because of the extreme demands upon my time, in view of the fact that the Delaware General Assembly is now in session, unfortunately, I was not able to appear at your hearings held from April 18-20. It was very kind of you to invite me to the hearings. If there is any further service or any other information which you desire I would like to designate Dr. Floyd I. Hudson as the official person to act as liaison on behalf of the State with your Committee.

If there is any other way in which I can be of service to you, please do not hesitate to contact this office.

Very sincerely yours,

CHARLES L. TERRY, Jr., *Governor.*

ELABORATION ON COMMENTS OF DR. FLOYD I. HUDSON IN MEMORANDUM DATED SEPTEMBER 13, 1965, IN COMPLIANCE WITH THE REQUEST CONTAINED IN THE LETTER DATED FEBRUARY 14, 1966, FROM THE HONORABLE PAUL G. ROGERS, CHAIRMAN, SUBCOMMITTEE ON HEW INVESTIGATION OF THE U.S. HOUSE OF REPRESENTATIVES

Delaware is a small State with a population of slightly more than 500,000 and a small geographic area. Any place in the State can be reached by automobile from the Health Department's Central Office in one (1) hour. Communications are excellent. State and Local Health Officers meet together with suitable staff members on a monthly basis. Delaware, therefore, should have very few problems in the planning, organization, implementation and evaluation of health problems. We have had some difficulty when special public health service projects have been established in local areas entirely without our knowledge.

In regard to the statement "State and Local Health Officers have, in the past, been handicapped and somewhat confused by having to deal with so many different Federal Agencies on health and medical matters.", special health projects (not categorical grants to states) have constituted the most serious problem to State and Local Health Officers. These projects grants are so established that the Public Health Service may frequently deal directly with hospitals, institutions and other local agencies to set up special health projects. This has been done without any consultation with the Health Department in the area where such a program is undertaken. Specifically, the Public Health Service wrote letters in the 1965 fiscal year to all general hospitals in the State of Delaware offering to finance cancer programs in such hospitals. Some cancer programs were initiated in these hospitals without any State or local Health Department's knowledge of what was going on. Detection programs were begun which were identical with the State program already in operation and could have been much better coordinated if the Health Department had been involved from the beginning. As a result there exist independent cancer programs in local situations which are in no way coordinated or integrated into any comprehensive health program. This appears to be contrary to good administrative health practice which must be implemented at the grass-roots level to assure a high quality of comprehensive care.

In securing categorical State and Local program grants, we must deal with the Children's Bureau for Maternal and Child Health and Crippled Children's Services, with many Divisions or Offices of the Public Health Service for Chronic Illness and Aging, General Health, Heart and Cancer planning. For example, Venereal Disease, Tuberculosis and Vaccine Assistance programs require clearance through the Communicable Disease Center in Atlanta. Hospital and Medical Facility Construction, Water Pollution Control, Air Pollution Control and Radiological Health grants must be sought through other Health, Education, and Welfare Departments or different Divisions in the Public Health Service.

In regard to the statement "In the past NIH has established programs in states and localities without any contact with the State or Local Health officials in the jurisdiction involved. The Health Officers in these jurisdictions frequently have no knowledge, therefore, of NIH projects until they are published months later.", the National Institutes of Health have always established programs in states and localities without any contact with State or Local Health Officers in the jurisdiction involved. I am attaching hereto a copy of such projects in the State of Delaware for fiscal year 1965 as printed in Public Health Service Publication No. 1346, Grants and Awards, Part I, and received in this office on March 14, 1966. This was the first notice that we received of any of these projects except what we had learned on our own initiative and through press releases from NIH of only four of these. State and Local Health Officers are intensely interested in knowing what research projects are being carried out in the health field within the area served. It would not appear too difficult for NIH to at least advise the State and Local Health Officers at the time that an award is made for any research project.

Delaware's problems in relation to this would appear to be much smaller than problems in the larger states. We, however, believe that State and Local Health Agencies will be able to provide comprehensive (including preventive) health care only when the Federal grant system is revised to give us some opportunity to participate in the planning for the overall needs of our people.

Research grants by area, institution, and principal investigator

DELAWARE

Investigator	Project title	Grant No.	S.S.	Amount
DELAWARE CITY				
Governor Bacon Health Center: Voegele, G. E.	Intensive treatment unit for mentally ill youth.	R20MH 001739-02	MPGH	$90,130
NEW CASTLE				
Delaware State Hospital: Anstreicher, Kurt.	Day-hospital program	R20MH 002113-01	MPGH	100,000
NEWARK				
Biochemical Research Foundation, Franklin Institute of the State of Pennsylvania:				
Castor, LaRoy N	Cell properties related to tumorigenesis in vitro.	R1CA 007846-02	PTHB	25,112
Ross, Morris H	Effect of changes in enzyme levels on life span.	R1HD 000086-07	PTHA	78,908
Do	Aging of cells and tissues—enzymatic correlation.	R1HD 000490-06	PTHB	11,160
Silver, Carl A	The use of muscular action potential to predict performance decrements.	R1AC 000223-01	EP	21,657
Yushok, Wesley D	Regulation of metabolism of ascites tumor cells.	R1CA 005118-06	PC	21,720
Institution total, 5 grants.				158,557
Delaware, University of:				
Boord, Robert L	An experimental study of auditory pathways.	R1NB 005056-02	CMS	7,845
Cicala, George A	Age as a parameter in learning and motivation.	R1HD 000698-04	EP	9,060
Clark, Arnold M	Genetic aspects of radiation-induced aging.	R1GM 007607-05	GEN	26,520
Crossan, D. F	Effects of air pollutants on plant growth.	R1AP 000403-01	SSS	6,000
Dalber, Franklin C	Comparative embryonic nutrition among elasmobranchs.	R1GM 006809-06	NTN	28,908
Dennis, Don	Lactic acid racemization	R1GM 011765-02	BIO	13,200
Dyer, Elizabeth	Preparation of heterocyclic nitrogen compounds.	R1CA 003477-08	MCHB	13,356
Exline, Ralph V	Recording patterns of visual interaction.	R3MH 010746-01	MSM	4,200
Kwart, Harold	Remote functional group influences on reaction rate.	R1GM 011415-02	MCHA	19,680
Powelson, Dorothy M.	Factors affecting cytopathogenicity of mycoplasmas.	R1AI 006030-02	BN	10,522
Preiss, John W	Localized effects of ionizing radiation.	R1CA 006837-03	RAD	10,413
Schweizer, Edward E.	Synthesis from vinyl triphenyl phosphonium bromide.	R1GM 012692-01	MCHB	17,028
Tripp, Marenes R	Comparative immunology of mollusks.	R1GM 012070-01	AIB	19,560
Wriston, John C., Jr.	The tumor inhibitory effect of L-asparaginase.	R1CA 006780-03	CY	25,044
Institution total, 14 grants.				211,336
State total, 21 grants.				560,023

STATE OF FLORIDA,
OFFICE OF THE GOVERNOR,
Tallahassee, Fla., May 3, 1966.

Hon. PAUL G. ROGERS,
Chairman, Special Subcommittee on HEW Investigation,
Congress of the United States,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROGERS: During the week of April 18, 1966, your special subcommittee on HEW investigation heard from a number of professional and lay persons involved and extremely interested in federal-state-local health relationship. As you know, I had directed Wilson T. Sowder, M.D., Florida State Health Officer, to represent Florida and the Governor's office for these discussions.

I have reviewed the statement that Dr. Sowder presented at the round-table discussion on April 22. It reflects my views as to the need for improvement in relationships with federal health agencies for delivering health services to our citizens. I am in accord with the views he has expressed and approve the statement he submitted.

I am well aware of the tremendous accomplishments that have been attained in the past through the federal-state-local relationship in public health. I clearly see the present as a turning point with far-reaching opportunities to bring to our citizens health services only recently made possible through great advances in medical technology. The federal and state authorities must look toward new goals and find the most logical administrative organization for efficient accomplishment.

I think that, without question, the reservation and concern about current federal-state-local relationship centers around the multitude of different types of health grants available on a project basis, all with distinct and different rules and regulations and guidelines for the utilization of the funds concerned. Sometimes the broad objective is lost in the detail of fund accountability. I am particularly concerned that too much emphasis is being placed on project type grants, weighted toward experimentation, demonstration and stimulation, which usually call for greater state and local appropriations. Most frequently these grants become available when our legislature is not in session and there is no opportunity for legislative review and approval before the state incurs a financial obligation. My colleagues and I are hesitant about any agency of state government entering into federal financial commitments without knowledge of the legislature.

I am encouraged that HR 13197 embodies the philosophy of comprehensive services on a broad base with coordination of long-range planning and continuing support of health services by federal funds. But this legislation, understandably, is not a cure-all. A number of other federal agencies and accompanying health grants continue to be a part of the federal-state relationship. There must be a constant effort and evaluation of coordination between federal agencies just as we must continue such effort at state level.

The time and consideration being given to these important public heatlh matters by your subcommittee and staff are very much appreciated by those of us in the states vitally concerned with delivery of the best health services possible to our citizens. I commend you for your forceful leadership in this area of service and am confident that our relationships with federal health authorities will be strengthened in the months ahead.

Sincerely,

HAYDON BURNS, *Governor.*

IOWA STATE DEPARTMENT OF HEALTH,
Des Moines, Iowa, April 19, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on H.E.W. Investigation,
Rayburn House Office Building,
Washington, D.C.

DEAR MR. ROGERS: Governor Hughes has asked me to develop some further material in connection with the study of the organizational structure of the Department of Health, Education, and Welfare as contemplated in your letter

to him of March 18, 1966. In my letter of September 9, written also at the request of the Governor, it was suggested that there is an apparent need for some correction of the diffusion and fragmentation of health oriented efforts in H.E.W. In view of this, it was recommended that there be developed and organized a separate national Department of Health to bring together the various agencies concerned primarily with health and environmental and other factors affecting health.

It was suggested that such a Department could well include a unit for over-all planning and another for research and development. It was suggested further that this separate Department of Health should have appropriate regional offices from which coordinated activities, including consultant services and advisory assistance, could be provided to the states in connection with their various programs and projects.

It is perhaps inevitable that some overlapping and even apparent conflict of health oriented programs and activities will develop in any large organization. However, at the present time within H.E.W. there seems to be considerable overlapping and apparent conflict among a number of agencies such as Public Health Service, The Children's Bureau, Food and Drug Administration, Vocational Rehabilitation Administration and perhaps others. In addition a number of other federal agencies provide assistance through loans or grants for environmental health related activities. Among these are: Department of Housing and Urban Development, Department of Commerce (Economic Development Administration), and Department of Agriculture (Farmers Home Administration).

Within the Public Health Service itself there seems to be some overlapping, perhaps duplication, and suggested competition if not conflict. An example is the related activity of the Bureau of State Services, The Division of Hospital and Medical Facilities and the National Institutes of Health. Similarly there is some apparent competition between or among individual agencies and programs such as can be found in the general areas of chronic illnesses—heart, cancer, stroke, tuberculosis, etc. A trend in recent years towards more and more special projects grants from all of the federal agencies or units of the federal agencies made directly to various levels over subordinate governmental jurisdiction has increased the overlapping, the conflict and the competition. Project grants to the state level, local health departments, educational institutions, private voluntary agencies and in some cases private individuals has essentially eliminated the possibility of over-all planning and control by any state administrative unit or group.

Thus, it is recommended that any contemplated re-organization of the Department of Health, Education, and Welfare should have as its goal the establishment of clear lines of control of more integrated over-all planning and administration and more clear-cut definitions of the limits of responsibility for the various bureaus, services, divisions, offices, branches, and sections.

Attached is an admittedly incomplete list (attachment A) resulting from a likewise incomplete study of the various federal agencies and organizations concerned with grants and other federal assistance available for assistance in various health oriented programs in this state. These programs include: construction and equipment, research and development, and training and educational aid. Not included in this study are similarly fragmented federal grant sources for Chronic Illness an Aging. Maternal and Child Health, Environmental Hygiene programs and others.

It is hoped that the foregoing and the attached provide further, more descriptive information of the type useful for your study.

Respectfully submitted.

ARTHUR P. LONG, M.D., Dr. P.H.,
Commissioner of Public Health.

[Attachment A]

Program	Purpose	Authorization	Financing	Who is eligible	Where to write
I. CONSTRUCTION AND EQUIPMENT					
Health research facilities construction.	To promote research toward prevention and cure of disease; to make available increased laboratory and accessory space and related scientific equipment. Priority is given to facilities contributing to research in areas which have the most urgent need.	$50,000,000 per year.	Matching grants: Cannot exceed 50 percent of total construction costs of the research portion of the facility.	Universities and other private nonprofit public institutions "authorized and competent to engage in the research for which the facility is constructed."	Chief, Division of Research Facilities and Resources, National Institutes of Health, Bethesda, Md.
Hospital and medical facilities construction (Hill-Burton).	To assist in construction of general hospitals and public health centers; diagnostic and treatment centers; chronic disease hospitals; rehabilitation facilities and nursing homes.	$220,000,000 per year.	Matching grants: Federal allotments are made to States based on population and per capita income. Grants range between 33⅓ percent and 66⅔ percent of construction cost, depending on the State.	Private nonprofit organizations and public agencies, provided the project meets a community need as determined by the State Hill-Burton agency.	Chief, Division of Hospital and Medical Facilities, Public Health Service, 7915 Eastern Ave., Silver Spring, Md.
Vocational rehabilitation research and training centers.	To establish centers at qualified teaching institutions which will enable comprehensive studies of patients with various disabilities to be conducted in medically oriented settings.	No statutory limit.	Grants: No specific matching ratio. Federal share of project cost is "a matter of administrative determination."	Educational institutions (including teaching hospitals) with special rehabilitation programs.	Vocational Rehabilitation Administration, Department of Health, Education, and Welfare, Washington, D.C.
Federal Housing Administration nursing home mortgage insurance.	To furnish mortgage insurance to nursing homes for the care and treatment of convalescents and others who do not need hospital care, but who require skilled nursing care and related medical services. Can be new project or renovation.	No restriction on loans that may be insured.	Mortgage insurance: 20-year maturity at 5¼ percent. Also, various FHA fees and charges. $12,500,000 limit per project.	Proprietary firms and individuals. Mortgagors must conform to FHA minimum property standards for nursing homes, plus other regulatory agreements.	Program handled by local FHA insuring offices. Prospective applicants should begin with consultation at this level.
Mental retardation research centers.	To enable construction of centers for research on mental retardation and related aspects of human development, whether biological, medical, social or behavioral	$6,000,000 (will increase to $8,000,000 in fiscal 1965).	Grants: Federal share cannot exceed 75 percent.	Universities and nonprofit research institutions for the retarded (including affiliated teaching hospitals.)	National Institute of Child Health and Human Development, Public Health Service, Bethesda, Md.

[Attachment A]—Continued

Program	Purpose	Authorization	Financing	Who is eligible	Where to write
I. CONSTRUCTION AND EQUIPMENT—continued					
University affiliated mental retardation facilities.	To enable construction of public and other nonprofit facilities for the mentally retarded. Associated with a college or university. Will provide full range of clinical care services as well as demonstration and professional training aids.	$5,000,000 (will increase to $7,500,000 in fiscal 1965).	Project grants: Federal share not to exceed 75 percent.	Universities and colleges	Division of Hospital and Medical Facilities, Public Health Service, 7915 Eastern Ave., Silver Spring, Md.
Community mental retardation facilities.	To construct, expand, or remodel local care facilities that will bring the benefits of modern medical knowledge to the mentally retarded. Facilities may provide diagnosis, treatment, training, or care of the retarded.	No authorization in current fiscal year. $10,000,000 authorized for fiscal 1965.	Formula grants admistered through State Hill-Burton agencies. Matching requirements range from ⅓ to ⅔ of cost.	Public and private nonprofit institutions.	Division of Hospital and Medical Facilities, Public Health Service, 7915 Eastern Ave., Silver Spring, Md. (or State Hill-Burton agency).
Community mental health centers.	To construct local centers that will provide a wide range of preventive, inpatient, outpatient and aftercare services. Centers will also offer consultative services to other community agencies.	The first annual authorization of $35,000,000 will take effect in fiscal 1966.	Formula grants: Administered through State Hill-Burton agencies. Matching requirements range from ⅓ to ⅔ of cost.	do	Do.
College housing loans	To finance construction of living quarters and related facilities for interns, residents, and student nurses.	$300,000,000. (No single hospital may receive more than $4,000,000 in a given year.)	Loans at 3⅝-percent interest with maximum maturity of 50 years.	Teaching hospitals	Community Facilities Administration, Housing and Home Finance Agency, Washington, D.C. (or to any HHFA regional office).
Small Business Administration.	To promote growth of for-profit enterprises by furnishing funds for construction, modernization, or operating capital.	$1,250,000,000 (revolving loan fund).	Loans: 5½-percent interest or 4 percent in localities designated as depressed areas by Area Redevelopment Administration. Maximum loan is $350,000. 10-year repayment limit.	Proprietary hospitals, nursing homes, and health facilities.	Small Business Administration, Washington, D.C. (or any of the 65 SBA field offices).
Surplus property program.	Disposal of federally owned goods and real estate to worthy organizations, based on need. Includes a wide variety such as vehicles, furniture, lab equipment, tools, etc. Actual disbursal is made through 50 State agencies acting on direction of Federal authorities.	No set amount. Depends on property available.	Donations are free, although recipients usually pay shipment, handling, etc.	Approved or accredited tax-supported or nonprofit institutions, hospitals, clinics, and health centers.	State surplus property agency.

National Institutes of Health research support.	To assist institutions heavily engaged in research. Research center grants are made to institutions to augment physical facilities and to integrate the components of a broad research program. General research support funds are awarded to institutions for overall program support.	No statutory limitation.	Grants: No matching requirements.	Colleges, medical and nursing schools, hospitals, laboratories, and other nonprofit organizations.	Chief, Division of Researchk Grants, National Institutes of Health, Public Health Service, Bethesda, Md.
Medical and related teaching facilities construction.	To increase the number of medical, dental, and other health professions teaching facilities. Includes funds for new facilities as well as replacement and rehabilitation of existing facilities.	$25,000,000 (increases to $75,000,000 in fiscal 1965).	Matching grants: Sufficient funds must be available to meet the nonfederal share.	Public or nonprofit schools of medicine, dentistry, osteopathy, pharmacy, nursing, public health. A qualified institution may apply on behalf of an affiliated hospital.	Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C.
Accelerated public works.	To promote and accelerate public works projects in high unemployment areas, as defined by the Accelerated Public Works Act. Health facilities such as hospitals, nursing homes, diagnostic centers, and long-term care institutions are among the wide range of public works projects eligible.	$400,000,000 (about 11 percent has been reserved for health facilities projects.	Formula grants: Awards range from 50 to 75 percent of project cost, depending on the location and project.	Public and private nonprofit institutions located in areas designated as depressed by the Area Redevelopment Administration or Labor Department.	Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C. (or to State Hill-Burton agencies).
II. RESEARCH AND DEVELOPMENT					
Mental retardation research.	To promote research and demonstration projects in the areas affecting mentally retarded and other health impaired children.	$2,000,000 per year.	Grants: No matching requirements.	State, public, or nonprofit educational or research agencies.	Division of Handicapped Children and Youth, Office of Education, Department of Health, Education, and Welfare, Washington, D.C.
Atomic Energy Commission research.	To increase understanding of radiation effects arising from atomic energy applications. Includes environmental radiation studies, individual and genetic effects of radiation, and cancer research.	No statutory limit (fiscal 1964 appropriation, approximately $1,500,000).	Contracts: No limit per contract.	Public and private nonprofit hospitals, research organizations, and health facilities.	Division of Biology and Medicine, U.S. Atomic Energy Commission, Washington, D.C.
National Institutes of Health—research.	To further knowledge in the health-medical sciences. Research project grants are awarded to an institution in behalf of 1 or more investigators. The research program project grant is awarded to an institution usually for a long-term research program with a central focus.	No statutory limitation (total NIH research grants in fiscal 1963 totaled $430,908,322).	Grants: No matching requirements.	Nonprofit institutions such as colleges, hospitals, nursing schools, laboratories, State agencies, etc.	Chief, Division of Research Grants, National Institutes of Health, Public Health Service, Bethesda, Md.

[Attachment A]—Continued

Program	Purpose	Authorization	Financing	Who is eligible	Where to write
II. RESEARCH AND DEVELOPMENT—con.					
Research and demonstration projects in child welfare.	To support research and demonstration projects of regional or national significance which contribute to the advancement of child welfare.	No limitation. (fiscal 1963 appropriation was $795,000).	Grants: No specific matching requirements, but each applicant expected to finance as large a part of the project cost as possible.	Public or other nonprofit institutions of higher learning, including university affiliated teaching hospitals.	Chief, Children's Bureau, Welfare Administration, Department of Health, Education, and Welfare, Washington, D.C.
Maternal and child health services.	To promote research related to maternal and child health services or crippled children's services which show promise of substantial contribution to the advancement of these programs.	$8,000,000 annual limit on appropriations.	Grants or contracts	Public and private nonprofit institutions.	Do.
U.S. Air Force research in biological and medical sciences.	To advance the understanding of fundamental processes and mechanisms found in living things. Topics designed to contribute to aerospace medicine, may extend from the subatomic level through molecular function to the organization and activity of tissues, organs, and entire living beings.	No statutory limit (an estimated $37,000,000 was awarded for grants in fiscal 1963, about 80 percent to private institutions).	Grants and contracts: No specific matching requirements. Grants range up to 5 years in length.	Nonprofit institutions of higher learning and nonprofit organizations whose primary purpose is the conduct of scientific research (includes teaching hospitals).	Air Force Office of Scientific Research, attention Assistant for Plans and Programs, Washington, D.C. 20333.
U.S. Army medical science research.	To promote research in medical sciences with military implications. Principal interests include such areas as preventive medicine, medical supplies and equipment, environmental medicine, immunology, and blood derivatives.	No statutory limitation (annual outlay approximately $70,000,000).	do	do	Army Research Office; Office, Chief of Research and Development, Department of the Army, Washington, D.C.
U.S. Navy medical science research.	To foster investigations into selected medical fields having important bearings on Navy problems. Fields emphasized are physiology, biochemistry, microbiology, medicine, and dentistry.	No statutory limitation.	Grants and contracts	do	Chief of Naval Research, building T-3, 17th and Constitution Ave. NW., Washington, D.C.
Environmental engineering and food protection.	To define health hazards in such fields as milk, food, interstate carrier sanitation, and environmental health planning. Research is expected to yield scientific information on which control programs may be based.	No set limit ($5,020,000 appropriated for fiscal 1964).	Grants-in-aid: No matching requirements.	Universities, health agencies, and other nonprofit institutions on behalf of a named investigator.	Chief, Division of Environmental Engineering and Food Protection, Public Health Service, Washington, D.C.

Hospital and medical facilities research and demonstration.	The development of scientific information through research, experiment, and demonstration relating to effective utilization and coordination of hospital services and facilities. Includes both research in effective hospital administration and experimental construction.	$10,000,000 per year.	Grants: No matching requirements in the research program. In experimental construction grants, the Federal share is limited to 66⅔ percent.	Universities, hospitals, and other public and private nonprofit institutions.	Chief, Division of Hospital and Medical Facilities, 7915 Eastern Ave., Silver Spring, Md.
Migrant health project grants.	Setting up and developing projects to improve health conditions for domestic agricultural workers and their families.	$3,000,000 per year.	Grants: No specific matching requirements. Qualified community groups are required to assume part of costs, share can be in money, supplies, equipment, or personal services.	Public agencies, nonprofit private agencies, institutions.	Migrant Health Section, Division of Community Health Services, Public Health Service, Washington, D.C.
Occupational health research.	To promote research in fields relevant to occupational health (includes occupational health nursing).	No set limit ($2,197,000 appropriated for fiscal 1964).	Grants: No matching requirements.	Universities, nonprofit institutions, and appropriate official and private groups.	Chief, Division of Occupational Health, Public Health Service, Washington, D.C.
Radiological health research.	To conduct research into problems of radiation and the mechanisms by which radiation produces damage.	No set limit. $2,209,000 appropriated in fiscal 1964.	Grants: No matching requirements.	Schools, hospitals, individuals, and nonprofit organizations.	Chief, Division of Radiological Health, Public Health Service, Washington, D.C.
Neurological and sensory disease service.	To simulate development and improvement of community programs to combat neurological, visual, and communicative disorders. May include patient services, demonstration of health techniques, etc.	$2,950,000	Project grants: No matching requirements.	Public agencies, nonprofit private agencies and institutions.	Chief, Division of Chronic Diseases, Public Health Service, Washington, D.C
Vocational rehabilitation research and demonstration.	To expand and improve vocational rehabilitation of the disabled through research, special facilities, and demonstrations of new methods already acquired in the program.	No set limit. $15,000,000 appropriated in fiscal 1964.	Grants: No specific matching requirements other than the stipulation that grants may not cover full cost.	Public agencies and private nonprofit organizations. Awards not available to individuals.	Division of Research Grant and Demonstrations, Vocational Rehabilitation Administration, Department of Health, Education, and Welfare, Washington, D.C.
Cooperative research or demonstration in social welfare and social security.	To increase knowledge of such problems as the prevention and reduction of dependency, coordination of planning between public and private welfare agencies, or improvement in administration of programs involving the Social Security Act or related laws.	$5,000,000 per year.	Grants: No specific matching requirements except the stipulation that the applicant must pay part of the cost.	Public agencies and other nonprofit organization. Support is not available to individuals.	Cooperative Research Grants Division, Welfare Administration, Department of Health, Education, and Welfare, Washington, D.C.
Air pollution research and demonstration.	To study causes and problems of air pollution. Demonstration projects evaluate the various methods of controlling air pollution.	$5,000,000 a year. Includes training funds.	Grants are made outright. Can cover total costs.	Public and private health institutions and individuals.	Chief, Research and Training Grants Branch, Division of Air Pollution, Bureau of State Services, Public Health Service, Washington, D.C.

[Attachment A]—Continued

Program	Purpose	Authorization	Financing	Who is eligible	Where to write
II. RESEARCH AND DEVELOPMENT—con.					
Cancer control and demonstration.	To initiate and further community programs to reduce morbidity and mortality from cancer. Emphasis is placed on programs relating to cervical and lung cancers.	No statutory limitations. Depends on appropriation.	Project grants are awarded. There are no matching requirements, but priority goes to institution which finances at least 25 percent of its project. Note also: Each State has a certain allotment of funds.	Voluntary and private nonprofit health agencies.	Chief, Division of Chronic Diseases, Public Health Service, Washington, D.C.
Community health services.	To stimulate experiments and demonstrations intended to improve methods of providing out-of-hospital community health services. Emphasis is put on in-home nursing care, homemaker care and other programs to help the aged and chronically ill.	$10,000,000 per year.	Project grants: No matching funds are required.	State or local public agencies. Nonprofit private agencies or organizations.	Chief, Division of Community Health Services, Public Health Service, Washington, D.C.
Crippled children's services.	To extend services for locating crippled children and for providing medical care, diagnostic facilities, hospitalization and aftercare.	$30,000,000 per year. (The great majority of this is reserved for State agencies.)	Project grants: No matching requirements for non-State agencies and institutions.	State crippled children's agencies and nonprofit teaching institutions (including hospitals).	Chief, Children's Bureau, Welfare Administration, Department of Health, Education, and Welfare, Washington, D.C.
Accident prevention research.	To study basic causes and conditions associated with accidents. Research should point toward development of preventive measures.	No set limit. $2,046,000 appropriated in fiscal 1964.	Grants are made outright. Can cover total costs.	Nonprofit organizations, and individuals "scientifically qualified."	Chief, Division of Accident Prevention, Public Health Service, Washington, D.C.
III. TRAINING AND EDUCATIONAL AID					
Radiological institutional training.	To strengthen programs for the training of radiation health specialists to serve in radiation protection and control. Includes faculty support, student stipends, equipment costs, etc.	No statutory limitation.	Grants: No matching requirements.	Educational institutions offering care study programs in radiological health, or planning to develop such programs.	Chief, Division of Radiological Health, Public Health Service, Washington, D.C.

Water supply and pollution control.	To support advanced training programs in water supply and pollution control.	----do----	----do----	Training grants awarded to public and private nonprofit educational institutions. Research fellowships awarded to individuals for graduate and specialized training.	Chief, Division of Water Supply and Pollution Control, Public Health Service, Washington, D.C.
Vocational rehabilitation training and traineeships.	To aid both educational institutions and individual students in an effort to improve the level of professional service in vocational rehabilitation. Includes both long-term (calendar year) instruction programs and short-term training in technical matters. Also provides research fellowships.	$16,930,000 appropriated in fiscal 1964.	Grants, which are intended to pay part of cost of training projects (average outlay has been about 45 percent of cost).	Long-term awards can go to public and other nonprofit organizations. Research fellowships are available to individuals affiliated with a "qualified institution." Contracts for short-term training are open to individuals or public agencies, both profitmaking and nonprofit.	Division of Training, Vocational Rehabilitation Administration, Department of Health, Education, and Welfare, Washington, D.C.
Air pollution training projects.	To aid: (1) Individuals, for postgraduate professional training in research or control activities relating to air pollution problems; (2) Academic institutions, for curriculum development, faculty costs, student stipends, and lab equipment connected with air pollution studies.	$5,000,000 a year. (Includes research funds).	Grants are made outright. Can cover total costs.	Public and private health institutions—and individuals.	Chief, Research and Training Grants Branch, Division of Air Pollution, Bureau of State Services, Public Health Service, Washington, D.C.
Public health service fellowships.	To increase the number of qualified research investigators and teachers in the medical-health sciences. Includes categories for predoctoral, postdoctoral, and career research awards.	No statutory limitation.	Fellowships: No matching requirements. Stipends range between $1,800 and $25,000 per year plus dependents' allowance. Amount depends on project and professional level.	Candidates must be nominated by a public or nonprofit institution engaged in health research; training must take place under sponsorship of the institution.	Career Development Review Branch, Division of Research Grants, NIH, Bethesda, Md.
Graduate training in public health.	To assist schools in improving their curriculums. To enable expansion of faculties.	$2,000,000 per year.	Project grants: No matching requirements.	Schools of nursing and public health which provide graduate or specialized training.	Chief, Division of Community Health Services, Public Health Service, Washington, D.C.
Migrant health project grants.	Training of persons to provide health services and care for domestic agricultural workers and their families.	$3,000,000 per year.	Grants: No specific matching requirements. Qualified "community groups" are required to assume part of costs. The share can be in money, supplies, equipment or personal services.	Public agencies, nonprofit private agencies, institutions.	Migrant Health Section, Division of Community Health Services, Public Health Service, Washington, D.C.

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Program	Purpose	Authorization	Financing	Who is eligible	Where to write
II. RESEARCH AND DEVELOPMENT					
Neurological and sensory disease service.	To train physicians and allied personnel for community service in detection, diagnosis, and management of neurological and sensory disorders. Grants may be for program expansion, improvement curriculum enrichment, or for trainee stipends.	No set limit.....	Project grants: No matching requirements.	Institutions with accredited service training programs for health personnel in neurological and sensory diseases.	Chief, Division of Chronic Diseases, Public Health Service, Washington, D.C.
Professional nurse traineeships.	To train graduate nurses as administrators, supervisors, and teachers in all fields of nursing. Includes (1) a short-term study program to update management nursing skills for those unable to undertake full-time study; (2) long-term study. Latter program includes tuition, and stipend for living expenses.	No set limit. Approximately $7,000,000 appropriated in fiscal 1964.	Grants: No matching requirements.	Long-term training aid is awarded to institutions offering graduate nurse training. Health agencies or other nonprofit organizations may apply for short-term training grants.	Chief, Division of Nursing, Public Health Service, Washington, D.C.
Public health traineeships.	To increase the number of trained public health personnel through graduate or specialized training. Includes grants directly to training institutions, or traineeships directly to individuals accepted by such institutions.	No limitation.....	.....do.....	(1) Accredited schools offering master of public health degree, (2) nursing schools offering a "recognized" program to prepare graduate nurses for public health nursing positions, (3) individuals such as physicians, nurses, specialists and health administrators.	Chief, Division of Community Health Services, Public Health Service, Washington, D.C.
National Institutes of Health direct traineeships.	To enable individuals to take postdoctoral training in health science fields of interest to the awarding Institutes.	No statutory limitation. (Fiscal 1963 appropriation of $2,825,839.)	Grants: No matching requirements. (Direct traineeships not available from all of the Institutes.)	Qualified physicians and scientists. Must have completed residency training plus 3 years of "pertinent" postdoctoral training or research experience. Must have an arrangement with a sponsoring institution.	Career Development Review Branch, Division of Research Grants, National Institutes of Health, Public Health Service, Bethesda, Md.

National Institutes of Health graduate training grants.	To assist institutions to establish or expand training for persons interested in research and clinical careers. Funds may also be used by institutions for student stipends.	No statutory limitation.	Grants: No matching requirements.	Public and other nonprofit institutions.	Career Development Review Branch, Division of Research Grants, National Institutes of Health, Public Health Service, Bethesda, Md.
Training in child welfare.	To promote special projects which train personnel for work in the field of child welfare. Also includes traineeship grants.	No limitation	Grants: No specific matching requirements, but each applicant is expected to finance "as large a part of the project cost as possible."	Public and other nonprofit institutions of higher learning (including teaching hospitals).	Chief, Children's Bureau Welfare Administration, Department of Health, Education, and Welfare, Washington, D.C.
Manpower development and training.	To train school dropouts and long-term unemployed workers in new occupationally useful skills. Includes both on-the-job training and/or instruction at approved vocational schools. (Projects have involved practical nurse, orderly, nurse aid, and related positions.)	$110,000,000 appropriation for 1964 fiscal year.	Subsistence stipends to enrolled trainees. Establishments sponsoring on-the-job training may receive grants to cover instruction expenses.	Any establishment which can offer reasonable assurance of future employment to trainees, as verified by the local bureau of employment security office.	Local bureau of employment security office; or Manpower Administration, U.S. Department of Labor, Washington, D.C.
Training of teachers for retarded and handicapped children.	To expand teacher training activities in areas of mental retardation and other health impaired children.	$13,000,000. Will increase to $14,500,000 in fiscal 1965.	Grants: No matching requirements.	Nonprofit institutions of higher education (including affiliated hospitals and State educational agencies).	Division of Handicapped Children and Youth, Office of Education, Department of Health, Education, and Welfare, Washington, D.C.

THE DIVISION OF HEALTH OF MISSOURI, STATEMENT IN REGARD TO THE FEDERAL STATE-LOCAL HEALTH RELATIONSHIP AND THE ORGANIZATIONAL STRUCTURE OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

It is my firm belief that the multiplicity of federal agencies involved in the administration and distribution of federal funds for health programs causes a serious fragmentation of health programs at both the state and local levels of operation. The establishment of a separate Department of Health at the federal level would, I am sure, tend to support and strengthen state and local health departments throughout the nation.

The magnitude of categorical, research, and other grants from various federal health related agencies makes it most difficult for state health departments to know what other agencies or organizations are receiving grants and funds for health purposes and how these programs relate to the over-all public health activities within a state. Even within the state health department, grants are received from distinct federal agencies related to the same program within the health department. Specifically, I would like to refer to the mental retardation activities—some of which are funded through grants from the United States Children's Bureau and some of which are funded from various categorical grants of the United States Public Health Service, including the categorical grant for the chronically ill and aged. Another example is in relation to the dental program which, historically, has been supported from funds received from the United States Children's Bureau. However, recently, specialized grants for dental health have been inaugurated by the Public Health Service; and, in addition, project grants in relation to dental health are in the process of being funded through the Office of Economic Opportunity. Further examples would be in the area of environmental services where a multiplicity of grants for categorical types of environmental sanitation are made available; such as, air pollution, water pollution, water resources, among many other funding mechanisms.

The present restrictions on the use of various categorical health grants are many times too strict and impractical. I refer specifically to the overlapping and intermingly of the categorical grants for the chronically ill and aged, heart disease control, cancer control, tuberculosis control, etc. The fragmentation in the funding in relation to these overlapping programs tends to defeat the purpose for which the funds were made available by the congress.

Public health must deal with the whole person and with the whole community and programs often are seriously hampered by the necessity for the strict validation of the various categorical funds utilized within this whole concept.

In Missouri, especially in the rural areas of the state, our personnel, limited in number, must provide generalized services. We cannot hire—and it would be impractical to do so—specialized nurses in the various health fields categorically; such as, a nurse for cancer, another for heart disease control, another for chronically ill and aged, and another for maternal and child health, another for tuberculosis, etc. The single nurse located in many of our rural communities must be competent to care for the whole person rather than for a single category of disease. The validation of her time and effort according to the multiplicity of funds aavilable for her support is time consuming and basically a waste of professional staff time. Greater flexibility in the utilization of federal health funds would be a giant step forward in the provision of health services to those citizens most in need of them.

Basically, I think that my recommendations can be summed up as follows:

(1) I would recommend that a Department of Health be established at the federal level.

(2) I would recommend that the block grant type of appropriations be initiated to allow states to utilize federal health funds for the health needs of each state rather than arbitrarily determining at the federal level what funds will be utilized for various health programs.

(3) I recommend the return to the generalized approach to public health as opposed to the specialized approach that, in my opinion, has caused much of the fragmentation of services.

L. M. GARNER, M.D.,
Acting Director.

THE STATE OF KANSAS,
OFFICE OF THE GOVERNOR,
Topeka, Kans., May 5, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation of the Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR PAUL: On April 4 you wrote to advise me that the Special Subcommittee on Investigation of the Committee on Interstate and Foreign Commerce would receive comments to be included in the printed record of the hearings previously held by the Subcommittee on federal and state relationships in the matters relating to public health.

I am enclosing a statement that reflects the official views of the State of Kansas. This statement is supported by the Kansas State Board of Health, the policy-making agency for the State, as well as myself as Governor.

Thank you for the opportunity to place these views upon the record.

Yours very truly,

WM. H. AVERY, *Governor.*

STATEMENT FOR THE RECORD ON PUBLIC HEARINGS CONCERNING INVESTIGATION OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Proceedings of the 1964 Annual Conference of the Surgeon General, Public Health Service, and Chief, Children's Bureau with State and Territorial Health Officers and the 1964 Annual Meeting of the Association of State and Territorial Health Officers, November 10–12, 1964, Washington, D.C., documents the discontent of the health officers of the various states and territories with the inadequacies of the methods, policies and arrangements of Federal agencies for providing a comprehensive health service for the states and rural and metropolitan communities of the Nation on an efficient and economical basis.

The conferences among the health officers and with the Surgeon General and his staff, and Chief of the Children's Bureau, resulted in an understanding in considerable detail of the problems which existed. These are the current problems in Federal-State-local relationship in public health matters, which I understand is the subject to be considered by the Special Subcommittee at public hearings concerning investigation of the Department of Health, Education, and Welfare, on April 18–20, 1966, in Washington, D.C.

The "Proceedings" of the 1964 Conference do not portray the problems in detail but the State and Territorial Health Officers did make some rather specific conference recommendations to the Surgeon General and the Chief of the Children's Bureau which indicated the major problems existing and suggestions for establishing an improved Federal-State-local relationship and thus providing efficient and economical comprehensive state and local health services.

A copy of the recommendations as they appeared in the proceedings is attached. (See attachment A.) The most important of these recommendations was probably No. 1, for the establishment of a Task Force:

"1. The State and Territorial Health Officers recommend that the Surgeon General of the Public Health Service and the Chief of the Children's Bureau join with the Association of State and Territorial Health Officers in immediately establishing a Task Force to develop a legislative proposal to replace sections 314(c) and 316 of the Public Health Service Act with new authority for assisting states and their subdivisions in sustaining and improving state and local health programs."

Immediately after the 1964 Conference the recommended Task Force was established. It is apparent that the labors of the Task Force were far-reaching and fruitful. The studies appear to have involved consultative participation by the Bureau of the Budget, the Office of the Secretary of the Department of Health, Education, and Welfare, and thus the Office of the President, as well as a number of other official and voluntary agencies concerned with providing comprehensive health services to the Nation.

On March 2, 1966 there was introduced simultaneously in the respective houses of Congress, identical Bills S. 3008 and H.R. 13197, "To amend the Public Health Service Act, to promote and assist in the extension and improvement of comprehensive health planning and public health services, to provide for a more effective use of available Federal funds for such planning and services and for other purposes."

Hearings were held on S. 3008 before the Subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate Eighty-ninth Congress, Second Session on March 16 and 17, 1966.

I have carefully studied the record of the hearings on S. 3008. It appears that well-qualified individuals representing official Federal, State and local health agencies, as well as representatives of voluntary agencies, indicated in some detail an understanding of the current problems in Federal-State-local relationship in public health matters, and their belief that S. 3008, with some minor changes and inclusion of a specific and adequate amount to be appropriated for the support grant would provide for the most efficient and economical comprehensive health service for the Nation.

I realize that your Special Subcommittee has the important responsibility of investigation of the Department of Health, Education, and Welfare. It is essential that any plan to supplant the gross inadequacies of our present system in providing comprehensive health services be formulated on the basis of specific experiences. Perhaps these experiences should be documented before they can be accepted on the basis of the manner in which statements of the gross deficiencies have come forth from individuals and groups. Criticism has been in calm generalized phrases, in emotionally accented bitter words, and in sarcastic cliche outbursts.

We must acknowledge, however, that whenever an investigation is made most of us expect that the investigators will come up with a culprit who is responsible for our horrible predicament. The truth of the matter is that we are all responsible for the way of life into which we gently drifted at first but now toward which we are rushing pell-mell and headlong. None of us is willfully attempting to scuttle the ship individually or as part of a sinister revoluntionary plot. We fabricate a rationale for going along with the way of life around us.

To document our experiences would require naming persons, places, and dates. This would further strain our relationships within our states and between states and the Federal agencies. With this in mind, I shall make comments on the three general issues which your background statement indicated would be emphasized at these hearings. These comments are based on actual experience:

(1) The multiplicity of Federal agencies involved in the administration and distribution of Federal health funds has a very deleterious effect upon the efficiency and economy of administration of the health programs of the various states.

a. Federal funds are offered and accepted by states for a multiplicity of individual programs which often have no relation to the basic needs for a comprehensive public health program to back up the categorical program administratively or by direction of operation of programs.

b. Many of the programs offered to a state or community have dramatic and emotional appeal heavily laden with wishful thinking, rather than with a precise knowledge that a disease can be prevented or cured or a health problem solved or substantially ameliorated.

c. Most of the programs are offered without any common formula for funding, even though their origin is in the same Federal agency. There are "formula grants," "project grants," "reimbursement grants" and many variations of these.

d. Grants are made available irregularly and this may be at any time in a fiscal year, having no relation to the state's established budget or program.

e. Federal agencies compete in offering almost identical programs. Some Federal agencies offer more for the matching dollar than a sister agency. This tempts local agencies to withhold matching funds for the highest bidder.

f. Programs and funds are offered to one state health agency on an entirely different basis than for another in the same state.

g. Generally, duplication of services, facilities and personnel within the state cannot be avoided.

(2) The alleged tendency of Federal authorities to by-pass state health authority when sponsoring health projects and activities within their states.

a. By-passing is common practice in the Federal-State-local relationship—BUT it is not done willfully. It is done rather in a "skinpass" fashion. With the multitude of programs and projects offered to states and communities, by various Federal agencies, without partnership planning it is not possible for the skeleton staff of either the state or Federal agency to take time

to give enough consideration to the need of the programs or the practicality of carrying them out in any state. The programs often require the direction and participation of highly specialized professional personnel who are not available to state of Federal agencies. The programs are often offered and accepted by state and Federal personnel who are not professionally qualified to know what is being offered and what is being accepted. It then becomes the responsibility of the State Health Authority to "approve" a program, project, agreement or contract often within twenty-four hours before the deadline time for submission of the voluminous "papers" to the Regional and Washington offices of the Federal agencies. When one of the several (and often many) "state health authorities" approves such programs he is often signing a "blank check." If a "health authority" does not approve an offered program he is considered incompetent because he does not accept a bag of "free" money which surely could be put to some good use in his state.

b. Some by-passing occurs because of the eagerness of program directors within the state health department "to get things moving." They individually confer by telephone with an individual in a Federal agency, often by-passing the Regional office of the Federal agency and formulate a plan, budget and program without consulting the director of the state or local health department or the director of an estabilshed program within the state which might be called upon to back up the "new" program—or the "new" program may duplicate an estabilshed program, or be in direct competition with it. Often the state health authority knows nothing about the planning for a new program or project until it reaches his desk for a signature to a formal request for the funds with the suggestion that it should be signed and forwarded immediately before the available funds are allocated to other states which are eager to obtain the "new" program.

I regret it appears that personnel in Federal agencies encourage this manner of "skim-passing" under the guise of "keeping things moving." Running a new program through the mill is considered efficiency and not by-passing by many health people both within the states and in the Federal agencies.

Many individuals in state health agencies turn to individuals in the Federal agencies for direction in well-established as well as new programs rather than to their state administrators, especially where their programs are heavily supported by Federal funds.

(3) The desirability of allowing the states greater flexibility in spending Federal grant money.

a. We believe that states should have sufficient flexibility in expenditure of Federal grant money so that support may be given to a comprehensive state health service program based upon the needs for service, as determined by a strong state health planning service in partnership with a strong Federal health planning service.

SUMMARY

It is well that the Special Subcommittee develop information concerning the current problems in Federal-State-local relationship in public health matters. Only through a careful appraisal of the problems can we hope to formulate a plan and legislation to put our house in order. Such a plan and legislation may be embodied in S. 3008 and H.R. 13197.

Hearings have already been held on S. 3008. In its original form (S. 3008) health services for the human body have been divided at the neck. During the hearings at least a half dozen different voluntary agencies strongly indicated that funds should be earmarked for their programs. It appears that it is going to take a lot of argument backed by hard, cold facts to convince the majority of our citizens that our present system of providing comprehensive public health services is grossly inefficient and very uneconomical.

Obviously we have been promising too much too soon without the knowledge, facilities and qualified personnel to back up our promises. We fashion programs to cope with some of our most acute health problems. The results of our efforts end in frustration both for those who must carry out the programs and the citizen who has had such great expectation. Because of this the Federal-State-local relationship concerning public health matters has been strained. I believe that the Federal and State agencies working in partnership can provide an efficient comprehensive health plan and program for the Nation. It may require a great deal of perseverance, patience and time but it can be done.

Your Special Subcommittee has an enormous responsibility in assembling the facts concerning the current problems in the Federal-State-local relationship in public health matters. If we can be of any assistance in your important labors, please advise us.

[Attachment A]

RECOMMENDATIONS ON THREE BROAD MAJOR PROBLEMS—STATE AND TERRITORIAL HEALTH OFFICERS, NOVEMBER 1964

FEDERAL GRANTS-IN-AID FOR HEALTH PROGRAMS

Legal authorization for several Public Health Service formula grants to the states expires in June, 1966. These include grants for Community Health Projects, Cancer, Chronic Illness, Dental Health, General Health, Heart Disease Control, Mental Health, Radiological Health, Tuberculosis, and Venereal Diseases. The General Health grant, initiated in 1936, was reduced by a million dollars in 1964–65 from the 1963–64 level. The reduction in the General Health grant is viewed as a symptom of a federal tendency to give greater emphasis to narrow-range categorical funds and special projects, rather than broad-base support for state and local public health programs. The grant authorization sections of the Public Health Service Act which will expire in 1966 are Sections 314(c) and 316. In the following material, state and territorial health officers set forth their position on this issue. For further background, see presentations by Doctor Terry and Mr. Staats which are part of this report.

Recommendations

1. The State and Territorial Health Officers recommend that the Surgeon General of the Public Health Service and the Chief of the Children's Bureau join with the Association of State and Territorial Health Officers in immediately establishing a Task Force to develop a legislative proposal to replace sections 314(c) and 316 of the Public Health Service Act with new authority for assisting states and their subdivisions in sustaining and improving state and local health programs.*

In developing this legislative proposal, the Association takes the position that such legislation:

A. Provide for grants to states to enable each state to conduct comprehensive community health studies in order to develop meaningful statewide health plans.

B. Establish in law the concept of the federal government sharing with the states and communities the cost of sustaining the full range of public health services necessary in each state.

C. Separately provide authority for categorical grants (both formula and special project) in problem areas identified by the Congress as being of significant national interest.

D. Provide that a report of progress in improving the health of the nation and recommendations for future legislative action be submitted to the Congress approximately four years after enactment and that the legislative authority have a five year termination date, and that this report and the proposed legislative changes be developed as a joint effort on the part of the Public Health Service, Children's Bureau, and the Association of State and Territorial Health Officers.

2. The State and Territorial Health Officers recommend that the Surgeon General of the Public Health Service and the Chief of the Children's Bureau be informed that the State and Territorial Health Officers reject in its entirety the proposal for change in the State Plans as submitted in our agenda book.*

The Association further recommends to the Surgeon General and the Chief of the Children's Bureau:

A. That plan procedures for formula grants which were in effect in the 1964 fiscal year be re-instituted for the 1966 fiscal year.

B. That the Surgeon General and the Chief of the Children's Bureau join with the Association in establishing a working group for the purpose of establishing guidelines for state planning as contemplated in recommendation one and that these be developed by June 1, 1965.

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*Conference recommendation.

C. That the Surgeon General and the Chief of the Children's Bureau join with the Association in conducting regional seminars to familiarize state and local health agency personnel with these planning guidelines.

D. That the states commit themselves to provide through the medium of procedures developed jointly by the Public Health Service, Children's Bureau, and the Association of State and Territorial Health Officers additional information necessary to the federal agencies to meet congressional needs in the interm prior to the development of a new state plan format.*

Some additional principles related to Federal health grant policies

Following are some additional principles which the Association of State and Territorial Health Officers offers as guides in developing federal health grant policies:

1. Grant policy should contain no provision which will penalize a state which exercises initiative in developing a program with its own funds prior to the availability of federal cost sharing.

2. Categorical grants, particularly project grants, should be so designed as to foster cohesion of programs rather than their fragmentation.

3. Grant policy should require evidence of value received in terms of meaningful program activities carried out rather than in terms of detailed fiscal records of separate federal funds accounting charges by object classification.

4. The federal agencies should strive to the maximum extent possible for uniformity and consistency in forms, policy, and procedures among different grant programs.

5. Categorical grants, especially of the project type, should be limited in their use of the following:

Stimulation of the "growing edge" of public health.

Experimentation and demonstration of newer or improved methods of rendering service.

Assistance with problems of limited geographical nature.

Assistance in unique health problem fields (poverty, industry, etc.).

Provision for specialized training.

6. Development of research competence and the conduct of research are essential components of public health administration and should be stimulated and supported by the federal government through general support type grants as well as individual research project grants.

EXECUTIVE DEPARTMENT,
Annapolis, Md., May 5, 1966.

Hon. PAUL G. ROGERS,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for your kind invitation to submit further statements to the Special Subcommittee on Investigations of the Committee on Interstate and Foreign Commerce. You will recall that I replied to your inquiry of last summer concerning Maryland's relationships with the Department of Health, Education, and Welfare.

I would like to comment further that fragmentation, restrictions on the utilization of Federal funds by the States and occasional by-pass of official health agencies have caused some problems in Maryland. H.R. 13197 and S. 3008 have been presented to my office and seem to offer an approach for solving some of the problems in Federal-State relationships in health planning and aid in providing basic health services. Maryland has developed outstanding programs in health and medical care, mainly supported by State appropriations, with more emphasis on establishing basic service programs rather than categorical disease programs or demonstrations. The possibility of Federal assistance in this specific area is one which I could enthusiastically support.

I have been made aware of the extensive hearings which your Subcommittee conducted during the latter part of April on this subject. I would not then wish to present repetitious arguments for clarifying the problems of Federal-State relationships with the Health, Education, and Welfare agency. The most severe problems exist in the areas which have been previously identified in this letter.

Any action which your Subcommittee can take to resolve them will be a decidedly progressive step.

With kindest personal regards, I am,

Sincerely yours,

J. MILLARD TAWES, *Governor.*

STATEMENT SUBMITTED TO THE SPECIAL SUBCOMMITTEE ON INVESTIGATIONS OF THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE BY HOLLIS S. INGRAHAM, M.D., COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH

I have been asked by Governor Rockefeller to present New York State's position in relation to the impact of Federal Health programs on state health activities. The Governor's intense interest in the direction, or should I say, drift, of Federal-State relations is demonstrated by the special committee of State officials he has named to study this vital issue. I have the pleasure to serve on that committee and its report should be ready for release in a few weeks. But today I hope to reflect to this subcommittee the views of my Department and, I believe of state health officials generally, to the overwhelming events taking place in the health field in the past year.

In 1965 Congress directed its attention to a range and depth of health problems unsurpassed in any previous period—Medicare, for example, offering not only hope for the aging but also generous assistance to the needy; the Heart, Cancer and Stroke regional bill to help close the gap between the potential and the performance of medicine; the liberalized—though still insufficient—Federal aid to clean up our polluted waters. These all come to mind immediately. There are several more.

But the passage of this undeniably fortunate package of health legislation also fills those of us on the State and local scene with foreboding. We can't help wonder, since we've witnessed unfortunate by-products arising from the good intentions of past Federal health programs, what can we expect from this crescendo of new Federal activity? More programs are being piled onto an already shaky administrative base. We're not complaining of substance—we need the programs you have enacted—but the form troubles us.

Let me make perfectly clear that my criticisms of the forms of Federal programs and Federal aid are not to be translated as criticism of the U.S. Public Health Service. In fact, part of our distress, as I'll explain later, can be traced to the fact that Federal health programs are splintered beyond any sole responsibility of any one agency for them. Actually our day to day relationship with both of the HEW elements most related to our work—the Public Health Service and the Children's Bureau—are excellent. We are continually impressed by the skill and competency of these people. We also appreciate the general tone of understanding and cooperation they display towards state problems. The difficulties we have experienced grow out of the uncoordinated and scattered health policies of the Federal government which are largely imposed on and not produced by our counterpart agencies in Washington.

Despite the fretfulness I've displayed so far, there are encouraging signs. One is the concern of this committee with the state of Federal health machinery. I was especially encouraged to see in Mr. Rogers' letter of invitation to Governor Rockefeller, for example, that you have accurately diagnosed what's troubling state and local health officials.

Our first concern is the absence of unified, coordinated health policies coming out of Washington. In a word—fragmentation. I don't have to inflict on you the list of Federal agencies with a finger in the health business. I need not bore you with the catalogue of separate, often unrelated, occasionally competing health programs within a single agency. We estimate, for example, that in the area of water management and water pollution alone, there are about 500 Federal employees in our State working for at least five Federal agencies—Public Health Service, U.S. Army Corps of Engineers, the Federal Power Commission, the Soil Conservation Service and the U.S. Geologic Survey.

Water pollution control provides a good, or rather, a bad, recent example of another splinter in the Federal health bundle. Water pollution control has been removed from the Public Health Service within HEW and its shift to even more distant parts is being considered. Yet, a pure water supply is the bedrock of good public health. Some of the most dramatic victories—victories measured in thousands of lives saved—were won because health departments fought for clean

water supplies. The virtual conquest of typhoid fever is a standout example. Of course, water is so universally vital a commodity that I suppose a case could be made for putting its control in any agency. Why not the Navy? The fact remains that the fight for a wholesome environment—including the air, as well as the water—is first and foremost a fight for a healthful world. Consequently—the supervision of the wholesomeness of these resources belongs in a health agency, in the states and in Washington.

The splintering off of water pollution control is only symptomatic of deeper fragmentation. My major recommendation for halting this destructive process and the major recommendation I will make in this statement is that the Federal government must create a single, strong Federal health agency, an agency with strong operational power to carry out all of the Federal government's health programs and strong coordinative power to harmonize the health-related activities of other Federal agencies. Such an agency could still fit organizationally into the Department of Health, Education and Welfare in which case it should be headed by an undersecretary.

The second accurate diagnosis that Mr. Rogers made in his letter to Governor Rockefeller is that state health officials are disturbed by the increasing Federal practice of by-passing the states and dealing directly with local public and even private agencies. In a state like my own, where we try to do intelligent statewide planning, it's demoralizing to see the mayors sidestepping the State House on their way to the White House. How can we deploy our manpower, resources and money to meet what we know best to be our priority health needs when these needs and priorities are distorted by Federally inspired and supported projects that we may not even know about and over which we have no control?

I have a recommendation that can go a long way towards ending this condition and restoring a creative, responsible function for the states. I urge the passage of HR 13197, the Comprehensive Health Planning and Public Health Service Amendments of 1966 now before your sister Subcommittee on Health and Safety. This legislation would provide grants for statewide planning to be done by a single state agency advised by a council broadly representing public, private and consumer viewpoints.

This bill will not curtail grants to localities and non-governmental agencies. But it will provide for statewide coordination. The state will know what each of its many hands are doing and will be able to move with unity of purpose, if not of action, towards its health goals.

HR 13197 also deals effectively with another major failing in present Federal grant programs. Mr. Rogers also noted this complaint of the states in his letter to Governor Rockefeller. I'm referring to the exasperating rigidity of grants awarded to combat a specific disease or a particular health problem. We now have these grants in about 40 varieties and sub-varieties in the health field alone. And we dare not, in fact by Federal law we can not, take funds from one grant and apply them to another program where our needs are greater.

We feel a little like a mother who can only serve one dish to one child, a different dish to a second child, still another to a third—and who dares not change this mindless routine even to meet the different nutritional needs of her brood. I'm not implying that any of our state programs are being starved. Just that they are nourished with mechanical arbitrariness. The net effect is that some overeat while others go to bed hungry.

HR 13197 would credit the states with enough initiative and intelligence to balance these diets. The bill would provide grants "for Comprehensive Public Health Services." These grants would be available to support basic health services. A flexible grant system like this elevates the state from servant to a full Federal partnership in the health field.

Besides this basic support for services the bill still authorizes Federal project grants to states, to localities and to non-governmental health institutions to spur new and daring health programs. But as I mentioned, under this legislation these grants would have to fit into a total framework of integrated state planning.

We do have some minor dissatisfactions with the bill. But we'd rather see its many virtues become law rather than endanger its passage by petty carping. But, as an example of what might be improved, we are not convinced that the seeming reasonableness of basing grants on population tempered by per capita income is all that reasonable. We will understand the historic function of grants to elevate the less fortunate states towards the more prosperous. But you don't have to modify grants downward just because the state's per capita income is high. Especially in the field of environmental and other health problems, population itself performs the equalizing function. People create problems. The

states with the sharpest water and air pollution problems are obviously the populous states—and hence the ones that must spend most heavily to curb pollution. Things, usually both goods and labor, usually cost more in heavily urbanized areas. The advantages of higher per capita income are quickly cancelled out. Consequently, we think it far more equitable to provide grant aid strictly on a population basis. But the greatest long-range good the committee can effect is to promote a single, strong Federal Health agency that will bring consistency and direction to Federal health programs and which can dependably and authoritatively advise the Congress in the enactment of health legislation. Such an agency will bring us closer to the twin objectives of a healthier nation and a healthier federalism.

STATE OF HAWAII,
EXECUTIVE CHAMBERS,
Honolulu, Hawaii, April 14, 1966.

Hon. PAUL G. ROGERS,
Chairman, Special Committee on HEW Investigation, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for your letter of April 4, 1966, in which you request my views on the present federal-state local relationship in matters of public health.

I am indeed sorry I cannot accept your invitation to appear at the hearings of the Special Committee on HEW Investigation, but I have asked our State Health Department for comments and would like to submit these for your consideration.

In order to keep our comments as brief as possible, I will restrict them to the three general issues which you stated would be emphasized in the deliberations of your committee.

1. In regard to the multiplicity of federal agencies in the administration and distribution of federal health funds and its effect on the health programs of the various States, I have been advised by our Director of Health that he does consider this a problem and that this matter has been discussed on several occasions at annual meetings of the State and Territorial Health Officers. It would be our recommendation that consideration be given to reducing the number of federal agencies involved in the administration and distribution of federal health funds, with thought being given to the combination of the Children's Bureau health functions and the Public Health Service functions since they are both concerned with public health. This should bring about more uniformity in provisions of the grants. This would also improve communications since it would eliminate the necessity of sending duplicate materials on related matters to both agencies. This might also provide for more uniform manuals concerning administration of grants.

2. We agree that Federal authorities should not by-pass state health authorities when sponsoring health projects and activities within their States.

3. Regarding the desirability of allowing the States greater flexibility in spending federal grant money, I would like to submit some suggestions. It is our recommendation that there be more general grants instead of special categorical grants such as cancer control, chronic illness and aging, tuberculosis control, heart disease control, etc. This would allow the States more flexibility and an opportunity to use funds for programs which are most critical in a particular state. Health needs in the various states differ and programs should be designed to fit the individual needs of the state. Furthermore, it sometimes happens that a state may have a well-advanced program in a particular category so that it would not need additional funds for that program, but would need assistance in initiating other programs. This should assist states in their long-range planning for health needs. Planning is somewhat hampered at present because the states must anticipate the specific area which federal funds will support.

Our Director of Health has advised me that we should endorse the recommendations of the State and Territorial Health Officers in this matter. These have been made available to me and I heartily agree.

We sincerely hope that this information will help in the deliberations of the committee.

With warm personal regards. May the Almighty be with you and yours always.

Sincerely,

JOHN A. BURNS.

STATE OF MICHIGAN,
OFFICE OF THE GOVERNOR,
Lansing, Mich., April 18, 1966.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on HEW Investigation, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: I am happy to have this opportunity to supplement my letter to you of September 27, 1965 on the study of the organization of the federal Department of Health, Education, and Welfare, which I trust is already part of the official record.

Since the mid-Thirties, federal programs have done much to help Michigan as well as other states to build effective public health services. However, after a generation of development, it is quite apparent that decisive action is needed to renovate and to remodel the organization and structure of federal health services and federal health aid to help meet complex health needs in our changing communities.

From the state's viewpoint, federal health programs have gotten out of hand. The hodge-podge of separate programs pouring from Washington breeds duplication, overlapping, competition, and waste. This is costly in health, and it is costly in dollars.

Our basic position in Michigan is that a new federal health organization and structure should be developed which will provide for maximum opportunity for effective state and local decision making, on a responsible basis, with minimum centralized control.

This means providing for the real coordination of programs both on a federal and state level. At some point in the federal structure, there should be sufficient authority to make sure that the various arms, including research, services, and grants, are working together. In addition, a mechanism should be provided so all federal health programs coming into a state can be coordinated.

This should not be construed as calling for some kind of a narrow, restrictive funnel. Instead, what we need is an agreed-upon basis for comprehensive health planning at the state level. This will result in fitting the various components of federal, state, and local programs together so that each strengthens the other; it will result in a working interrelationship of resources which will benefit all concerned.

This means providing grants and services which are sufficiently broad to allow the states and localities to establish priorities based on actual and projected needs, rather than upon categories predetermined on a centralized basis. The current emphasis upon "disease categories" and upon the "project" approach too often undermines responsible state and local level program planning. What we need is a federal health grant structure which uses the health talents developed in the states rather than by-passing or tying the hands of those who know the over-all state problems best.

Coordination and some broad-range assistance from the national level, matched by comprehensive planning at the state and local level, will put us on the road to recovery in the management of health programs. We will be able to focus together on the priority problems and opportunities in this field. We will be able to make a much more balanced use of dollars resources, both private and governmental. We will be able to optimize our use of scarce, expensive technical manpower. We will hold down red tape. We will, together, serve the best interests of the health of our citizens and communities.

Sincerely,

GEORGE ROMNEY, *Governor.*

STATE OF MONTANA,
OFFICE OF THE GOVERNOR,
Helena, Mont., April 18, 1966.

Congressman PAUL G. ROGERS,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Athough it will not be possible for me to attend the public hearing before your subcommittee, I appreciate the opportunity to express my views on state-federal relationships with regard to health programs.

I will comment on the three general issues which will be combined at the hearing:

I. MULTIPLICITY OF FEDERAL AGENCIES INVOLVED IN THE ADMINISTRATION OF FEDERAL HEALTH FUNDS

When a health problem occurs in Montana, I will refer to the State Board of Health. There has been very little fragmentation of health programs on a state level. The same thing cannot be said for the federal government. It requires an expert to be knowledgeable about federal administrative structure.

Our best federal contact is the regional office of Health, Education and Welfare. Unfortunately, not all federal programs relating to health are tied to this regional office. The Federal Food and Drug Administration regional office is at Seattle. The Mental Retardation Facility Construction Program is handled out of the San Francisco Health, Education and Welfare office, while all other medical construction programs are out of the Denver office. The Health, Education, and Welfare auditors, which have been located in Helena, are scheduled to be transferred to Salt Lake City. This does not make sense to me since they will work under greater handicaps because of travel time.

The Office of Economic Opportunity has entered the health field to a large extent. Their regional office is in Kansas City. It is too early to know what will happen to the new Department of Housing and Urban Development, but there will be still another administrative channel to be followed.

I would urge a consolidation of health programs into the Department of Health, Education and Welfare, giving the regional office of Health, Education and Welfare more responsibility of coordination of health programs.

II. ALLEGED TENDENCY OF FEDERAL AUTHORITIES TO BY-PASS THE STATE HEALTH AUTHORITY WHEN SPONSORING HEALTH PROJECTS AND ACTIVITIES WITHIN THE STATE

I am pleased to state that there has been very little complaint of his in Montana. There is no complaint whatsoever of H.E.W. through its regional office.

I am concerned with what may happen in the future, particularly with air and water pollution enforcement programs. It seems to me that the federal government is moving into areas that have been traditionally the sole concern of states.

Montana is very proud of its water pollution program. We have been able to take care of our own problems. There would be absolutely no justification of any federal intervention into any water pollution problem in Montana.

I view with concern S. 2987, which would require every municipality, corporation and individual to get permission from the federal government to discharge any wastes into a stream. This is being handled satisfactorily at the state level in Montana. Besides an encroachment into the state jurisdiction, it would seem a senseless red tape procedure.

An example did occur in December, 1963, which illustrated bad faith on the part of the federal government. I submit a copy (attachment A) of our State Health Officer's letter which describes this situation. The letter should have been addressed to the Secretary of Health, Education, and Welfare instead of the Surgeon General of the U.S. Public Health Service. Dr. Anderson did not know at the time that the enforcement branch was directly responsible to the Secretary of H.E.W. and not the Surgeon General. I think this also illustrates the point I was making earlier about not knowing which federal agency has jurisdiction.

The Office of Economic Opportunity deals directly with communities without going through the state health agency. A solution to this would be to have the Department of H.E.W. coordinate health programs undertaken by the Office of Economic Opportunity. The Department of H.E.W. would work with state agencies in the traditional manner.

III. DESIRABILITY OF ALLOWING STATES GREATER FLEXIBILITY IN SPENDING FEDERAL GRANT MONEY

We place great hopes that S. 3008 and H.R. 13197 will be passed. These bills would allow the states to do a better job of planning for their particular health problems and have greater flexibility of use of federal funds.

One aspect of providing health services hasn't been given much attention. This is the fact that it is more expensive and difficult to organize and dispense services to populations that are sparsely distributed. Our State Health Officer has de-

vised a formula which would provide a more equitable distribution of federal funds to the states. He has submitted this to the Surgeon General of the U.S. Public Health Service. In essence, it would give some additional subsidy to states in rural populations. I hope that this suggestion will be given proper consideration.

Sincerely yours,

TIM BABCOCK,
Governor of Montana.

[Attachment A]

JANUARY 31, 1964.

Dr. LUTHER L. TERRY,
Surgeon General, U.S. Public Health Service,
Washington, D.C.

DEAR DR. TERRY: We have just undergone a traumatic experience. Since it resulted from the enforcement policy of your agency, we would like to relate this experience to you.

Before describing the event that has just taken place, it would be well to mention some background information.

1. Montana has an effective water pollution control program. We like to brag about it. We are producing results. Our program has the support of the state administration, municipalities, industry and conservation groups.

2. We live in harmony with the surrounding states. Downstream states do not complain about us. We do not complain about upstream states. We have no reason to complain.

a. We do not feel that there is an interstate problem.

b. We feel Wyoming is competent to handle their problems without our intervention.

3. We have always felt that the U.S. Public Health Service was working with us to achieve the same ends. We believe in keeping water pollution control in the U.S. Public Health Service.

4. We do have water pollution problems in Montana, but they are intra—not inter-state problems and they are being solved.

Our difficulty started when we requested assistance from the Public Health Service to analyze a carbon filter. This was the result of a taste and odor problem that developed at Hardin, Montana, on the Big Horn River. First notice of this reached us on December 21, 1963. Mr. Williamson, Wyoming State Sanitary Engineer was contacted by us on Sunday morning, December 22. He arranged to have a man check the sugar factories at Worland that afternoon and at Lovell the following day. By the afternoon of the 23rd, the difficulties had been located and all parties concerned were taking care of the situation. We, in the meantime, had a man collect a sample at Hardin and found 19 ppb of phenol in the water. There was some question as to whether this might be due to vegetation or if there was also some difficulty with an oil refinery. In order to make this separation, we decided that it was desirable to have the people at Hardin install a carbon filter. However, we needed the assistance of the Public Health Service to make the analysis and wrote requesting this service. This was our mistake.

Either because of our request for a carbon filter analysis, or some criteria unknown to us, your office decided to investigate. Public Law 660, Section VIII, was cited as justification. We have no arguments as to the legality. We do question the wisdom of the decision and the manner in which it was handled.

We have no doubt that the U.S. Public Health Service is extremely desirous of showing enforcement results to Senator Muskie and others who desire more and stronger enforcement. We doubt that anyone would be particularly impressed by the alleged interstate pollution of the Big Horn River and the need for federal investigation over the protest of the downstream state.

From the point where the Big Horn River enters Montana from Wyoming to where it joins the Yellowstone River, there is only one place where its waters are used, except for irrigation. This is at Hardin, where it serves as the community water supply. The rest of the time it flows in almost utter isolation. It is a most difficult feat even to get access to the river for practically its entire course in Montana. The community of Hardin has noticed taste and odor in its water only twice during the past three years, and then only briefly. With construction of Yellowtail Dam above Hardin, even this slight "problem" would be corrected whether or not anything further in the way of pollution control was done in Wyoming.

Nevertheless, your agency decided that it was worth the time and money for eleven men to conduct an investigation.

We tried unsuccessfully to persuade the survey team to sample only at a point as near the Montana border as possible. This would fulfill the requirement of finding out if an interstate pollution problem existed. To take samples further downstream would only be of interest to an *intra* state situation. Our plea resulted in telephone calls to the Cincinnati home office of the survey team. Your office decided to sample at Hardin and at the junction with the Yellowtail in addition to the sample at Yellowtail dam.

What will happen in the future? We are afraid to call for assistance from the U.S. Public Health Service for fear that this will be used to produce further federal intervention.

Montana has carried on a successful stream pollution abatement campaign during the past ten years and, as a result, all sewered communities in this state, with the exception of three, have some type of sewage treatment. Most of our industries have adequate waste treatment in use. All are moving in the right direction and we see the completion of our campaign to clean up Montana streams within the next few years. If the U.S. Public Health Service were to enter this picture, we visualize retrogression and delay of five to ten years, since these industries certainly will not want to clean up if they are of the opinion that they may have to do something else when the federal government moves in.

The damage by the Public Health Service on the Big Horn has already been done, but we certainly do not want to see this sort of a situation develop elsewhere in the state. If Montana is causing, or creating, an interstate pollution problem, let us know and we will certainly go after it. I am certain that the states involved would let us know if we were causing any trouble.

We have conferred with Governor Tim Babcock on this situation, and he wholeheartedly agrees with our position.

We hope that you will give this your careful consideration. We believe that this is a matter of principle and if we cannot develop proper working relationships with the Public Health Service, it will be necessary to tell our story wherever it can be heard.

Sincerely yours,

JOHN S. ANDERSON, M.D.,
Executive Officer.

STATEMENT BY GOVERNOR DAN MOORE, STATE OF NORTH CAROLINA, APRIL 19, 1966

The State of North Carolina is pleased to have the opportunity of commenting upon the study of the present organizational structure and health programs of the Department of HEW, as this relates to our State. This matter is an important one and deserves full consideration.

It should be noted that the relationships between the health agencies of HEW, particularly the Public Health Service and the Children's Bureau, and North Carolina have, over the years, been pleasant ones. Much mutual benefit has accrued through this association. Much good has resulted in the form of effective and efficient health programs. It is nonetheless true that careful attention needs to be given to the present organizational structure. Careful study needs to be made of the administration and implementation of programs. The State of North Carolina, represented both by its Administration and its health agencies, heartily endorses any effort to build upon the fine work of the past, and to improve health benefits for the future.

We also endorse consideration of the three general issues to which attention will be given, and appreciate an occasion to comment upon them.

(1) The multiplicity of Federal agencies involved in the administration and distribution of Federal health funds, and its effect on the health programs of the various states.

This matter has long been a very real concern to public health administration. It is certainly true that there is duplication and overlap both in fiscal and activity reporting. The multiplicity of Federal granting agencies is complicated by the fact that there are usually different mechanisms for reporting, for matching requirements, for accounting procedures, and other administrative practices. Often, local health departments and the State Board of Health must make duplicate records for more than one agency's use; unfortunately, often without

information as to the nature of their use or why the information is being collected. Often, too, the complexity of matching requirements causes complications and confusion in reporting activity of staff and accounting of funds. If a study of HEW organization and procedures would result in a simpler and more uniform practice, administration of health programs could be greatly facilitated. Perhaps a central channel of communication through which data and reports would be filed would expedite matters.

Problems are also encountered in meeting varying programs requirements. Some requirements, it is felt are so restrictive as to be unrealistic. Others, erring in the other direction, are so lax as to actually conflict with our professional practices acts (e.g., with regard to supervision of nursing activities in one recent program). We have the unhappy experience, with differing channels of Federal lines of authority and funding mechanisms, and having health programs administered by more than one agency (not all of whose primary responsibility is health), of encountering difficulties in coordination and even competition for scarce personnel. With some crash programs, ill-coordinated at the Federal level, it is difficult for the State or its constituent communities to integrate their own programs effectively.

(2) The alleged tendency of Federal authorities to by-pass State health authority when sponsoring health projects and activities within their States.

This aspect is related to comments made above. There tends to be not only the divisive trend already commented upon, but difficulty in the State performing its role of consultant and advisor to the community. Frequently, the State health agency receives a query regarding a program or potential activity within a community, about which it has not been previously advised by the appropriate Federal authority. Unfortunately there is sometimes little effort to explore with the State the matter of reconciling local projects with pertinent State programs, objectives, or regulations. It must be admitted that this also occurs in agencies ouside HEW, who also have an interest in health as well as other community programs.

(3) The desirability of allowing the States greater flexibility in spending Federal grant money.

It is true that the multiplicity of program areas has often resulted in rigidity of implementation. The State is often at a disadvantage in fulfilling its task of identifying needs and assigning priorities of effort. Instead, it must often neglect certain areas, while emphasizing efforts which in a particular time and locale may not be of primary importance. There needs to be, within limits of certain performance standards, the flexibility by the State to identify and attack high-priority problems and to decide its greatest areas of needs. There should be greater ease of initiation of new ventures of an investigative or demonstration basis. There needs to be greater ability to shore up areas which are not now receiving adequate attention. For example, while there is great activity on the Federal level to stimulate categorical programs, there is no compensatory effort to assist states or communities in meeting one of the greatest needs: that of achieving sound, competent over-all administration, with both the leadership and the ability to weld the many programs into a comprehensive, coordinated, community-directed operation.

Again, let it be noted that the State of North Carolina appreciates the chance to be heard on this occasion. Its Administration and its professional health workers stand ready to cooperate in achieving even more vital and effective health programs. This is a time when, as never before, we are called upon to best utilize the resources—human, institutional, and financial—of the community, for the health of the community. We are pleased and privileged to offer our efforts in any endeavor to achieve this goal.

STATE OF NORTH DAKOTA,
EXECUTIVE OFFICE,
Bismarck, N. Dak., April 14, 1966.

Hon. PAUL G. ROGERS,
Chairman, Special Subcommittee on HEW Investigation,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you for the invitation to appear at the hearings of your Special Subcommittee on Federal-State-local relationship in public health matters. I will not be able to attend the hearings. Below is a statement reflecting my viewpoint in the matter.

It would be helpful to North Dakota in carrying out our health programs if a reorganization of the Department of Health, Education, and Welfare was effected so that its administration of health services would more adequately serve the following:

1. Decrease the scattering of health programs within HEW. Place them all in one of its units.
2. Use of the State's Health Department as its liaison when promoting or sponsoring health activities and projects. This would prevent the necessity of HEW setting up an office and staff in each state to coordinate the grants with the programs awarded to the various local agencies.
3. More leeway in using federal grant-in-aid funds so as to better assist the State in meeting its special or unique health needs. States may be more sophisticated in the appropriate and effective use of health funds than the credit often given them.

Sincerely,

WILLIAM L. GUY, *Governor.*

TENNESSEE EXECUTIVE CHAMBER,
Nashville, Tenn., April 15, 1966.

Representative PAUL G. ROGERS,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: Thank you so much for your letter concerning the public hearings of the Special Subcommittee on HEW Investigations which are being held this month.

I regret very much that it is not going to be possible for me to appear before the Subcommittee, however, I am enclosing a brief statement which I hope can be included in the record of the Subcommittee hearings.

Sincerely,

FRANK G. CLEMENT, *Governor.*

STATEMENT

Since it is a well known fact that a multiplicity of Federal agencies are involved in the administration and distribution of Federal health funds, and since because of the growing tendency toward project grants Tennessee experiences many difficulties in our relations with local governments (city and county), the following suggestion is made concerning Issue No. 1 and Issue No. 2:

A. Explore the possibility of establishing a Division (or Department) of Administration, through which all Federal health funds from all agencies would be Allocated to the various states, under uniform regulations and procedures.

Regarding Issue No. 3, it is recommended that the Congress seek means of emphasizing and promoting the control of specific diseases other than specific-categorical appropriations. The generalized public health program is the foundation of the total public health program; special local-level projects and categorical programs are implemented by workers engaged in generalized public health work. Therefore, instead of categorical grants we need increased General Health funds.

THE STATE OF WISCONSIN,
EXECUTIVE OFFICE,
Madison, Wis., April 26, 1966.

Hon. PAUL G. ROGERS,
Chairman, Special Subcommittee on HEW Investigation,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: The health of our citizens is one of our most precious national assets. It is my belief that the health of the people in the United States would be more effectively served if the multiplicity of federal agencies involved in the administration and distribution of health funds were centered under one federal health agency with cabinet status. This would tend to correct existing fragmentation of health services, both on the federal as well as on the state levels.

I also favor allowing greater flexibility in the use of federal grant funds by the state health agency in contrast to specific categorical grants. This policy permits the state health agency to use available funds in the area of greatest need, which may differ in one state from another.

Sincerely,

WARREN P. KNOWLES, *Governor.*

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