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COMPREHENSIVE HEALTH PLANNING AND PUBLIC  
HEALTH SERVICES AMENDMENTS OF 1966

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HEARING  
BEFORE THE  
COMMITTEE ON  
INTERSTATE AND FOREIGN COMMERCE  
HOUSE OF REPRESENTATIVES  
EIGHTY-NINTH CONGRESS

SECOND SESSION

ON

H.R. 13197, H.R. 18231, H.R. 18232, S. 3008

BILLS ESTABLISHING COMPREHENSIVE PLANNING FOR  
HEALTH SERVICES AND AUTHORIZING PROJECT GRANTS  
AND FORMULA GRANTS FOR HEALTH SERVICES TO THE  
STATES

OCTOBER 11, 1966

Serial No. 89-52

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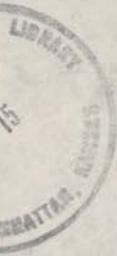
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## COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES AMENDMENTS OF 1966

TUESDAY, OCTOBER 11, 1966

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,  
*Washington, D.C.*

The committee met, pursuant to notice, at 9 a.m., room 2123, Rayburn House Office Building, Hon. Harley O. Staggers (chairman) presiding.

The CHAIRMAN. The committee will come to order.

The hearings today are on H.R. 13197 and S. 3008, H.R. 18231, and H.R. 18232, bills establishing comprehensive planning for health services and authorizing project grants and formula grants for health services to the States.

H.R. 13197 and S. 3008, as introduced, were recommended by the administration as part of the President's health message.

S. 3008 was amended substantially and passed the Senate on October 3. As passed by the Senate, the bill provides a 4-year program for grants for comprehensive health planning conducted by the States, and a 4-year program of project and formula grants for health services.

The bill contains authorization of over \$1 billion for these programs. It is very late in this session—too late I am afraid—for our committee to be able to conduct the extensive hearings which this subject deserves, although much background information concerning the problems with which this bill deals was developed in hearings held by the Special Subcommittee of this Committee on Investigations of the Department of Health, Education, and Welfare, chaired by the gentleman from Florida, Mr. Rogers.

It therefore seems best to me to schedule hearings on a much more limited bill, with the view in mind of going into the subject in some depth next year. Therefore, the gentleman from Florida and I have worked out a revision of S. 3008, which he and I then introduced on Thursday, October 6, as H.R. 18231 and H.R. 18232.

These bills authorize a total of \$44 million over a 3-year period for new, and continuation of, existing programs of comprehensive planning for health services on the State and local levels.

In addition, the bill authorizes a program of project and formula grants for the fiscal year 1968 and 1969, totaling \$125 million for each fiscal year, which represents a slight increase over the appropriation levels currently contained in the health, education, and welfare appropriation bill. The bill would modify existing law in the same fashion as S. 3008 by eliminating the so-called categorical formula grants so as to provide added flexibility in the conduct of State programs.

The committee decided last week that we would hold hearings on this bill and it is intended to complete these hearings today. I hope that the witnesses will keep this in mind, because time is very short.

At this point in the record there will be included the text of the bills and the agency reports thereon.

(H.R. 13197, H.R. 18231, S. 3008, and agency reports thereon follow:)

[H.R. 13197, 89th Cong., 2d sess.]

A BILL 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

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Comprehensive Health Planning and Public Health Services Amendments of 1966".*

#### FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress declares that fulfillment of our National purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; and that Federal financial assistance must be directed to support the marshaling of all health resources—National, State, and local—to assure comprehensive health services of high quality for every person.

(b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.

SEC. 3. Section 314 of the Public Health Service Act (42 U.S.C. 246) is amended to read as follows:

#### "GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

##### "Grants to States for Comprehensive State Health Planning

"SEC. 314. (a) (1) AUTHORIZATION.—In order to assist the States in comprehensive and continuing planning for their current and future health needs, the Surgeon General is authorized during the period beginning July 1, 1966, and ending June 30, 1972, to make grants to States which have submitted, and had approved by the Surgeon General, State plans for comprehensive State health planning.

"(2) STATE PLANS FOR COMPREHENSIVE STATE HEALTH PLANNING.—In order to be approved for purposes of this subsection, a State plan for comprehensive State health planning must—

"(A) designate, or provide for the establishment of, a single State agency as the sole agency for administering or supervising the administration of the State's health planning functions under the plan;

"(B) provide for the establishment of a State health planning council, which shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, to advise such State agency in carrying out its functions under the plan;

"(C) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Surgeon General, are designated to provide for comprehensive State planning for health services (both public and private), including the facilities and persons required for the provision of such services, to meet the health needs of the people of the State;

"(D) provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations, and groups concerned with health services, facilities, or manpower, and for cooperative efforts between such

agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, and rehabilitation;

"(E) contain or be supported by assurances satisfactory to the Surgeon General that the funds paid under this subsection will be used to supplement and to the extent practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

"(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(G) provide that the State agency will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

"(H) provide that the State agency will from time to time, but not less often than annually, review its State plan approved under this subsection and submit to the Surgeon General appropriate modifications thereof;

"(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this subsection; and

"(J) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

"(3) (A) STATE ALLOTMENTS.—From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year pursuant to paragraph (1). Any such allotment to a State for a fiscal year shall remain available for obligation by the State, in accordance with the provisions of this subsection and the State's plan approved thereunder, until the close of the succeeding fiscal year.

"(B) The amount of any allotment to a State under subparagraph (A) for any fiscal year which the Surgeon General determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallocation by the Surgeon General from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under subparagraph (A) for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Surgeon General estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallocated among the States whose proportionate amounts were not so reduced. Any amount so reallocated to a State from funds appropriated pursuant to this subsection for a fiscal year shall be deemed part of its allotment under subparagraph (A) for such fiscal year.

"(4) PAYMENTS TO STATES.—From each State's allotment for a fiscal year under this subsection, the State shall from time to time be paid the Federal share of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this subsection. Such payments shall be made on the basis of estimates by the Surgeon General of the sums the State will need in order to perform the planning under its approved State plan under this subsection, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The 'Federal share' for any State for purposes of this subsection shall be all, or such part as the Surgeon General may determine, of the cost of such planning, except that in the case of the allotments for the fiscal year ending June 30, 1970, and for each of the next two fiscal years, it shall not exceed 75 per centum of such cost.

#### "Project Grants for Areawide Health Planning

"(b) The Surgeon General is authorized, during the period beginning July 1, 1966, and ending June 30, 1972, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under

subsection (a), project grants to any other public or nonprofit private agency or organization to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants.

"Project Grants for Training, Studies, and Demonstrations

"(c) The Surgeon General is also authorized, during the period beginning July 1, 1966, and ending June 30, 1972, to make grants to any public or nonprofit private agency, institution, or other organization to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation.

"Grants for Comprehensive Public Health Services

"(d) (1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the fiscal year ending June 30, 1968, and each of the next four fiscal years such sums as may be necessary to enable the Surgeon General to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for provision of public health services.

"(2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH SERVICES.—In order to be approved under this subsection, a State plan for provision of public health services must—

"(A) provide for administration or supervision of administration by the State health authority or, with respect to mental health services, the State mental health authority;

"(B) set forth the policies and procedures to be followed in the expenditure of the funds paid under this subsection;

"(C) contain or be supported by assurances satisfactory to the Surgeon General that (i) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions in order to improve the health of the people; (ii) such funds will be made available to other public or nonprofit private agencies, institutions, and organizations, in accordance with criteria which the Surgeon General determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; and (iii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds;

"(D) provide for the furnishing of public health services under the State plan in accordance with such plans as have been developed pursuant to subsection (a) and, effective July 1, 1970, provided that except to the extent permitted in regulations, such services will be provided thereunder only to the extent included in and in accordance with the plans so developed;

"(E) provide that public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

"(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(G) provide that the State health authority or, with respect to mental health services, the State mental health authority, will from time to time, but not less often than annually, review its State plan approved under this

subsection and submit to the Surgeon General appropriate modifications thereof;

"(H) provide that the State health authority or, with respect to mental health services, the State mental health authority, will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

"(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of an accounting for funds paid to the State under this subsection; and

"(J) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

"(3) STATE ALLOTMENTS.—From the sums appropriated to carry out the provisions of this subsection the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States.

"(4) (A) PAYMENTS TO STATES.—From each State's allotment under this subsection for a fiscal year, the State shall be paid the Federal share of the expenditures incurred during such year under its State plan approved under this subsection. Such payments shall be made from time to time in advance on the basis of estimates by the Surgeon General of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this subsection.

"(B) For the purpose of determining the Federal share for any State, expenditures by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions as may be prescribed by regulations, be regarded as expenditures by such State or a political subdivision thereof.

"(5) FEDERAL SHARE.—The 'Federal share' for any State for purposes of this subsection shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than  $33\frac{1}{3}$  per centum or more than  $66\frac{2}{3}$  per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, American Samoa, and the Virgin Islands shall be  $66\frac{2}{3}$  per centum.

"(6) DETERMINATION OF FEDERAL SHARES.—The Federal shares shall be determined by the Surgeon General between July 1 and September 1 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on the next July 1. The populations of the several States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

"(7) ALLOCATION OF FUNDS WITHIN THE STATES.—At least 15 per centum of a State's allotment under this subsection shall be available only to the State mental health authority for the provision under the State plan of mental health services. At least 70 per centum of such amount and at least 70 per centum of the remainder of a State's allotment under this subsection shall be available only for the provision under that State plan of services in the communities of the State.

#### "Project Grants for Health Services Development

"(e) There are authorized to be appropriated for the fiscal year ending June 30, 1968, and each of the next four fiscal years such sums as may be necessary for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of specialized regional or national significance, (2) stimulating and supporting for an initial period new programs of health services, or (3) undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services. Such grants may be made pursuant to clause (1) or (2) of the preceding sentence with respect to projects involving the furnishing of public health services only if such services are provided in accordance with such plans as have been developed pursuant to subsection (a) and, effective July 1, 1970, except to the extent permitted in regulations, only to the extent such services are included in and are furnished in accordance with plans so developed.

## "Interchange of Personnel With States

"(f) (1) For the purposes of this subsection, the term 'State' means a State or a political subdivision of a State, or any agency of either of the foregoing engaged in any activities related to health or designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a); the term 'Secretary' means (except when used in paragraph (3)(D)) the Secretary of Health, Education, and Welfare; and the term 'Department' means the Department of Health, Education, and Welfare.

"(2) The Secretary is authorized, through agreements or otherwise, to arrange for assignment of officers and employees of States to the Department and assignment to States of officers and employees in the Department engaged in work related to health, for work which the Secretary determines will aid the Department in more effective discharge of its responsibilities in the field of health as authorized by law, including cooperation with States and the provision of technical or other assistance. The period of assignment of any officer or employee under an arrangement shall not exceed two years.

"(3) (A) Officers and employees in the Department assigned to any State pursuant to this subsection shall be considered, during such assignment, to be (i) on detail to a regular work assignment in the Department, or (ii) on leave without pay from their positions in the Department.

"(B) Persons considered to be so detailed shall remain as officers or employees, as the case may be, in the Department for all purposes, except that the supervision of their duties during the period of detail may be governed by agreement between the Department and the State involved.

"(C) In the case of persons so assigned and on leave without pay—

"(i) if the rate of compensation (including allowances) for their employment by the State is less than the rate of compensation (including allowances) they would be receiving had they continued in their regular assignment in the Department, they may receive supplemental salary payments from the Department in the amount considered by the Secretary to be justified, but not at a rate in excess of the difference between the State rate and the Department rate; and

"(ii) they may be granted annual leave and sick leave to the extent authorized by law, but only in circumstances considered by the Secretary to justify approval of such leave.

Such officers and employees on leave without pay shall, notwithstanding any other provision of law, be entitled—

"(iii) to continuation of their insurance under the Federal Employees' Group Life Insurance Act of 1954, and coverage under the Federal Employees Health Benefits Act of 1959, so long as the Department continues to collect the employee's contribution from the officer or employee involved and to transmit for timely deposit into the funds created under such Acts the amount of the employee's contributions and the Government's contribution from appropriations of the Department; and

"(iv) (I) in the case of commissioned officers of the Service, to have their service during their assignment treated as provided in section 214(d) for such officers on leave without pay, or (II) in the case of other officers and employees in the Department, to credit the period of their assignment under the arrangement under this subsection toward periodic or longevity step increases and for retention and leave accrual purposes, and, upon payment into the civil service retirement and disability fund of the percentage of their State salary, and of their supplemental salary payments, if any, which would have been deducted from a like Federal salary for the period of such assignment and payment by the Secretary into such fund of the amount which would have been payable by him during the period of such assignment with respect to a like Federal salary, to treat (notwithstanding the provisions of the Independent Offices Appropriation Act, 1959, under the head 'Civil Service Retirement and Disability Fund') their service during such period as service within the meaning of the Civil Service Retirement Act; except that no officer or employee or his beneficiary may receive any benefits under the Civil Service Retirement Act, the Federal Employees Health Benefits Act of 1959, or the Federal Employees' Group Life Insurance Act of 1954, based on service during an assignment hereunder for which the officer or employee or if he dies without making such election) his beneficiary elects to receive benefits, under any State retirement or insurance law or program, which the Civil Service Commission determines to be similar. The Department shall deposit currently

in the funds created under the Federal Employees' Group Life Insurance Act of 1954, the Federal Employees Health Benefits Act of 1959, and the civil service retirement and disability fund, respectively, the amount of the Government's contribution under these Acts on account of service with respect to which employee contributions are collected as provided in subparagraph (iii) and the amount of the Government's contribution under these Acts on Service Retirement Act on account of service with respect to which payments (of the amount which would have been deducted under that Act) referred to in subparagraph (iv) are made to such civil service retirement and disability fund.

"(D) Any such officer or employee on leave without pay (other than a commissioned officer of the Service) who suffers disability or death as a result of personal injury sustained while in the performance of his duty during an assignment hereunder, shall be treated, for the purposes of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

"(4) Assignment of any officer or employee in the Department to a State under this subsection may be made with or without reimbursement by the State for the compensation (or supplementary compensation), travel and transportation expenses (to or from the place of assignment), and allowances, or any part thereof, of such officer or employee during the period of assignment, and any such reimbursement shall be credited to the appropriation utilized for paying such compensation, travel or transportation expenses, or allowances.

"(5) Appropriations to the Department shall be available, in accordance with the standardized Government travel regulations or, with respect to commissioned officers of the Service, the joint travel regulations, the expenses of travel of officers and employees assigned to States under an arrangement under this subsection on either a detail or leave-without-pay basis and, in accordance with applicable law, orders, and regulations, for expenses of transportation of their immediate families and expenses of transportation of their household goods and personal effects, in connection with the travel of such officers and employees to the location of their posts of assignment and their return to their official stations.

"(6) Officers and employees of States who are assigned to the Department under an arrangement under this subsection may (A) be given appointments in the Department covering the periods of such assignments, or (B) be considered to be on detail to the Department. Appointments of persons so assigned may be made without regard to the civil service laws. Persons so appointed in the Department shall be paid at rates of compensation determined in accordance with the Classification Act of 1949, and shall not be considered to be officers or employees of the Service for the purposes of (A) the Civil Service Retirement Act, (B) the Federal Employees' Group Life Insurance Act of 1954, or (C) unless their appointments result in the loss of coverage in a group health benefits plan whose premium has been paid in whole or in part by a State contribution, the Federal Employees Health Benefits Act of 1959. State officers and employees who are assigned to the Department without appointment shall not be considered to be officers or employees of the Department, except as provided in subsection (7), nor shall they be paid a salary or wage by the Service during the period of their assignment. The supervision of the duties of such persons during the assignment may be governed by agreement between the Secretary and the State involved.

"(7) (A) Any State officer or employee who is assigned to the Department without appointment shall nevertheless be subject to the provisions of sections 203, 205, 207, 208, and 209 of title 18 of the United States Code.

"(B) Any State officer or employee who is given an appointment while assigned to the Department, or who is assigned to the Department without appointment, under an arrangement under this subsection, and who suffers disability or death as a result of personal injury sustained while in the performance of his duty during such assignment shall be treated, for the purpose of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury

or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents, in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

"(8) The appropriations to the Department shall be available, in accordance with the standardized Government travel regulations, during the period of assignment and in the case of travel to and from their places of assignment or appointment, for the payment of expenses of travel of persons assigned to, or given appointments by, the Service under an arrangement under this subsection.

"(9) All arrangements under this subsection for assignment of officers or employees in the Department to States or for assignments of officers or employees of States to the Department shall be made in accordance with regulations of the Secretary.

#### "General

"(g) (1) All regulations and amendments thereto with respect to grants to States under subsection (a) shall be made after consultation with a conference of the State health planning agencies designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a). All regulations and amendments thereto with respect to grants to States under subsection (d) shall be made after consultation with a conference of State health authorities and, in the case of regulations and amendments which relate to or in any way affect grants for services or other activities in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of such regulations or amendments, of the State authorities or agencies with whom such consultation is required.

"(2) The Surgeon General, at the request of any recipient of a grant under this section, may reduce the payments to such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the State plan or the project with respect to which the grant under this section is made. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Surgeon General, but shall, for purposes of determining the Federal share under subsection (a) or (d), be deemed to have been paid to the State.

"(3) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of a State or a State health planning agency designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a), finds that, with respect to money paid to the State out of appropriations under subsection (a) or (d) there is a failure to comply substantially with either—

"(A) the applicable provisions of this section;

"(B) the State plan submitted under such subsection; or

"(C) applicable regulations under this section;

the Surgeon General shall notify such State health authority, mental health authority, or health planning agency, as the case may be, that further payments will not be made to the State from appropriations under such subsection (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Surgeon General shall make no payment to such State from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

"(4) For the purposes of this section—

"The term 'nonprofit' as applied to any private agency, institution, or organization means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and

"(B) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the District of Columbia, and,

except with respect to paragraphs (5) and (6) of subsection (d), the term 'United States' means all such States."

SEC. 4. Effective July 1, 1967, section 309 of the Public Health Service Act is amended by adding after subsection (b) the following new subsection:

"(c) There are also authorized to be appropriated \$5,000,000 each for the fiscal year ending June 30, 1968, and the fiscal year ending June 30, 1969, to enable the Surgeon General to make grants, under such terms and conditions as may be prescribed by regulations, for provision, in public or nonprofit private schools of public health accredited by a body or bodies recognized by the Surgeon General, of comprehensive professional training, specialized consultative services, and technical assistance in the fields of public health and in the administration of State or local public health programs, except that in allocating funds made available under this subsection among such schools of public health, the Surgeon General shall give primary consideration to the number of federally sponsored students attending each such school."

SEC. 5. Effective July 1, 1967, section 311 of the Public Health Service Act is amended by adding at the end thereof the following new sentence: "The Surgeon General is also authorized to train personnel for State and local health work."

SEC. 6. The amendments made by section 3 shall become effective, and section 318 of the Public Health Service Act shall be repealed as of July 1, 1966, except that the provisions of section 314 of the Public Health Service Act as in effect prior to the enactment of this Act shall be effective until July 1, 1967, in lieu of the provisions of subsections (d) and (e), and the provisions of subsection (g) insofar as they relate to such subsections (d) and (e), of section 314 of the Public Health Service Act as amended by this Act. Effective July 1, 1967, section 316 of the Public Health Service Act is repealed.

[H.R. 18231, 89th Cong., 2d sess.]

A BILL To amend section 314 of 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

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That this Act may be cited as the "Comprehensive Health Planning and Public Health Services Amendments of 1966".

#### FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshaling of all health resources—national, State, and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.

(b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.

#### GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

SEC. 3. Section 314 of the Public Health Service Act (42 U.S.C. 246) is amended to read as follows:

#### "GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

##### "Grants to States for Comprehensive State Health Planning

"SEC. 314. (a) (1) AUTHORIZATION.—In order to assist the States in comprehensive and continuing planning for their current and future health needs, the

Surgeon General is authorized during the period beginning July 1, 1966, and ending June 30, 1969, to make grants to States which have submitted, and had approved by the Surgeon General, State plans for comprehensive State health planning. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$2,500,000 for the fiscal year ending June 30, 1967, \$5,000,000 for the fiscal year ending June 30, 1968, and \$7,500,000 for the fiscal year ending June 30, 1969.

"(2) STATE PLANS FOR COMPREHENSIVE STATE HEALTH PLANNING.—In order to be approved for purposes of this subsection, a State plan for comprehensive State health planning must—

"(A) designate, or provide for the establishment of, a single State agency, which may be an interdepartmental agency, as the sole agency for administering or supervising the administration of the State's health planning functions under the plan;

"(B) provide for the establishment of a State health planning council, which shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, to advise such State agency in carrying out its functions under the plan;

"(C) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Surgeon General, are designed to provide for comprehensive State planning for health services (both public and private), including the facilities and persons required for the provision of such services, to meet the health needs of the people of the State;

"(D) provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations and groups concerned with health services, facilities, or manpower, and for cooperative efforts between such agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, and rehabilitation;

"(E) contain or be supported by assurances satisfactory to the Surgeon General that the funds paid under this subsection will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

"(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(G) provide that the State agency will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

"(H) provide that the State agency will from time to time, but not less often than annually, review its State plan approved under this subsection and submit to the Surgeon General appropriate modifications thereof;

"(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this subsection; and

"(J) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

"(3) (A) STATE ALLOTMENTS.—From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year pursuant to paragraph (1). Any such allotment to a State for a fiscal year shall remain available for obligation by the State, in accordance with the provisions of this subsection and the State's plan approved thereunder, until the close of the succeeding fiscal year.

"(B) The amount of any allotment to a State under subparagraph (A) for any fiscal year which the Surgeon General determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallocation by the Surgeon General from time

to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under subparagraph (A) for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Surgeon General estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallocated among the States whose proportionate amounts were not so reduced. Any amount so reallocated to a State from funds appropriated pursuant to this subsection for a fiscal year shall be deemed part of its allotment under subparagraph (A) for such fiscal year.

"(4) PAYMENTS TO STATES.—From each State's allotment for a fiscal year under this subsection, the State shall from time to time be paid the Federal share of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this subsection. Such payments shall be made on the basis of estimates by the Surgeon General of the sums the State will need in order to perform the planning under its approved State plan under this subsection, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The 'Federal share' for any State for purposes of this subsection shall be all, or such part as the Surgeon General may determine, of the cost of such planning.

#### "Project Grants for Areawide Health Planning

"(b) The Surgeon General is authorized, during the period beginning July 1, 1966, and ending June 30, 1969, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under subsection (a), project grants to any other public or nonprofit private agency or organization to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$5,000,000 for the fiscal year ending June 30, 1967, \$7,500,000 for the fiscal year ending June 30, 1968, and \$10,000,000 for the fiscal year ending June 30, 1969.

#### "Project Grants for Training, Studies, and Demonstrations

"(c) The Surgeon General is also authorized, during the period beginning July 1, 1966, and ending June 30, 1969, to make grants to any public or nonprofit private agency, institution, or other organization to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$1,500,000 for the fiscal year ending June 30, 1967, and \$2,500,000 each for the fiscal year ending June 30, 1968, and for the fiscal year ending June 30, 1969.

#### "Grants for Comprehensive Public Health Services

"(d) (1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$62,500,000 each for the fiscal year ending June 30, 1968, and for the fiscal year ending June 30, 1969, to enable the Surgeon General to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for provision of public health services.

"(2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH SERVICES.—In order to be approved under this subsection, a State plan for provision of public health services must—

"(A) provide for administration or supervision of administration by the State health authority or, with respect to mental health services, the State mental health authority;

"(B) set forth the policies and procedures to be followed in the expenditure of the funds paid under this subsection;

"(C) contain or be supported by assurances satisfactory to the Surgeon General that (i) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions in order to improve the health of the people; (ii) such funds will be made available to other public or nonprofit private agencies, institutions, and organizations, in accordance with criteria which the Surgeon General determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; and (iii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds;

"(D) provide for the furnishing of public health services under the State plan in accordance with such plans as have been developed pursuant to subsection (a);

"(E) provide that public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

"(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(G) provide that the State health authority or, with respect to mental health services, the State mental health authority, will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection and submit to the Surgeon General appropriate modifications thereof;

"(H) provide that the State health authority or, with respect to mental health services, the State mental health authority, will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

"(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of an accounting for funds paid to the State under this subsection; and

"(J) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

"(3) STATE ALLOTMENTS.—From the sums appropriated to carry out the provisions of this subsection the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States, except that no State's allotment shall be less for any year than the total amounts allotted to such State under formula grants for cancer control, plus other allotments under this section, for the fiscal year ending June 30, 1967.

"(4) (A) PAYMENTS TO STATES.—From each State's allotment under this subsection for a fiscal year, the State shall be paid the Federal share of the expenditures incurred during such year under its State plan approved under this subsection. Such payments shall be made from time to time in advance on the basis of estimates by the Surgeon General of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this subsection.

"(B) For the purpose of determining the Federal share for any State, expenditures by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions as may be prescribed by regulations, be regarded as expenditures by such State or a political subdivision thereof.

"(5) FEDERAL SHARE.—The 'Federal share' for any State for purposes of this subsection shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than 33½ per centum or more than 66⅔ per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, American Samoa, and the Virgin Islands shall be 66⅔ per centum.

"(6) DETERMINATION OF FEDERAL SHARES.—The Federal shares shall be determined by the Surgeon General between July 1 and September 1 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on next July 1. The populations of the several States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

"(7) ALLOCATION OF FUNDS WITHIN THE STATES.—At least 15 per centum of a State's allotment under this subsection shall be available only to the State mental health authority for the provision under the State plan of mental health services.

"Project Grants for Health Services Development

"(e) There are authorized to be appropriated \$62,500,000 each for the fiscal year ending June 30, 1968, and for the fiscal year ending June 30, 1969, for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of specialized regional or national significance, (2) stimulating and supporting for an initial period new programs of health services, or (3) undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services. Such grants may be made pursuant to clause (1) or (2) of the preceding sentence with respect to projects involving the furnishing of public health services only if such services are provided in accordance with such plans as have been developed pursuant to subsection (a).

"Interchange of Personnel With States

"(f) (1) For the purposes of this subsection, the term 'State' means a State or a political subdivision of a State, or any agency of either of the foregoing engaged in any activities related to health or designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a); the term 'Secretary' means (except when used in paragraph (3)(D)) the Secretary of Health, Education, and Welfare; and the term 'Department' means the Department of Health, Education, and Welfare.

"(2) The Secretary is authorized, through agreements or otherwise, to arrange for assignment of officers and employees of States to the Department and assignment to States of officers and employees in the Department engaged in work related to health, for work which the Secretary determines will aid the Department in more effective discharge of its responsibilities in the field of health as authorized by law, including cooperation with States and the provision of technical or other assistance. The period of assignment of any officer or employee under an arrangement shall not exceed two years.

"(3) (A) Officers and employees in the Department assigned to any State pursuant to this subsection shall be considered, during such assignment, to be (i) on detail to a regular work assignment in the Department, or (ii) on leave without pay from their positions in the Department.

"(B) Persons considered to be so detailed shall remain as officers or employees, as the case may be, in the Department for all purposes, except that the supervision of their duties during the period of detail may be governed by agreement between the Department and the State involved.

"(C) In the case of persons so assigned and on leave without pay—

"(i) if the rate of compensation (including allowances) for their employment by the State is less than the rate of compensation (including allowances) they would be receiving had they continued in their regular assignment in the Department, they may receive supplemental salary payments from the Department in the amount considered by the Secretary to be justified, but not at a rate in excess of the difference between the State rate and the Department rate; and

"(ii) they may be granted annual leave and sick leave to the extent authorized by law, but only in circumstances considered by the Secretary to justify approval of such leave.

Such officers and employees on leave without pay shall, notwithstanding any other provision of law, be entitled—

"(iii) to continuation of their insurance under the Federal Employees' Group Life Insurance Act of 1954, and coverage under the Federal Employees Health Benefits Act of 1959, so long as the Department continues

to collect the employee's contribution from the officer or employee involved and to transmit for timely deposit into the funds created under such Acts the amount of the employee's contributions and the Government's contribution from appropriations of the Department; and

"(iv) (I) in the case of commissioned officers of the Service, to have their service during their assignment treated as provided in section 214(d) for such officers on leave without pay, or (II) in the case of other officers and employees in the Department, to credit the period of their assignment under the arrangement under this subsection toward periodic or longevity step increases and for retention and leave accrual purposes, and, upon payment into the civil service retirement and disability fund of the percentage of their State salary, and of their supplemental salary payments, if any, which would have been deducted from a like Federal salary for the period of such assignment and payment by the Secretary into such fund of the amount which would have been payable by him during the period of such assignment with respect to a like Federal salary, to treat (notwithstanding the provisions of the Independent Officers Appropriation Act, 1959, under the head 'Civil Service Retirement and Disability Fund') their service during such period as service within the meaning of the Civil Service Retirement Act;

except that no officer or employee or his beneficiary may receive any benefits under the Civil Service Retirement Act, the Federal Employees Health Benefits Act of 1959, or the Federal Employees' Group Life Insurance Act of 1954, based on service during an assignment hereunder for which the officer or employee or (if he dies without making such election) his beneficiary elects to receive benefits, under any State retirement or insurance law or program, which the Civil Service Commission determines to be similar. The Department shall deposit currently in the funds created under the Federal Employees' Group Life Insurance Act of 1954, the Federal Employees Health Benefits Act of 1959, and the civil service retirement and disability fund, respectively, the amount of the Government's contribution under these Acts on account of service with respect to which employee contributions are collected as provided in subparagraph (iii) and the amount of the Government's contribution under the Civil Service Retirement Act on account of service with respect to which payments (of the amount which would have been deducted under that Act) referred to in subparagraph (iv) are made to such civil service retirement and disability fund.

"(D) Any such officer or employee on leave without pay (other than a commissioned officer of the Service) who suffers disability or death as a result of personal injury sustained while in the performance of his duty during an assignment hereunder, shall be treated, for the purposes of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

"(4) Assignment of any officer or employee in the Department to a State under this subsection may be made with or without reimbursement by the State for the compensation (or supplementary compensation), travel and transportation expenses (to or from the place of assignment), and allowances, or any part thereof, of such officer or employee during the period of assignment, and any such reimbursement shall be credited to the appropriation utilized for paying such compensation, travel or transportation expenses, or allowances.

"(5) Appropriations to the Department shall be available, in accordance with the standardized Government travel regulations or, with respect to commissioned officers of the Service, the joint travel regulations, the expenses of travel of officers and employees assigned to States under an arrangement under this subsection on either a detail or leave-without-pay basis and, in accordance with applicable law, orders, and regulations, for expenses of transportation of their immediate families and expenses of transportation of their household goods and personal effects, in connection with the travel of such officers and employees to the location of their posts of assignment and their return to their official stations.

"(6) Officers and employees of States who are assigned to the Department under an arrangement under this subsection may (A) be given appointments in

the Department covering the periods of such assignments, or (B) be considered to be on detail to the Department. Appointments of persons so assigned may be made without regard to the civil service laws. Persons so appointed in the Department shall be paid at rates of compensation determined in accordance with the Classification Act of 1949, and shall not be considered to be officers or employees of the Service for the purposes of (A) the Civil Service Retirement Act, (B) the Federal Employees' Group Life Insurance Act of 1954, or (C) unless their appointments result in the loss of coverage in a group health benefits plan whose premium has been paid in whole or in part by a State contribution, the Federal Employees Health Benefits Act of 1959. State officers and employees who are assigned to the Department without appointment shall not be considered to be officers or employees of the Department, except as provided in subsection (7), nor shall they be paid a salary or wage by the Service during the period of their assignment. The supervision of the duties of such persons during the assignment may be governed by agreement between the Secretary and the State involved.

"(7) (A) Any State officer or employee who is assigned to the Department without appointment shall nevertheless be subject to the provisions of section 203, 205, 207, 208, and 209 of title 18 of the United States Code.

"(B) Any State officer or employee who is given an appointment while assigned to the Department, or who is assigned to the Department without appointment, under an arrangement under this subsection, and who suffers disability or death as a result of personal injury sustained while in the performance of his duty during such assignment shall be treated, for the purpose of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents, in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

"(S) The appropriations to the Department shall be available, in accordance with the standardized Government travel regulations, during the period of assignment and in the case of travel to and from their places of assignment or appointment, for the payment of expenses of travel of persons assigned to, or given appointments by, the Service under an arrangement under this subsection.

"(9) All arrangements under this subsection for assignment of officers or employees in the Department to States or for assignments of officers or employees of States to the Department shall be made in accordance with regulations of the Secretary.

#### "General

"(g) (1) All regulations and amendments thereto with respect to grants to States under subsection (a) shall be made after consultation with a conference of the State health planning agencies designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a). All regulations and amendments thereto with respect to grants to States under subsection (d) shall be made after consultation with a conference of State health authorities and, in the case of regulations and amendments which relate to or in any way affect grants for services or other activities in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of such regulations or amendments, of the State authorities or agencies with whom such consultation is required.

"(2) The Surgeon General, at the request of any recipient of a grant under this section, may reduce the payments to such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the State plan or the project with respect to which the grant under this section is made. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Surgeon General, but shall, for purposes of determining the Federal share under subsection (a) or (d), be deemed to have been paid to the State.

"(3) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of a State or a State health planning agency designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a), finds that, with respect to money paid to the State out of appropriations under subsection (a) or (d), there is a failure to comply substantially with either—

"(A) the applicable provisions of this section;

"(B) the State plan submitted under such subsection; or

"(C) applicable regulations under this section; the Surgeon General shall notify such State health authority, mental health authority, or health planning agency, as the case may be, that further payments will not be made to the State from appropriations under such subsection (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Surgeon General shall make no payment to such State from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

"(4) For the purposes of this section—

"(A) The term 'nonprofit' as applied to any private agency, institution, or organization means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and

"(B) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the District of Columbia and the term 'United States' means the fifty States and the District of Columbia."

#### CONTINUATION OF GRANTS TO SCHOOLS OF PUBLIC HEALTH

SEC. 4. Effective July 1, 1967, section 309 of the Public Health Service Act is amended by adding after subsection (b) the following new subsection:

"(c) There are also authorized to be appropriated \$5,000,000 each for the fiscal year ending June 30, 1968, and the fiscal year ending June 30, 1969, to enable the Surgeon General to make grants, under such terms and conditions as may be prescribed by regulations, for provision, in public or nonprofit private schools of public health accredited by a body or bodies recognized by the Surgeon General, of comprehensive professional training, specialized consultive services, and technical assistance in the fields of public health and in the administration of State or local public health programs, except that in allocating funds made available under this subsection among such schools of public health, the Surgeon General shall give primary consideration to the number of federally sponsored students attending each such school."

#### CONTINUATION OF AUTHORIZATION FOR TRAINING OF PERSONNEL FOR STATE AND LOCAL HEALTH WORK; COOPERATION BETWEEN THE STATES

SEC. 5. (a) Effective July 1, 1966, section 311 of the Public Health Service Act is amended by inserting "(a)" after "311." and by adding at the end of such section the following new subsection:

"(b) The Surgeon General shall encourage cooperative activities between the States with respect to comprehensive and continuing planning as to their current and future health needs, the establishment and maintenance of adequate public health services, and otherwise carrying out the purposes of section 314."

(b) Effective July 1, 1967, section 311 of the Public Health Service Act is further amended by adding at the end of subsection (b) thereof the following new sentence: "The Surgeon General is also authorized to train personnel for State and local health work."

#### EFFECTIVE DATE AND REPEALER

SEC. 6. The amendments made by section 3 shall become effective as of July 1, 1966, except that the provisions of section 314 of the Public Health Service Act as in effect prior to the enactment of this Act shall be effective until July 1, 1967, in lieu of the provisions of subsections (d) and (e), and the provisions of subsection (g) insofar as they relate to such subsections (d) and (e), of section 314 of the Public Health Service Act as amended by this Act. Effective July 1, 1967, sections 316 and 318 of the Public Health Service Act are repealed.

## REORGANIZATION PLAN

SEC. 7. The provisions enacted by this Act shall be subject to the provisions of Reorganization Plan Numbered 3 of 1966.

[S. 3008, 89th Cong., 2d sess.]

AN ACT 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

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Comprehensive Health Planning and Public Health Services Amendments of 1966".*

## FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshaling of all health resources—national, State, and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.

(b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.

## NATIONAL HEALTH POLICY

SEC. 3. In order to assure planning and direction on the national level leading to the construction of a national health policy, the Surgeon General is authorized during the period beginning July 1, 1966, and ending June 30, 1972, to conduct studies, research, and investigations to establish a coherent set of national health goals and to formulate comprehensive guidelines to assist States in developing health plans consistent with the purposes of this Act.

## GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

SEC. 4. Section 314 of the Public Health Service Act (42 U.S.C. 246) is amended to read as follows:

## "GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

## "Grants to States for Comprehensive State Health Planning

"SEC. 314. (a) (1) AUTHORIZATION.—In order to assist the States in comprehensive and continuing planning for their current and future health needs, the Surgeon General is authorized during the period beginning July 1, 1966, and ending June 30, 1972, to make grants to States which have submitted, and had approved by the Surgeon General, State plans for comprehensive State health planning. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$2,500,000 for the fiscal year ending June 30, 1967, \$5,000,000 for the fiscal year ending June 30, 1968, \$10,000,000 each for the fiscal year ending June 30, 1969, and for the fiscal year ending June 30, 1970.

"(2) STATE PLANS FOR COMPREHENSIVE STATE HEALTH PLANNING.—In order to be approved for purposes of this subsection, a State plan for comprehensive State health planning must—

"(A) designate, or provide for the establishment of, a single State agency, which may be an interdepartmental agency, as the sole agency for adminis-

tering or supervising the administration of the State's health planning functions under the plan;

"(B) provide for the establishment of a State health planning council, which shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, to advise such State agency in carrying out its functions under the plan;

"(C) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Surgeon General, are designed to provide for comprehensive State planning for health services (both public and private), including the facilities and persons required for the provision of such services, to meet the health needs of the people of the State;

"(D) provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations and groups concerned with health services, facilities, or manpower, and for cooperative efforts between such agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, are rehabilitation;

"(E) contain or be supported by assurances satisfactory to the Surgeon General that the funds paid under this subsection will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

"(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(G) provide that the State agency will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

"(H) provide that the State agency will from time to time, but not less often than annually, review its State plan approved under this subsection and submit to the Surgeon General appropriate modifications thereof;

"(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this subsection; and

"(J) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

"(3) (A) STATE ALLOTMENTS.—From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year pursuant to paragraph (1). Any such allotment to a State for a fiscal year shall remain available for obligation by the State, in accordance with the provisions of this subsection and the State's plan approved thereunder, until the close of the succeeding fiscal year.

"(B) The amount of any allotment to a State under subparagraph (A) for any fiscal year which the Surgeon General determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallocation by the Surgeon General from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under subparagraph (A) for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Surgeon General estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallocated among the States whose proportionate amounts were not so reduced. Any amount so reallocated to a State from funds appropriated pursuant to this subsection for a fiscal year shall be deemed part of its allotment under subparagraph (A) for such fiscal year.

"(4) PAYMENTS TO STATES.—From each State's allotment for a fiscal year under this subsection, the State shall from time to time be paid the Federal share

of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this subsection. Such payments shall be made on the basis of estimates by the Surgeon General of the sums the State will need in order to perform the planning under its approved State plan under this subsection, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The 'Federal share' for any State for purposes of this subsection shall be all, or such part as the Surgeon General may determine, of the cost of such planning, except that in the case of the allotments for the fiscal year ending June 30, 1970, and for each of the next two fiscal years, it shall not exceed 75 per centum of such cost.

#### "Project Grants for Areawide Health Planning

"(b) The Surgeon General is authorized, during the period beginning July 1, 1966, and ending June 30, 1972, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under subsection (a), project grants to any other public or nonprofit private agency or organization to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$5,000,000 for the fiscal year ending June 30, 1967, \$10,000,000 each for the fiscal year ending June 30, 1968, for the fiscal year ending June 30, 1969, and for the fiscal year ending June 30, 1970.

#### "Project Grants for Training, Studies, and Demonstrations

"(c) The Surgeon General is also authorized, during the period beginning July 1, 1966, and ending June 30, 1972, to make grants to any public or nonprofit private agency, institution, or other organization to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the nation. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$1,500,000 for the fiscal year ending June 30, 1967, \$5,000,000 each for the fiscal year ending June 30, 1968, for the fiscal year ending June 30, 1969, and for the fiscal year ending June 30, 1970.

#### "Grants for Comprehensive Public Health Services

"(d) (1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, \$170,500,000 for the fiscal year ending June 30, 1968, and for each of the next two fiscal years \$230,700,000 to enable the Surgeon General to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for provision of public health services.

"(2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH SERVICES.—In order to be approved under this subsection, a State plan for provision of public health services must—

"(A) provide for administration or supervision of administration by the State health authority or, with respect to mental health services, the State mental health authority;

"(B) set forth the policies and procedures to be followed in the expenditure of the funds paid under this subsection;

"(C) contain or be supported by assurances satisfactory to the Surgeon General that (i) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions in order to improve the health of the people; (ii) such funds will be made available to other public or nonprofit private agencies, institutions, and organizations, in accordance with criteria which the Surgeon General determines are designed to secure maximum participation of local, regional, or metropolitan

agencies and groups in the provision of such services; (iii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds; and (iv) public health services under the plan will be established and maintained for individuals confined to institutions for the mentally ill and mentally retarded;

"(D) provide for the furnishing of public health services under the State plan in accordance with such plans as have been developed pursuant to subsection (a) and, effective July 1, 1970, provide that except to the extent permitted in regulations, such services will be provided thereunder only to the extent included in and in accordance with the plans so developed;

"(E) provide that public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

"(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

"(G) provide that the State health authority or, with respect to mental health services, the State mental health authority, will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection and submit to the Surgeon General appropriate modifications thereof;

"(H) provide that the State health authority or, with respect to mental health services, the State mental health authority, will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

"(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of an accounting for funds paid to the State under this subsection; and

"(J) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

"(3) STATE ALLOTMENTS.—From the sums appropriated to carry out the provisions of this subsection the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States.

"(4) (A) PAYMENTS TO STATES.—From each State's allotment under this subsection for a fiscal year, the State shall be paid the Federal share of the expenditures incurred during such year under its State plan approved under this subsection. Such payments shall be made from time to time in advance on the basis of estimates by the Surgeon General of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this subsection.

"(B) For the purpose of determining the Federal share for any State, expenditures by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions as may be prescribed by regulations, be regarded as expenditures by such State or a political subdivision thereof.

"(5) FEDERAL SHARE.—The 'Federal share' for any State for purposes of this subsection shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than 33 $\frac{1}{4}$  per centum or more than 66 $\frac{2}{3}$  per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, American Samoa, and the Virgin Islands shall be 66 $\frac{2}{3}$  per centum.

"(6) DETERMINATION OF FEDERAL SHARES.—The Federal shares shall be determined by the Surgeon General between July 1 and September 1 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on the next July 1. The populations of the several

States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

"(7) ALLOCATION OF FUNDS WITHIN THE STATES.—At least 15 per centum of a State's allotment under this subsection shall be available only to the State mental health authority for the provision under the State plan of mental health services. At least 70 per centum of such amount and at least 70 per centum of the remainder of a State's allotment under this subsection shall be available only for the provision under that State plan of services in the communities of the State.

#### "Project Grants for Health Services Development

"(e) There are authorized to be appropriated \$100,000,000 for the fiscal year ending June 30, 1968, \$125,000,000 each for the fiscal year ending June 30, 1969, and for the fiscal year ending June 30, 1970, for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of specialized regional or national significance, (2) stimulating and supporting for an initial period new programs of health services, or (3) undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services. Such grants may be made pursuant to clause (1) or (2) of the preceding sentence with respect to projects involving the furnishing of public health services only if such services are provided in accordance with such plans as have been developed pursuant to subsection (a) and, effective July 1, 1970, except to the extent permitted in regulations, only to the extent such services are included in and are furnished in accordance with plans so developed.

#### "Interchange of Personnel With States

"(f) (1) For the purposes of this subsection, the term 'State' means a State or a political subdivision of a State, or any agency of either of the foregoing engaged in any activities related to health or designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a); the term 'Secretary' means (except when used in paragraph (3) (D)) the Secretary of Health, Education, and Welfare; and the term 'Department' means the Department of Health, Education, and Welfare.

"(2) The Secretary is authorized, through agreements or otherwise, to arrange for assignment of officers and employees of States to the Department and assignment to States of officers and employees in the Department engaged in work related to health, for work which the Secretary determines will aid the Department in more effective discharge of its responsibilities in the field of health as authorized by law, including cooperation with States and the provision of technical or other assistance. The period of assignment of any officer or employee under an arrangement shall not exceed two years.

"(3) (A) Officers and employees in the Department assigned to any State pursuant to this subsection shall be considered, during such assignment, to be (i) on detail to a regular work assignment in the Department, or (ii) on leave without pay from their positions in the Department.

"(B) Persons considered to be so detailed shall remain as officers or employees, as the case may be, in the Department for all purposes, except that the supervision of their duties during the period of detail may be governed by agreement between the Department and the State involved.

"(C) In the case of persons so assigned and on leave without pay—

"(i) if the rate of compensation (including allowances) for their employment by the State is less than the rate of compensation (including allowances) they would be receiving had they continued in their regular assignment in the Department, they may receive supplemental salary payments from the Department in the amount considered by the Secretary to be justified, but not at a rate in excess of the difference between the State rate and the Department rate; and

"(ii) if they may be granted annual leave and sick leave to the extent authorized by law, but only in circumstances considered by the Secretary to justify approval of such leave.

Such officers and employees on leave without pay shall, notwithstanding any other provision of law, be entitled—

"(iii) to continuation of their insurance under the Federal Employees' Group Life Insurance Act of 1954, and coverage under the Federal Em-

ployees Health Benefits Act of 1959, so long as the Department continues to collect the employee's contribution from the officer or employee involved and to transmit for timely deposit into the funds created under such Acts the amount of the employee's contributions and the Government's contribution from appropriations of the Department; and

"(iv) (I) in the case of commissioned officers of the Service, to have their service during their assignment treated as provided in section 214(d) for such officers on leave without pay, or (II) in the case of other officers and employees in the Department, to credit the period of their assignment under the arrangement under this subsection toward periodic or longevity step increases and for retention and leave accrual purposes, and, upon payment into the civil service retirement and disability fund of the percentage of their State salary, and of their supplemental salary payments, if any, which would have been deducted from a like Federal salary for the period of such assignment and payment by the Secretary into such fund of the amount which would have been payable by him during the period of such assignment with respect to a like Federal salary, to treat (notwithstanding the provisions of the Independent Offices Appropriation Act, 1959, under the head 'Civil Service Retirement and Disability Fund') their service during such period as service within the meaning of the Civil Service Retirement Act;

except that no officer or employee or his beneficiary may receive any benefits under the Civil Service Retirement Act, the Federal Employees Health Benefits Act of 1959, or the Federal Employees' Group Life Insurance Act of 1954, based on service during an assignment hereunder for which the officer or employee or (if he dies without making such election) his beneficiary elects to receive benefits, under any State retirement or insurance law or program, which the Civil Service Commission determines to be similar. The Department shall deposit currently in the funds created under the Federal Employees' Group Life Insurance Act of 1954, the Federal Employees Health Benefits Act of 1959, and the civil service retirement and disability fund, respectively, the amount of the Government's contribution under these Acts on account of service with respect to which employee contributions are collected as provided in subparagraph (iii) and the amount of the Government's contribution under the Civil Service Retirement Act on account of service with respect to which payments (of the amount which would have been deducted under that Act) referred to in subparagraph (iv) are made to such civil service retirement and disability fund.

"(D) Any such officer or employee on leave without pay (other than a commissioned officer of the Service) who suffers disability or death as a result of personal injury sustained while in the performance of his duty during an assignment hereunder, shall be treated, for the purposes of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

"(4) Assignment of any officer or employee in the Department to a State under this subsection may be made with or without reimbursement by the State for the compensation (or supplementary compensation), travel and transportation expenses (to or from the place of assignment), and allowances, or any part thereof, of such officer or employee during the period of assignment, and any such reimbursement shall be credited to the appropriation utilized for paying such compensation, travel or transportation expenses, or allowances.

"(5) Appropriations to the Department shall be available, in accordance with the standardized Government travel regulations or, with respect to commissioned officers of the Service, the joint travel regulations, the expenses of travel of officers and employees assigned to States under an arrangement under this subsection on either a detail or leave-without-pay basis and, in accordance with applicable law, orders, and regulations, for expenses of transportation of their immediate families and expenses of transportation of their household goods and personal effects, in connection with the travel of such officers and employees to the location of their posts of assignment and their return to their official stations.

"(6) Officers and employees of States who are assigned to the Department under an arrangement under this subsection may (A) be given appointments in

the Department covering the periods of such assignments, or (B) be considered to be on detail to the Department. Appointments of persons so assigned may be made without regard to the civil service laws. Persons so appointed in the Department shall be paid at rates of compensation determined in accordance with the Classification Act of 1949, and shall not be considered to be officers or employees of the Service for the purposes of (A) the Civil Service Retirement Act, (B) the Federal Employees' Group Life Insurance Act of 1954, or (C) unless their appointments result in the loss of coverage in a group health benefits plan whose premium has been paid in whole or in part by a State contribution, the Federal Employees Health Benefits Act of 1959. State officers and employees who are assigned to the Department without appointment shall not be considered to be officers or employees of the Department, except as provided in subsection (7), nor shall they be paid a salary or wage by the Service during the period of their assignment. The supervision of the duties of such persons during the assignment may be governed by agreement between the Secretary and the State involved.

"(7) (A) Any State officer or employee who is assigned to the Department without appointment shall nevertheless be subject to the provisions of sections 203, 205, 207, 208, and 209 of title 18 of the United States Code.

"(B) Any State officer or employee who is given an appointment while assigned to the Department, or who is assigned to the Department without appointment, under an arrangement under this subsection, and who suffers disability or death as a result of personal injury sustained while in the performance of his duty during such assignment shall be treated, for the purpose of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents, in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

"(8) The appropriations to the Department shall be available, in accordance with the standardized Government travel regulations, during the period of assignment and in the case of travel to and from their places of assignment or appointment, for the payment of expenses of travel of persons assigned to, or given appointments by, the Service under an arrangement under this subsection.

"(9) All arrangements under this subsection for assignment of officers or employees in the Department to States or for assignments of officers or employees of States to the Department shall be made in accordance with regulations of the Secretary.

#### "General

"(g) (1) All regulations and amendments thereto with respect to grants to States under subsection (a) shall be made after consultation with a conference of the State health planning agencies designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a). All regulations and amendments thereto with respect to grants to States under subsection (d) shall be made after consultation with a conference of State health authorities and, in the case of regulations and amendments which relate to or in any way affect grants for services or other activities in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of such regulations or amendments, of the State authorities or agencies with whom such consultation is required.

"(2) The Surgeon General, at the request of any recipient of a grant under this section, may reduce the payments to such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the State plan or the project with respect to which the grant under this section is made. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Surgeon General, but shall, for purposes of determining the Federal share under subsection (a) or (d), be deemed to have been paid to the State.

"(3) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of a State or a State health planning agency designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a), finds that, with respect to money paid to the State out of appropriations under subsection (a) or (d), there is a failure to comply substantially with either—

"(A) the applicable provisions of this section;

"(B) the State plan submitted under such subsection; or

"(C) applicable regulations under this section; the Surgeon General shall notify such State health authority, mental health authority, or health planning agency, as the case may be, that further payments will not be made to the State from appropriations under such subsection (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Surgeon General shall make no payment to such State from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

"(4) For the purposes of this section—

"(A) The term 'nonprofit' as applied to any private agency, institution, or organization means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and

"(B) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the District of Columbia and the term 'United States' means the fifty States and the District of Columbia."

#### CONTINUATION OF GRANTS TO SCHOOLS OF PUBLIC HEALTH

SEC. 5. Effective July 1, 1967, section 309 of the Public Health Service Act is amended by adding after subsection (b) the following new subsection:

"(c) There are also authorized to be appropriated \$5,000,000 each for the fiscal year ending June 30, 1968, and the fiscal year ending June 30, 1969, to enable the Surgeon General to make grants, under such terms and conditions as may be prescribed by regulations, for provision, in public or nonprofit private schools of public health accredited by a body or bodies recognized by the Surgeon General, of comprehensive professional training, specialized consultive services, and technical assistance in the fields of public health and in the administration of State or local public health programs, except that in allocating funds made available under this subsection among such schools of public health, the Surgeon General shall give primary consideration to the number of federally sponsored students attending each such school."

#### CONTINUATION OF AUTHORIZATION FOR TRAINING OF PERSONNEL FOR STATE AND LOCAL HEALTH WORK; COOPERATION BETWEEN THE STATES

SEC. 6. (a) Effective July 1, 1966, section 311 of the Public Health Service Act is amended by inserting "(a)" after "311." and by adding at the end of such section the following new subsection:

"(b) The Surgeon General shall encourage cooperative activities between the States with respect to comprehensive and continuing planning as to their current and future health needs, the establishment and maintenance of adequate public health services, and otherwise carrying out the purposes of section 314."

(b) Effective July 1, 1967, section 311 of the Public Health Service Act is further amended by adding at the end of subsection (b) thereof the following new sentence: "The Surgeon General is also authorized to train personnel for State and local health work."

#### EFFECTIVE DATE AND REPEALER

SEC. 7. The amendments made by section 4 shall become effective, and section 318 of the Public Health Service Act shall be repealed, as of July 1, 1966, except that the provisions of sections 314 of the Public Health Service Act as in effect prior to the enactment of this Act shall be effective until July 1, 1967, in lieu of the provisions of subsections (d) and (e), and the provisions of subsection (g) insofar as they relate to such subsections (d) and (e), of section 314 of the

Public Health Service Act as amended by this Act. Effective July 1, 1967, section 316 of the Public Health Service Act is repealed.

#### GRANTS FOR INITIATING SERVICES AT MENTAL RETARDATION FACILITIES

SEC. 8. The Mental Retardation Facilities and Community Mental Health Centers Construction Act is amended by adding at the end of title I, the following new part:

#### "PART D—GRANTS FOR COSTS OF INITIATING SERVICES IN COMMUNITY MENTAL RETARDATION FACILITIES

##### "AUTHORIZATION OF GRANTS

"SEC. 141. For the purpose of assisting public and non-profit private agencies, organizations, or institutions to initiate, extend, and improve services in facilities for the mentally retarded principally designed to serve the needs of the particular community or communities in or near which the facility is situated, the Secretary may, in accordance with the provisions of this part, make grants to meet not to exceed 75 per centum of the costs (determined pursuant to regulations under section 144) of providing services in such facilities for the mentally retarded.

"In making such grants after June 30, 1968, the Secretary shall give preference to new or expanded services part of the cost of which will be borne out of State or local public funds.

##### "APPLICATIONS AND CONDITIONS FOR APPROVAL

"SEC. 142. Grants under this part with respect to any facility for the mentally retarded may be made only upon application, and only if—

"(1) the applicant is a public or nonprofit private agency, organization, or institution which owns or operates the facility;

"(2) the services to be provided by the facility will provide principally for persons residing in a particular community or communities in or near which such facility is situated, one or more of the types of services for the mentally retarded which are determined by the Secretary to be basic and necessary services for the mentally retarded;

"(3) the Secretary determines that the types of services to be supported are not sufficiently available in other facilities in said communities;

"(4) the Secretary determines that, with respect to the particular type or types of service to be so assisted Federal financial assistance is not, in fact, available to the applicant under any other Act (or portion thereof) which is administered by the Department of Health, Education, and Welfare.

"(5) the Secretary determines that there is satisfactory assurance that Federal funds made available under this part for any period will be so used as to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds for mental retardation services that would in the absence of such Federal funds be made available for the services described in paragraph (2) of this subsection, and will in no event supplant such State, local, and other non-Federal funds; and

"(6) in the case of an applicant in a State which has in existence a State plan relating to the provision of services for the mentally retarded, the services to be provided by the facility are consistent with the plan.

##### "PAYMENTS

"SEC. 143. Payment of grants under this part may be made (after necessary adjustment on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

##### "REGULATIONS

"SEC. 144. The Secretary shall prescribe general regulations concerning the eligibility of facilities under this part, determination of eligible costs with respect to which grants may be made, and the terms and conditions (including those specified in section 142) for approving applications under this part.

"Payments under this part with respect to any project may be made for a period of not to exceed five years beginning with the commencement of the first fiscal year for which any payment is made.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 145. There are authorized to be appropriated \$1,000,000 for the fiscal year ending June 30, 1967, \$7,000,000 for the fiscal year ending June 30, 1968, \$12,000,000 each for the fiscal year ending June 30, 1969, and for the fiscal year ending June 30, 1970, to enable the Secretary to make grants under the provisions of this part."

DEFINITION OF CONSTRUCTION

SEC. 9. Subsections (e) and (f) of section 401 of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, as amended, are amended to read as follows:

"(e) The term 'construction' includes construction of new buildings, acquisition of existing buildings, and expansion, remodeling, alteration, and renovation of existing buildings, and initial equipment of such new, newly acquired, expanded, remodeled, altered, or renovated buildings.

"(f) The term 'cost of construction' includes the cost of architects' fees and acquisition of land in connection with construction, but does not include the cost of off-site improvements."

SEC. 10. The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 is amended by adding at the end thereof the following:

"TITLE V—TRAINING OF PHYSICAL EDUCATORS AND RECREATION PERSONNEL FOR MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

"GRANT; AUTHORIZATION OF APPROPRIATIONS

"SEC. 501. (a) The Secretary is authorized to make grants to public and other nonprofit institutions of higher learning to assist them in providing professional or advanced training for personnel engaged or preparing to engage in employment as physical educators or recreation personnel for mentally retarded and other handicapped children or as supervisors of such personnel, or engaged or preparing to engage in research or teaching in fields related to the physical education or recreation of such children.

"(b) For the purpose of making the grants authorized under subsection (a), there is authorized to be appropriated for the fiscal year ending June 30, 1968, \$1,000,000, for the fiscal year ending June 30, 1969, and for the fiscal year ending June 30, 1970, \$2,000,000 each. Any sums appropriated for any such fiscal year and not obligated before the end thereof shall remain available for the succeeding fiscal year for the purpose for which appropriated.

"RESEARCH AND DEMONSTRATION PROJECTS IN PHYSICAL EDUCATION AND RECREATION FOR MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

"SEC. 502. (a) (1) There is authorized to be appropriated for the fiscal year ending June 30, 1968, \$1,000,000, and for each of the two succeeding fiscal years, \$1,500,000, to enable the Secretary to make grants to States, State or local educational agencies, public and nonprofit private institutions of higher learning, and other public or nonprofit private educational or research agencies and organizations, for research or demonstration projects relating to physical education or recreation for mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other children with specific or serious learning disabilities, who by reason thereof require special or modified physical education and recreation activities to enhance their physical and mental development.

"(2) Grants under paragraph (1) shall be made in installments, in advance or by way of reimbursement, and on such conditions as the Secretary may determine.

"(b) The Secretary shall from time to time appoint panels of experts who are competent to evaluate various types of research or demonstration projects under

this section, and shall secure the advice and recommendations of one such panel before making any grant under this section.

"ADVISORY COMMITTEE

"SEC. 503. (a) (1) The Secretary shall appoint an advisory committee which shall consist of fifteen members to advise him on matters of general policy relating to the administration of this title. Seven members of such committee shall be individuals from the field of physical education, five members thereof shall be individuals from the field of recreation, and three members thereof shall be individuals with experience or special interest in the education of the mentally retarded or other handicapped children.

"(2) The Secretary shall, from time to time, designate one of the members of such committee to serve as the chairman thereof.

"(b) Members of the advisory committee and members of any panel appointed pursuant to section 502(b), who are not regular full-time employees of the United States, shall, while serving on the business of such committee or such panel, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time; and, while so serving away from their homes or regular place of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

"DELEGATION OF FUNCTIONS

"SEC. 504. The Secretary is authorized to delegate any of his functions under this title to any officer or employee of the Department of Health, Education, and Welfare."

REORGANIZATION PLAN

SEC. 11. The provisions enacted by this Act shall be subject to the provisions of Reorganization Plan Numbered 3 of 1966.

Passed the Senate October 3, 1966.

Attest:

FRANCIS R. VALEO,  
*Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,  
*Washington, D.C., March 25, 1966.*

HON. HARLEY O. STAGGERS,  
*Chairman, Committee on Interstate and Foreign Commerce,  
House of Representatives,  
Washington, D.C.*

DEAR MR. CHAIRMAN: This is in response to your request of March 7, 1966, for a report on H.R. 13197, the "Comprehensive Health Planning and Public Health Services Amendments of 1966".

This bill embodies the provisions of a draft bill transmitted by us to the Congress in order to carry out the recommendations for grants to States for comprehensive health planning and services contained in the President's message to the Congress on domestic health and education.

We urge that your committee give favorable consideration to this bill and that it be enacted by the Congress.

Sincerely,

WILBUR J. COHEN,  
*Acting Secretary.*

COMPTROLLER GENERAL OF THE UNITED STATES,  
*Washington D.C., April 13, 1966.*

HON. HARLEY O. STAGGERS,  
*Chairman, Committee on Interstate and Foreign Commerce,  
House of Representatives.*

DEAR MR. CHAIRMAN: Your letter of March 7, 1966, requests our comments on H.R. 13197, which, if enacted, would be cited as the "Comprehensive Health Planning and Public Health Services Amendments of 1966."

The purpose of the bill is stated in its title as being to promote and assist in the extension and improvement of comprehensive health planning and public health services and to provide for a more effective use of available Federal funds for such planning and services. We have no special information on the desirability of the proposed legislation and since the purpose thereof appears to be a matter of policy primarily for the Congress to determine, we have no recommendations to offer concerning the merits of the bill. However, we offer the following comments for consideration of your committee.

Section 3 of the proposed bill would amend section 314 of the Public Health Service Act to provide formula and project grants to States and other public or nonprofit private agencies and organizations to be used for health planning and establishment and maintenance of adequate public health services. In order to be eligible for funds, States would be required to submit State plans for comprehensive State health planning.

Section 314(g) (3) of the Public Health Service Act as amended by the bill would authorize the Surgeon General, after reasonable notice to the grantee, to withhold further payments from appropriated funds if there is a failure to substantially comply with applicable legislation, State plans, or regulations.

A similar provision is now contained in section 314 of the Public Health Service Act. We have been informed by Public Health Service officials that to their knowledge the Surgeon General has never exercised his authority under this provision to withhold payments to the State because of noncompliance with applicable legislation, State plans, or regulations. We have observed, however, that Department of Health, Education, and Welfare auditors have taken numerous exceptions to expenditures of Federal health grant funds as not being in accordance with applicable requirements. We have further observed that pursuant to the Department's administrative procedures, the States have not been required to either repay the amount of the exceptions or to demonstrate that other expenditures were made in accordance with applicable requirements in the same year in which the grant funds were paid to the States which could be recognized as substitutes for the expenditures to which exceptions were taken.

Since, for the most part, audits by the Department's auditors of grant funds are made from one to three years after the grant funds have been expended, the Surgeon General does not have all current information concerning noncompliance by the grant recipient with applicable legislation, State plans, or regulations and, therefore, is not in a position to exercise his authority to withhold funds at the time the noncompliance exists. In the light of these circumstances, the committee may wish to include in the bill language which would require the grant recipient to repay to the United States the amount of Federal grant funds which are determined to have been expended not in accordance with applicable legislation, State plans, or regulations.

The bill does not provide criteria to be used by the Surgeon General in determining the Federal share of (1) formula grants for comprehensive State health planning under section 314(a); (2) project grants for areawide health planning under section 314(b); (3) project grants for training, studies, and demonstrations for comprehensive health planning under section 314(c); and (4) project grants for health services development under section 314(e). Also, the bill does not provide criteria to be used by the Surgeon General in the allotment of grant funds for programs authorized by section 314(b), (c), and (e). The committee may wish to include in the bill specific criteria to be used by the Surgeon General in determining the Federal share and the allotment of funds for the aforementioned programs authorized by the bill.

Sections 314(a) (2) (G) and 314(d) (2) (H) of the Public Health Service Act as amended by the bill would require the State agency to make such reports, in such form, and containing such information as is required by the Surgeon General. Also, sections 314(a) (I) and 314(d) (2) (I) would require such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the States. However, no provision is made in the bill with respect to the other proposed grant programs requiring a grantee to keep adequate cost records of the projects to which the Federal Government makes financial contributions, nor is there any provision in the bill specifically authorizing the Secretary of Health, Education, and Welfare or the Comptroller General to have access to the grantee's records for purposes of audit and examination. In view of the increase in grant programs over the

last several years, we feel that in order to determine whether grant funds have been expended for the purpose for which the grant was made, the grantee should be required by law to keep records which fully disclose the disposition of such funds. We also feel that the head of the agency as well as the General Accounting Office should be permitted to have access to the grantee's records for the purpose of audit and examination. We therefore suggest that consideration be given to adding a new section to the bill including such requirements with respect to the proposed new grant programs. This could be accomplished by the following language:

"RECORDS AND AUDIT

"(a) Each recipient of assistance under this Act shall keep such records as the Surgeon General shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grants, the total cost of the project or undertaking in connection with which such funds are given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the grants received under this Act."

Language similar to that suggested above under other parts of the Public Health Service Act is codified in sections 280b-11, 291d(10) and (11), and 2991 of title 42, United States Code.

There appears to be a typographical error in lines 10 and 11, page 18 of the bill. Also, the word "Service" should either be defined or changed to "Public Health Service."

Sincerely yours,

FRANK H. WEITZEL,

*Assistant Comptroller General of the United States.*

CIVIL SERVICE COMMISSION,  
Washington, D.C., May 13, 1966.

HON. HARLEY O. STAGGERS,  
*Chairman, Committee on Interstate and Foreign Commerce, House of Representatives.*

DEAR MR. CHAIRMAN: This is in further reply to your request for the views of the Civil Service Commission on H.R. 13197, a bill "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."

This legislation would permit closer collaboration among all levels of Government and private health resources to assure high quality comprehensive health services for our entire population. The Civil Service Commission supports this objective and is in agreement with the specific provisions of the bill.

Of particular interest to the Civil Service Commission is section 3 of the bill which amends section 314 of the Public Health Service Act. Section 3 authorizes grants to States to aid in comprehensive planning, health services and training, and sets the conditions under which grants may be made. An important condition contained therein is that State plans for comprehensive State health planning, and for the provision of comprehensive public health services must, if they are to receive Federal funds, contain merit system features which meet standards set by the Surgeon General.

To increase the effectiveness of joint Federal-State programs, the bill authorizes temporary interchanges of personnel between the Public Health Service and State health jurisdictions. This feature (subsection (f), beginning on page 14, line 15) closely parallels two interchange authorities already existing and of proven value—section 507 of P.L. 89-10 which provides for interchanges between the Office of Education and the States, and P.L. 84-918 which provides for interchanges between the Department of Agriculture and the States.

The Civil Service Commission has long favored the interchange idea as a means of improving governmental service at all levels, and accordingly endorses this feature of the bill.

With the steady rise in the number of joint Federal-State programs, the need for greater sharing of knowledge and skills by the various levels of Government is becoming increasingly apparent. With this in mind the Commission is developing a legislative proposal which would apply generally and would authorize the head of any Federal agency to arrange for the temporary assignment of employees of his agency to a State when work of mutual concern to his agency and the State is involved, and when he determines that the arrangement would be beneficial to both.

The Commission has two technical points to mention: (1) on page 18, line 10, the words "these Acts on" should be, for purposes of accuracy, replaced by the words "the Civil" so that sentence would read "... the Government's contribution under the Civil Service Retirement Act . . ."; and (2) on page 24, line 19, an "(A)" is apparently missing between the opening quotation marks and the first word of the paragraph which begins on that line, since the following paragraph, page 25, line 1, is preceded by "(B)".

The Bureau of the Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this report.

By direction of the Commission:

Sincerely yours,

JOHN W. MACY, Jr., *Chairman.*

The CHAIRMAN. We are happy to welcome as our first witness this morning Dr. William H. Stewart, the Surgeon General of the Public Health Service.

Dr. Stewart, you may proceed, and, as I have said, we will try to complete this hearing today; so, if you have a long statement, if you would put it in the record and summarize it, we would appreciate it.

STATEMENT OF DR. WILLIAM H. STEWART, SURGEON GENERAL, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. PHILIP LEE, ASSISTANT SECRETARY FOR HEALTH AND MEDICAL AFFAIRS; SAM A. KIMBLE, ASSOCIATE CHIEF FOR GRANTS, BUREAU OF STATE SERVICES; AND WILLIAM HISCOCK, DEPUTY CHIEF, DIVISION OF PUBLIC HEALTH METHODS, SURGEON GENERAL'S OFFICE

Dr. STEWART. Thank you, Mr. Chairman. I will submit the longer statement for the record and read a shorter summary of the statement.

Before I begin, I am accompanied, on my right, by Dr. Philip Lee, the Assistant Secretary for Health and Medical Affairs; on my immediate left, Mr. Sam Kimble, the Associate Chief for Grants of the Bureau of State Services, and on his left Mr. William Hiscock, the Deputy Chief of the Division of Public Health Methods in the Surgeon General's Office.

Mr. Chairman and members of the committee, I am pleased to appear before this committee today to support the Comprehensive Health Planning and Public Health Services Amendments of 1966, introduced by the distinguished chairman, Congressman Staggers, and other bills before the committee, including H.R. 18232, introduced by Congressman Rogers.

Provisions of these bills would revise the pattern of relationships and health grants, revitalize State and local health administration, and encourage the most effective pursuit of health goals through planning as the foundation for a rational and efficient use of our resources for health, flexibility to put the kinds and amounts of resources where they are needed most to serve the health of the people in local communities, and third, development to find new or better methods of organizing and delivering personal and environmental health services.

Hearings on Federal-State relationships which this committee's Subcommittee on Investigations held early in this session, pointedly documented some of the shortcomings of the present arrangements. These include fragmentation both in health programs and health organizations, gaps in health service coverage, lack of coordination in health planning and services at the State and local levels, undue rigidity in the categorical financing of federally assisted health programs, and inability to use efficiently scarce professional health personnel.

Mr. Chairman, I would like to comment on the major differences between the several bills which you have under consideration.

S. 3008, as passed by the Senate, is basically the same as the administration bill when introduced, with the exception of two amendments made by the Senate committee.

Section 8 of the Senate-passed bill provides for grants to assist staffing of community mental retardation facilities; and section 10 provides for the training of physical educators and recreation personnel for mentally retarded and other handicapped children. We do not believe these amendments are necessary at this time.

The President's Committee on Mental Retardation will submit a report next year. At that time, we will be better prepared to assess the needs for the mentally retarded and request legislation to meet these needs.

Likewise, Secretary Gardner's Task Force on the Handicapped is now preparing its final report which will serve as the basis for future legislative proposals. In both cases we would prefer to have the opportunity to study these reports carefully before we receive additional authority to serve the mentally retarded and handicapped.

Enactment of H.R. 13197, as introduced, would be an ideal result, so far as we are concerned. It would allow us to find needed health services at an optimum level. There are activities, such as the program to control tuberculosis and venereal disease, which should be expanded and which cannot be expanded under the authorization limitations of H.R. 18231 and H.R. 18232.

We know, however, that the time remaining in this session is short, and we sincerely appreciate the committee's holding hearings now. We believe it is vitally important, as the members of this committee, to move now to restructure the categorical health grants. Because we also believe it is essential to begin the planning process immediately, as a basis for any future expansion of public health activities in the States, we are willing to accept a more limited bill.

But in that event, we will be prepared to come back to the committee next year, when there is more time for a fuller evaluation

of the need for funding of State and local health activities, with legislation providing for the increased ceilings and, possibly, with other necessary measures. We sincerely believe that public health programs will be harmed if more funds are not made available in the future.

Mr. Chairman, I should note that the authorizations under existing law which would be replaced by this bill will expire on June 30, 1967. Therefore, it is critically important that this legislation's enactment have a high priority among the remaining actions of the Congress.

Mr. Chairman, that completes my summary statement and I would be very happy to answer any questions.

(The prepared statement submitted by Dr. Stewart follows:)

STATEMENT OF DR. WILLIAM H. STEWART, SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE

Mr. Chairman and members of the Committee, I am pleased to appear before this Committee today to support the "Comprehensive Health Planning and Public Health Service Amendments of 1966", introduced by the distinguished Chairman, Congressman Staggers.

President Johnson, in his March 1st message on Health and Education, proposed legislation to deal with three vital areas of health: improved organization and delivery of health services; modernization of obsolete health facilities; and training needed additional health manpower. H.R. 13197, H.R. 18231 and H.R. 18232, which you are considering today, can strengthen and improve the organization and delivery of health services in States and communities throughout the Nation. A companion bill (S. 3008) has already passed the Senate.

Mr. Chairman, our Nation is committed to promoting and assuring the best level of health attainable for every person. The 88th and 89th Congresses have enacted landmark health legislation toward meeting this national goal. The setting for this commitment is one of great magnitude and complexity. The population of this Nation is growing rapidly—with a net increase last year of 2.2 million for a total of 196.8 million. New knowledge, accelerating scientific and technological potential progressively add to our capabilities for preventing, diagnosing and curing disease. Our growing national wealth enables us to increase investment in the health of the Nation. But with the rise in our scientific and fiscal capabilities must also come increased attention to economy—economy not just of dollars, but of time, of talent and of organization.

To meet these challenges, to deploy our resources most effectively, and to fulfill our present national health potential requires that we strengthen vital partnerships—private and public; local, State and national; individual and organizational—in creative action for health. These kinds of partnerships are fostered by these proposals.

The provisions of these bills revise the pattern of relationships and health grants, revitalize State and local health administration, and encourage the most effective pursuit of health goals through:

*Planning*, as the foundation for a rational and efficient use of our resources for health;

*Flexibility*, to put the kinds and amounts of resources that are needed, where they are needed most to serve the health of people in local communities, and

*Development*, to find new or better methods of organizing and delivering personal and environmental health services.

Hearings on Federal-State relationships, which this Committee's Subcommittee on Investigations held early in this Session, pointedly documented some of the shortcomings of the present arrangements. These include fragmentation both in health programs and health organizations, gaps in health service coverage, lack of coordination in health planning and services at the State and local levels, undue rigidity in the categorical financing of Federally-assisted health programs, and inability to use efficiently scarce professional health personnel.

One of the major problems in planning and delivering health services in the State arises from the tremendous and varied workload imposed on State agencies as a result of new programs authorized during the past several years. State

health departments, especially, have had to assume new responsibilities in a variety of fields without a corresponding strengthening of their capacities. Actions taken by the Congress have placed increasing responsibilities for the delivery of health services and for controlling environmental pollution on State and local health agencies. At the same time, however, State and local health departments have not been receiving the kind of support needed to make them strong administrative organizations. Their capacity to carry out the new responsibilities they have been given must be strengthened.

The first thrust of the bills is to strengthen State and local capacity to deal with myriad health problems and resources, by establishing a continuing process of comprehensive health planning. The bill would authorize Federal financial assistance to enable States to establish State health planning agencies and representative councils, to determine health needs and to develop plans for health services, utilization of health facilities, and health manpower requirements for meeting these needs. It would authorize financial assistance to areawide local health planning agencies to expand their community and metropolitan health planning efforts and facilitate wide cooperation and coordination among public and private agencies throughout the State. It would also authorize financial assistance to improve health planning through training, studies and demonstrations.

The bill is not designed to supplant with new State health planning agencies the existing planning mechanisms in specialized programs—(for example, hospital and other health facilities construction programs, mental retardation programs, or construction of community mental health centers). Rather, it is designed to help bring order into the Statewide health planning process, which is now spotty and fragmented. It would provide, for the first time, resources to measure and understand the special health needs of each of the States, and would make it possible to establish priorities for meeting these needs.

Comprehensive health planning is a process which depends on, complements, and links up existing and varied health program planning activities. It is not limited in time, or to a particular set of disease entities, or to a segment of the health services system, or to a collection of health programs. This essential process provides the mechanism through which:

All health planning can be linked and strengthened and clear purpose secured;

Health status can be measured, goals and objectives defined, priorities set, and actions planned for;

Service, manpower, and facility needs can be identified and interrelated and program accomplishments assessed.

Project grants for areawide health planning activities would stimulate the development of essential planning activities in areas where the need is very great. Health problems do not fit neatly into political jurisdictions or subdivisions. The public and private efforts to deal with them are not presently organized in a way which would contribute to the most orderly and efficient use of scarce resources. These grants would extend and expand the successful areawide planning experiences of the Hill-Burton program.

The second thrust of the bills redirects Federal health grants so that program activities would be more clearly focused on bringing health services to people, by providing flexible formula grant support. The effect of this proposal would be to eliminate eight categories of formula grants, and to provide a single formula grant to States for comprehensive public health services. Each of the bills under consideration would create a new section 314(d) of the Public Health Service Act to provide formula grants to States for comprehensive health services which would replace the several categorical programs now carried out almost wholly under the present section 314, for which \$55 million has been requested in the fiscal 1967 budget.

The proposed new section 314(e), to provide project grants for health service development would replace existing authorities in the present section 316 and annual appropriation acts, for which \$53 million has been requested in the fiscal 1967 budget. In addition, the authorization for areawide health facility planning now found in section 318 (for which present appropriations were \$5 million) would be contained in the new planning provisions, and the authorization for assistance to schools of public health, with the present \$3.5 million appropriation, would be transferred to section 309 of the act.

In summary, there is a total of somewhat more than \$116.5 million in the 1967 budget for the existing programs which would be covered by the provisions

of this bill plus \$10 million in the budget for the new authorizations in H.R. 13197 for planning. A table comparing the authorizations under S. 3008 as passed by the Senate, and H.R. 18231 is being submitted for the record.

*Comparison of appropriation authorizations in S. 3008 and H.R. 18231*

[In millions of dollars]

	1967		1968		1969		1970	
	S. 3008	H.R. 18231						
A. Planning grants.....	9.0	9.0	20.0	15.0	25.0	20.0	25.0	.0
B. Health service formula grants.....	.0	.0	170.5	62.5	230.7	62.5	230.7	.0
C. Health service project grants.....	.0	.0	100.0	62.5	125.0	62.5	125.0	.0
D. Grants to schools of public health.....	.0	.0	5.0	5.0	5.0	5.0	.0	.0
E. Mental retardation services.....	1.0	.0	7.0	.0	12.0	.0	12.0	.0
F. Recreation personnel.....	.0	.0	2.0	.0	3.5	.0	3.5	.0
Total authorization.....	10.0	9.0	304.5	145.0	401.2	150.0	396.2	.0
Difference compared to S. 3008 as passed by Senate, Oct. 3, 1966.....		1.0		150.5		251.5		396.2

NOTE.—Total difference, fiscal year 1967-1970, \$882,200,000.

Fiscal year 1967 Appropriation Act (as passed by Senate) includes \$55,250,000 for categorical grant activities under sec. 314 of the Public Health Service Act; \$55,179,000 for project grants under sec. 316 and annual appropriation acts; \$5,000,000 for areawide health facility planning under sec. 318; and \$3,750,000 for schools of public health—a total of \$119,179,000. In addition, the fiscal year 1967 budget includes \$10,000,000 for the new planning activities authorized by H.R. 13197.

The new formula grant program would strengthen the capabilities of State health and mental agencies to carry out increasingly complex leadership functions within States. It would extend and improve the quality and scope of local community public health services. And it would focus these programs on the multiple problems of individuals and families living in communities throughout the Nation, rather than on narrow disease categories.

Health problems vary from place to place, even within the same community. As priority needs are identified and developed through the comprehensive health planning efforts, localities and States will have greater flexibility in using Federal assistance to meet their most important health problems.

Finally, the Health Services Development projects authorized by these bills would provide a means of supporting programs to meet health problems which are nationally important but not nationwide in incidence. Targeted attacks can be mounted on such problems as narcotics and drug abuse, alcoholism, and venereal diseases. This is an effective and economical way to develop new approaches to combatting particular health problems, and better ways to organize and deliver health services.

In addition to differences in the level of authorization, which are compared in the table we have submitted, there are other important differences between the various bills.

S. 3008 as passed by the Senate is basically the same as when introduced, with the exception of two amendments made by the Senate Committee. Section 8 of the Senate passed bill provides for grants to assist staffing of Community Mental Retardation Facilities. Section 10 provides for the training of physical educators and recreation personnel for mentally retarded and other handicapped children. The President's Committee on Mental Retardation will report next year. At that time we will be better prepared to assess the needs for the mentally retarded and request legislation to meet these needs. Likewise, Secretary Gardner's Task Force on the Handicapped is now preparing its final report which will serve as the basis for future legislative proposals. In both cases we

would prefer to have the opportunity to study these reports carefully before our authority to serve the mentally retarded and the handicapped is broadened.

Enactment of H.R. 13197 as introduced would be an ideal result, so far as we are concerned. It would allow us to fund needed health services at an optimum level. There are activities, such as the programs to control tuberculosis and venereal disease, which should be expanded, and which cannot be expanded under the authorization limitations of H.R. 18231 and 18232.

We know, however, that the time remaining in this session is short, and we sincerely appreciate the Committee's holding hearings now. We believe it is vitally important, as the members of this Committee are aware, to move now to restructure the categorical health grants. Because we also believe it is essential to begin the planning process immediately—as the basis for any future expansion of public health activities in the States—we are willing to accept a more limited bill.

But in that event we will be prepared to come back to the Committee next year, when there is more time for a fuller evaluation of the need for funding of State and local health activities. We sincerely believe that public health programs will be harmed if more funds are not made available in the future. And we will seek the opportunity next year to demonstrate the need for these funds.

Our national health goals are but an expression of the justifiable expectation of the American people—that this country can and will provide the best in health care and protection to all its citizens. The fulfillment of this expectation will require that we plan and organize health resources efficiently; finance programs adequately to extend the availability and scope of public health services; use skilled health manpower economically; and effectively coordinate health activities through dynamic local-State-Federal partnership for health.

In concluding my statement, Mr. Chairman, I should note that the authorizations under existing law to which I have already referred, and which would be replaced by this bill, will expire on June 30, 1967. Therefore, it is critically important that this legislation's enactment have a high priority among the remaining actions of the Congress.

Mr. CHAIRMAN. Thank you very much, Dr. Stewart.

I have just one question.

Assuming that our committee decides to report H.R. 18231, what would be the Department's attitude if the committee were to delete from the bill the authorization for project grants and formula grants for the fiscal year 1969, but left the remainder of the bill intact?

Dr. STEWART. Mr. Chairman, you understand our basic position which I outlined in the statement, that we would have preferred the original administration bills, but we realize the time is short, and, as I mentioned, we planned to come back in the 1st session of the 90th Congress with legislation to provide for more adequate funding.

Therefore, I do not think that it really makes too much difference whether the 1969 year is there or not, as far as our opinion goes, because we do intend to come back next year to examine in more detail the funding levels with the committee.

The CHAIRMAN. Is your 1968 funding—that would give you time then?

Dr. STEWART. The 1968 funding, as you know, somewhat of an increase over the present estimated 1967 levels. It will give us some flexibility. It is still limited, but we can probably get along with that, although we want to examine that, too, when we come back next year.

The CHAIRMAN. All right.

Mr. Rogers?

Mr. ROGERS of Florida. Thank you, Mr. Chairman.

Just a couple of points. It may be well to call this up when you come back next year, but I just wondered what was your feeling about

in a State plan requiring that they submit some criteria or set forth some criteria for evaluating their programs as to what they are actually doing, if the program is doing some good, rather than just saying that they will keep a proper audit and make sure that the funds are spent right?

Dr. STEWART. Well, Mr. Rogers, I think that is implicit in the language now. We certainly would want that in the State plans.

Mr. ROGERS of Florida. You have no objection to a requirement like that?

Dr. STEWART. Not at all.

Mr. ROGERS of Florida. I just wanted to ask one quick question about repeal, I guess of section 318.

How does that tie in now with the Council on Hill-Burton?

It is done all in one planning.

Dr. STEWART. Yes. The repeal of 318, but then it emerges again within the planning section of this present bill, at the same level it was at, and then it steps up into the future as it is now programed.

Mr. ROGERS of Florida. As you know, we went into this whole type of approach in our hearings by our special committee, and all of the State offices and the Government were very much in favor of this type of approach that is embodied in this bill.

So, I congratulate the Department in looking forward in its dealing with the States in this problem, and I think this is an excellent approach.

Thank you, Mr. Chairman.

Dr. STEWART. Thank you, Mr. Rogers.

The CHAIRMAN. Mr. Springer.

Mr. SPRINGER. Doctor, looking at this sheet here—do you have this sheet here?

Dr. STEWART. Yes.

Mr. SPRINGER. Under B. Health Service formula grants—what all is included in that \$62.5 million?

Dr. STEWART. This is a series of formula grants which are now authorized until 1967 that I want—

Mr. SPRINGER. Through 1967?

Dr. STEWART. That is correct. This is the chronic illness and aged formula grants, the dental health formula grants, the general health formula grants, heart disease control formula grants, home health services formula grants, mental health formula grants, radiological health and TB control.

Mr. SPRINGER. Well, now what is the difference between those and some of the legislation we have already passed on mentally retarded, heart, stroke, cancer?

Dr. STEWART. Well, on the mentally retarded, there was a planning and the mental retardation programs, which was related to the development of the facilities for the care of the mentally retarded in other legislation. It is not related to this formula grant at all.

Mr. SPRINGER. What does the formula grant do?

Dr. STEWART. Well, the formula grant is in the mental health field. The formula grant—these are all formula grants to States, they are matched by the States, and then they go for services within the State. Each State may choose a different way of using it within that category.

Mental health money may go to staff mental health clinics somewhere, or it may go to train some more people.

Mr. SPRINGER. Aren't there mental health staffs—isn't there mental health staffing in mental hospitals?

Dr. STEWART. It more likely will not be used for staffing mental hospitals. This is in the public health realm apart from the hospital. We have one authority for improvement of mental health hospitals, which is in another piece of authorization.

Mr. SPRINGER. Well, didn't we have something in legislation last year or the year before that we could not use any funds which would diminish the State's current liability for funds, for programs undertaken by the State? Nothing that these funds could be used to take away already existing responsibilities of the State. That is what I am trying to find out is whether you are plowing new ground or whether we are going back over old ground.

Dr. STEWART. Well, you are going back over old ground, in effect.

Mr. SPRINGER. What I am trying to find out is what that old ground is.

Dr. STEWART. These are formula grants to the States for health services in the communities which have been in existence for some period of time and have been extended by the Congress the last couple of times. These provide for some staffing within the mental health authority, if there is a separate authority in the State or the Health Department if it is in the Health Department, training for people to work within the official health agency in the mental health field, some work in the various types of clinics.

It may be a type of clinic that is not supported anywhere else. I think what you have in mind, Mr. Springer, was the mental health legislation which we had which had to do with the staffing of mental health clinics—

Mr. SPRINGER. That is true.

Dr. STEWART (continuing). In which there was language which said, in effect, that you could not use other money at the same time, or something like that.

Mr. SPRINGER. You could not use this money to diminish already created responsibilities of the State—

Dr. STEWART. That is right.

Mr. SPRINGER. Which were in existence.

Dr. STEWART. Because the mental health staffing grant was one that went down over time, the Federal share went down over time, and I think you have reference to the fact that there was the non-replacement of State and local money with the Federal money in the initial staffing.

Mr. SPRINGER. That was a part of it, yes.

Dr. STEWART. This is also contained in this bill.

Mr. SPRINGER. The same language.

Dr. STEWART. Very much alike.

Mr. SPRINGER. Can you point that out in this bill?

Dr. STEWART. On page 5, in section (E), the language is—

contain or be supported by assurances satisfactory to the Surgeon General that the funds paid under this subsection will be used to supplement, and to the extent practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds.

That was relating to the planning function.

On page 11, starting with line 2—

such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds.

This relates to the formula grants.

Mr. SPRINGER. All right. Now, let us go to (C) for just a moment. The \$62.5 million for that. What is covered under Health Service project grants?

Dr. STEWART. There is a series of project grants which are covered under that title which I will get the list on, in just a minute. For 1967, it covers the expiring section 316 of the Public Health Service Act which are the project grants for community health services. It also covers project grants for venereal disease control, tuberculosis control, cancer control, mental retardation, neurological and sensory diseases, which are contained in appropriation language.

Mr. SPRINGER. What are such projects? That is what I am trying to get at.

Dr. STEWART. Well, in tuberculosis control, the project may be made, say, to the City Health Department of New York City, and because they have an area within the city where there is a higher incidence of tuberculosis, and they want to intensify control efforts in that area, or in many other cities or areas around the country where there is a concentration of tuberculosis. They have been using it to study the level of tuberculosis in their community to see whether it is going down.

Mr. SPRINGER. What else besides tuberculosis?

Dr. STEWART. Well, in venereal disease control.

Mr. SPRINGER. All right, go ahead.

Dr. STEWART. Cancer control.

Mr. SPRINGER. All right. How does cancer control work?

Dr. STEWART. In many instances, the cancer-control project grants are used to develop and open up demonstration clinics for the detection of cervical cancer, and for the detection of oral cancer, and to experiment with other methods of detecting cancer on a screening kind of basis.

These are now being developed.

Mr. SPRINGER. Those are three. Go ahead to the next one.

Dr. STEWART. Neurology and sensory diseases.

Mr. SPRINGER. What is that, the nervous system?

Dr. STEWART. Yes, nervous systems that could be conditions that lead to blindness, conditions that lead to neurological conditions like deafness or speech defects, or something like this.

Mr. SPRINGER. Anything else?

Dr. STEWART. Pardon?

Mr. SPRINGER. Anything else?

Dr. STEWART. There is one other, mental retardation. This was an extension of the money which started as the mental retardation planning money that was extended to the implementation phase, and now it is beginning to support various types of studies and activities in mental retardation.

Mr. SPRINGER. Pardon me. Are you through?

Dr. STEWART. Yes.

Mr. SPRINGER. Under (B) and (C), give me a rough idea, under (B), how many grants—how long has this legislation been in existence?

Dr. STEWART. Well, if you go back, it actually all started with the Social Security Act in 1935.

Mr. SPRINGER. But the big money has been just in recent years.

Dr. STEWART. Well, I was just noticing some figures. We have a table. We had a total of \$30 million in formula grants now in 1950. In 1936, it started with the Social Security Act, and the total was \$3 million. This is formula grants for the States. In 1950, it had gone to \$30 million. It then dropped during the 1950's, getting back to over \$30 million in 1961, and the estimate for formula grants in the 1967 appropriation is \$55.2 million. At the present time that has been divided into general grants, and then the tuberculosis, heart, mental health and cancer, which started in later years, and as the categorical grants have been coming along in numbers and in amount, the general grant which is what the Health Department uses to support its laboratories, its public health nursing in general, has been going down, and almost from its inception.

Mr. SPRINGER. How many grants did you make last year?

Dr. STEWART. These are to the States, so it would be—

Mr. SPRINGER. In other words, how many States participated?

Dr. STEWART. Fifty-four jurisdictions, all of them, including the Virgin Islands.

Mr. SPRINGER. In other words, everybody, all 54 agencies, participated in the whole thing.

Dr. STEWART. They all participated, that is correct.

Mr. SPRINGER. Well, then, you do not know how many grants there were. Does that come to you for final approval?

Dr. STEWART. Mr. Springer, what they do is put together a State plan which covers not only these grants but the Children's Bureau grants, every other year, and the regional offices review the State plan, negotiate, and finally they approve for the Surgeon General, and within that State is what they spend the money for.

Mr. SPRINGER. All right.

Now, going to (C), do all 54 jurisdictions participate?

Dr. STEWART. The project grants may go to State health departments, but they may go to a local health department or a nonprofit agency.

Mr. SPRINGER. They can go to any one of those three?

Dr. STEWART. Yes, sir; it could go to a hospital, for example, starting one of these cancer clinics we are talking about.

Mr. SPRINGER. Does that grant go directly from you?

Dr. STEWART. Yes, it does.

Mr. SPRINGER. It does not go to a State agency?

Dr. STEWART. In many instances we have, through just practice, gotten the recommendation from the State health department or the State agency as to what they think about it.

Mr. SPRINGER. But that is a direct grant to you directly to the agency involved?

Dr. STEWART. That is correct.

Mr. SPRINGER. Can you tell me again, have all 54 jurisdictions participated?

Dr. STEWART. Has there been a grant in every State?

Yes, there has.

Mr. SPRINGER. Is the bulk of that money going to any particular State?

Dr. STEWART. The distribution of the project grants by States is what you are asking?

Mr. SPRINGER. No, the distribution of the Health Service project grants.

Dr. STEWART. It is widely distributed around the country, but I would have to get the information as what has been the distribution State by State, Mr. Springer.

Mr. SPRINGER. I was trying to find out whether that was being concentrated in any particular city or any particular State.

Dr. STEWART. Well, from my knowledge of what it is, I would say the answer is that it is not being, but I will have to get the information.

Mr. SPRINGER. Is that a matching grant?

Dr. STEWART. It is to pay part of the costs, but there is no set matching under the project grants.

Mr. SPRINGER. All right.

How much is that generally, about 10, 20, 30 percent from you?

Dr. STEWART. I would say, we think that on the average the matching to the project grant is about a third to two-thirds, on the average now.

Mr. SPRINGER. Your part is a third to two-thirds?

Dr. STEWART. No, ours is two-thirds.

Mr. SPRINGER. Theirs is one-third.

Dr. STEWART. One-third.

Mr. SPRINGER. How about the health service formula grants; how are they determined?

Dr. STEWART. The formula grants are 50-50 matching with the State and us. Actually, over the years, the States have put up more—over the years, the moneys have been overmatched by the States and localities.

Mr. SPRINGER. Is there any reason—and this is my last question. Is there any reason why your health service project grants are so high, two-thirds? Is there a reason for it?

Dr. STEWART. Yes, I think so. In many instances here you are dealing with a community agency or a hospital or a local health department where a project is more delimited. He is trying out something, he has to bring in more people on a shorter-term basis. It is not a continuous kind of arrangement.

We are hoping, for example, in these cancer clinics that once it has been demonstrated, then the hospital will take it over or the health department will take it over. So, there is what you might call a little higher risk factor for the recipient of a project grant.

Mr. SPRINGER. Just this last question, Doctor.

With this \$154 million, I believe it is—or \$159 million, under the chairman's bill, you can do your job all right?

Dr. STEWART. Well, as I stated, Mr. Springer, in our statement, we recognize the time shortage, and we think the establishment of the principle of getting these grants so they are more flexible, getting the planning started, is very important, but we will be back next year to talk about the authorized ceilings that are in there.

The \$62.5 million in 1968 for the (B) and (C) is a slight increase over the estimate for 1967, but with the demands for increased work in tuberculosis, alcoholism, drug addiction, all the things that these moneys will be used for by State and local agencies, we will have very little flexibility in 1968. Well, actually, as we went into 1968, we will have decreased programs more than we have at the present time. Therefore, we think when the committee has more time we will be back, next year, to have a more thorough examination of the authorized ceilings.

Mr. SPRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Kornegay.

Mr. KORNEGAY. Dr. Stewart, I would like to thank you and your colleagues for coming up and testifying in behalf of the bill this morning.

I do not have any particular questions to ask, but I would like to call your attention to one defect in the bill which is an expression of concern from those in my district who are concerned with mental retardation and mental health in these bills.

Now, inquiry on my part causes me to believe that they are not included in the bills. Is that correct?

Dr. STEWART. No. One could provide mental retardation services under the formula grant if the State health department so chose to use the money for that purpose. Also the project grants would be available for projects for the mentally retarded, so it would be available.

Now, within the limitations on the authorization, there is not very much flexibility, but then that is what we will address ourselves to next year.

Mr. KORNEGAY. Yes, you will do that specifically.

Do you have any reason—do you have any knowledge as to why these people would be opposed to this bill?

Dr. STEWART. Well, there is a great deal of interest in the persons who are concerned about the mentally retarded in the amendment that was made to S. 3008 in the Senate which had to do with staffing of the mental retardation clinics. We recognized the growing number of clinics under our own construction program, that this is happening.

But, as I stated in my short summary, the Committee on Mental Retardation is in session now, and it is going to report early in the year; the Secretary's Committee on the Care of the Handicapped is going to report soon, and we would like to take a look at these reports, study them, and see what legislative proposals are necessary in order to carry out adequate programs next year.

Mr. KORNEGAY. Thank you, sir.

That is all, Mr. Chairman.

The CHAIRMAN. Mr. Younger.

Mr. YOUNGER. Thank you, Mr. Chairman.

Dr. Stewart, on the (A) planning grants, \$9 million, do you have funds already in 1967 for that purpose?

Dr. STEWART. Yes. There are \$5 million of the \$9 million contained in the estimates for 1967 under section 318. This is repealing that and inserting this in there; \$5 million is there. The rest was contained in the President's budget under new legislation.

Mr. YOUNGER. Well, you mean there are only \$5 million or \$4 million of new money for 1967?

Dr. STEWART. That is correct, for the planning portion of this, 1967.

Mr. YOUNGER. And the other \$5 million is money that is already appropriated?

Dr. STEWART. Well, it is in the estimate of 1967. We do not have an appropriation lawyer.

Mr. YOUNGER. No, but some of the appropriations are still being acted upon. I appreciate that.

But I could not understand why, in all the other categories with the exception of (E) where the Senate added \$1 million, and yet on (A) you added \$9 million, which would be over and above what has been already appropriated.

Dr. STEWART. Yes. S. 3008 repeals section 318 which is in the Hill-Burton Act, and moved it over to be a part of the planning grants section. That contains three parts. That portion that was in section 318 was grants to areawide planning councils for, like, a metropolitan hospital council would get their money in this type of project grant.

It also includes the formula money to the States for their planning—this is new—\$2.5 million of the \$9 million, and then there is a million and a half dollars which would be for studies related to the planning and training of people to do the planning.

There is a scarcity of health planners in the country, and in embarking upon this State health planning agency, the States are going to have to train some people.

Mr. YOUNGER. There is nothing in here whatsoever in regard to, that I could find, in regard to family planning. Is there any idea on your part or the Department's part to cooperate with the poverty program and provide, where requested, family planning as a project?

Dr. STEWART. Well, Mr. Younger, within this formula grant, which would be part (B), since we are now taking the categorical labels off and we are saying to the State: "What do you think are your real problems, this is the way to mold this money within the State health planning function as you have done?"

If they wish to embark upon family planning within this, it would certainly be appropriate under part (B), of the formula money; likewise, the project money could be used to initiate a program or do demographic studies or population studies that are necessary in order to understand the family planning problem. This would all be done in cooperation and in relationship to what the Office of Economic Opportunity, because it is within the context of the State health agency which is trying to relate all of these things, these various things, together.

In addition, there is the maternal and maternal care grants of the Children's Bureau, which also would part of this putting together all these various facets that are occurring now into this State health plan and would relate family planning to it.

Now, since the increased authorization for 1968 or 1969 is not in, very greatly beyond what we have in, the estimate for 1967, until we have had an examination of the authorized ceilings next year, there is not much room to expand into anything, any additional programs, such as family planning or drug addiction or whatever else health problem the State would like to get into.

Mr. YOUNGER. As far as your Department is concerned, where there is a need and a request for embarking on a family planning project, that would receive your approval?

Dr. STEWART. It certainly would. It is part of a health program, and we think it is a very central part of a health program.

Dr. LEE. I might add, Mr. Younger, at the present time, we are scheduling a series of regional meetings. There will be nine regional meetings. The first one has been held in Roanoke on family planning, to inform the people in State and local agencies, particularly governmental agencies, also in hospitals and physicians in private practice, about the Federal resources that are available to support local family planning programs, and we feel it is a very important thing that this information get out, because despite the fact we have had a policy since January, there are many people in State and local agencies and physicians in private practice, and hospitals that are unaware of the fact that Federal funds are available now to support this. We do not have adequate funds to support it. We estimate that we will need at least \$15 million next year to support requests that we are presently expecting, and that more will be needed in subsequent years. But we do have some funds currently available for this.

A number of States have changed policy with respect to family planning, under their public assistance medical care programs. California is a good example.

With a change in Federal policy, California now provides family planning services through the title 19 program for mothers, for example, who are on aid to families with dependent children. These services were not provided before this year.

So there has been a significant change and the States can carry out and can support family planning programs, purchase oral contraceptives or other contraceptives as needed under this program, and that is one that has not been used in many States yet, but California certainly has led the way in that regard.

Mr. ROGERS of Florida. Would the gentleman yield?

Mr. YOUNGER. Yes.

Mr. ROGERS of Florida. Actually, any of those programs instituted though would be done at the decision of the State or local facility.

Dr. STEWART. Yes, sir. Under the formula grants we are working with whatever the State has planned to use the funds for within broad guidelines of the public grant service.

Mr. ROGERS of Florida. Thank you.

Mr. YOUNGER. But you are conducting regional conferences on that subject now?

Dr. LEE. That is correct.

Dr. STEWART. Yes.

Mr. YOUNGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Van Deerlin.

Mr. VAN DEERLIN. In establishing the State health planning councils, Dr. Stewart, do you think it might be wise to designate that the majority would be public or consumer members?

Dr. STEWART. Well, I think that I would see no objection to that. Consumers certainly have a great interest in the health developments in the country. Actually, our Hill-Burton Council, I think, is that way at the present time.

Mr. VAN DEERLIN. There is a precedent for it in successful national health legislation.

Dr. STEWART. That is right.

Mr. VAN DEERLIN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

I might preface any comments of mine by saying, calling attention to the fact, that Dr. Barr, from our State, called me and was very much interested, and likewise Dr. DeBakey called, feeling that this area is something which needs some attention.

I understand the question was asked about whether it was in the budget, and the answer was "Yes," as I understand it.

Dr. STEWART. That is correct.

Mr. NELSEN. And I am becoming a little bit sensitive about programs that roll by pretty fast, and then we fail to fund them, and when we fund them we are accused of raising the budget, so I want to be very sure that this is in the budget.

I notice a reference to the mental health, mental retardation, program in the Senate bill. It refers to staffing grants for mental retardation facilities, and while this has no relation to this bill particularly but the mental health, mental retardation, bill that we passed, throughout the hearings, in the discussion I made reference to the need for some community center for the training of the mentally retarded and day-care centers, and also used as an example a vacated, four-room brick school building, with playground, with toilet facilities, with heating equipment—everything there. All you need to do is buy it for \$1, and it was my understanding from the hearings that under the terms of this bill, this facility could be put into operation, and certainly, to the betterment of the community, if it happened.

To this day, nothing has happened. The center is staffed, and has been put into shape by local voluntary contributions.

I have called the State by telephone, and I have written letters, and we completely miss the mark on something that I thought Congress acted correctly on, and it is my understanding now that there are priorities on which procedure develops in a State and this does not happen to have the priority that outranks some others.

Now, what good does research do, what good does conversation do, what good does talk do when here we have a facility available for nothing, for no charge, and we have money that I think Congress intended to go in that direction, and this is now 2 or 3 years ago when it started, and we have not gotten to it.

I know this is under your—it is not exactly something I can criticize you for, Doctor, but I think my point is to bring this out in the open for the record with the hope that we can get this thing off the ground.

I might mention that the local people have built a fence around there with local contributions. They have an instructor there, and the children are brought to this day-care center, and I think we will finally get this thing put together. But it takes some time. So, I want to be gracious in my criticism, if that is a proper way to express it. You may have some comment now that I have made my little pitch.

Dr. STEWART. Mr. Nelsen, we welcome criticism in not delivering services to people who need them.

If you will remember, the mental retardation construction program, the community retardation centers were modeled somewhat after the Hill-Burton Act.

Mr. NELSEN. Yes.

Dr. STEWART. In which there is a State-developed plan, priorities, and they decide where the projects will go within the State, within the money that is allocated to the State.

So, it is actually for some reason or other the State has chosen to set up a prior system which has not gotten, as I understand, to this project that you had in mind.

Now, in addition to that, you also recall that we had initial staffing money for the community mental health centers. There was no similar provision for mental retardation centers. The amendment in the Senate was for that purpose, and, as I mentioned in my opening statement, that, with the President's Committee on Mental Retardation reporting soon, and the Secretary's Committee on the Handicapped reporting, we would prefer to get these reports and then to mold whatever seems to be the proper legislative proposals for next year.

Mr. NELSEN. It is my feeling that there is a very wonderful building and a very quiet little community close to two of our larger towns in our county, and the service that could be provided there would be not only to one school district but several. I think it has a very strategic location, and I just wanted to mention it, because I have talked to one of the men from HEW at considerable length. They have been in contact with the State and have advised the President's Commission about this, because, it would seem to me, that here is an opportunity, at no cost, to have a facility, no bricks and mortar at all, and certainly was our intention on this committee—I remember Congressman O'Brien had a similar feeling—that this would be a nice thing to do. So, if there is anything we can do in this bill to implement these two ideas, of some center where children in rural areas who are mentally retarded can accept a certain amount of education and training, there is a great need, and I would go all out for everything we can do in that direction. Thank you very much.

The CHAIRMAN. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I have no questions, other than to compliment Dr. Stewart here.

I have heard his remarks, and I assume that you attach a great deal of priority to this measure. Although it is not complete, it is the best we can live with under the conditions.

Dr. STEWART. Yes, sir; very much so.

The CHAIRMAN. Mr. Curtin.

Mr. CURTIN. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Mackay.

Mr. MACKAY. Thank you, Mr. Chairman.

If this Congress does not adjourn, I am not likely to be able to help you in the 90th Congress, so I would like to do what I can to help you right now.

Dr. Venable, who is here to testify, has interpreted to me his judgment of the impact on our State health program if we fail to take some action at this session.

I would like for you to comment generally on the possible impact of our failure to act, because this bill is getting up before us so late

in the session that the usual arguments sometimes that are effective: "Why not let it go over to the next Congress?" What do you think the cost of letting it go over would be, the possible cost?

Dr. STEWART. Well, I think that we fail to capture, at least, a piece of the results of a clear examination of a problem which we all understand and all have a feel of now, and that it badly needs solution.

If we were to delay until the next Congress, we would not get the planning function started.

I think the constant cry of this multiplicity of programs that are flowing into the States and communities at the present time unrelated to one another is evidence enough in itself for the need for planning.

But, more important than that I think, is the demand for services of all types is increasing for a variety of reasons, and we do not have unlimited supply of resources.

We need to be able to know that when we invest into that hospital, that is the right investment rather than investing in this particular laboratory or this particular clinic, and we have no mechanism at the present time to do this at any level of government.

Secondly, we would go forward with the formula grants as we now have them, categorized into various narrow categories in which the State health offices, and particularly Dr. Venable can tell you, completely puts them into rigidity, and in which they cannot have any flexibility of the Federal-aided programs they have to really meet the needs as they see them in their area, and the needs do vary from area to area.

In the project planning program there are many needs for project money now beyond disease-control programs. We need to experiment with new ways to deliver health services into rural areas. This is getting to be an increasing problem in the country, and I am not sure that we really know how to solve the problem and we need to have experimentation where they are willing to do it.

This is the type of broadening. If we wait a year or 2 years, we are ducking the problem.

Mr. MACKAY. Doctor, I enthusiastically support the principle of this bill and hope we can pass it at this session.

As a recent member of the Georgia Legislature, I think this will help the relationship between the State legislature and the State health department, and between the State and the Federal Government, because you often hear the question: "Why these priorities when other priorities look more logical?"

I do not think it is fully understood that the director of our State health department is sort of locked up in a legal formula or legal arrangements that do not give him flexibility.

So, I understand your answer to be that there would be a loss really to the Nation if we do not pass this at this time.

Dr. STEWART. I think it would be a serious loss if we did not establish the planning process and the principle of flexibility.

I understand why the authorizations must be as they are, because we do not have time enough to really go into it. But I think it is terribly important that we have a serious look at the amount of money that should be within these programs next year.

Mr. MACKAY. Thank you.

No further questions, Mr. Chairman.

The CHAIRMAN. Mr. Watson.

Mr. WATSON. Thank you, Mr. Chairman.

Doctor, I support this measure as introduced by our able chairman. I can see only one disadvantage at this juncture, and that is the lateness of the hour in this session, but I am not deterred by that particular factor.

Now, since it has come to us rather late, or at least the interest manifested itself rather late, I have not had an opportunity to study the two bills. So, if you could just help me to understand the difference between H.R. 13197, which, I understand, you say is the ideal solution or the ideal bill at this time—

Dr. STEWART. Correct.

Mr. WATSON. I notice in your chart your comparison of authorizations. You compare S. 3008 and H.R. 18231. So, I wonder if you could explain briefly the difference between H.R. 13197 and H.R. 18231?

Dr. STEWART. Yes, sir.

Mr. WATSON. First, to start it off, there is a difference between \$9 and \$10 million, is that not correct, in the amounts we authorized for these planning grants?

Dr. STEWART. In H.R. 13197, which was the companion piece to S. 3008 introduced for the administration it was \$10 million.

S. 3008, as it emerged from the Senate, had \$9 million in the planning.

H.R. 18231 would contain the same \$9 million.

I think, Mr. Watson, that we have a chart which compares 13197, S. 3008 and H.R. 18231, which I might provide for you, instead of—it is four pages long, and there are significant differences.

I think I might point out that the major differences between 18231 and 13197 are as follows:

The planning stays essentially the same except it is \$1 million reduced.

The formula grant, the language stays essentially the same except in 13197 there was a provision that 70 percent of the funds in the formula grant had to go to the local community.

In 18231, this had been struck out. The reasons for this were that by lowering the authorized ceilings to the levels to which they are lowered, there would be some States which would be embarrassed under the 70-percent requirement to the local area, because at the present time they have less than that. They would, in effect, have to decrease the State health department budget in order to carry out that function.

If the authorized ceilings had been as they were in the Senate bill, 3008, as it emerged—the amount of money I mean—then there would have been enough flexibility to put that provision in.

It also provides for 1968 and 1969 authorized ceilings of \$62.5 million which is in H.R. 13197. It was different from that.

In H.R. 13197 there were no authorized ceilings except for the planning, and in S. 3008, as it was introduced in the Congress.

Those are the essential changes, the 70 percent figure, the authorized ceilings of \$62.5 million, and the 3 years—1967, 1968, and 1969.

There are a lot of other changes within this, I could give you, in this chart.

Mr. WATSON. Am I to understand at this juncture, though, that although you feel 13197 is the optimum bill—

Dr. STEWART. Correct.

Mr. WATSON (continuing). That you feel in the essence of practicality at this time that you are favoring 18231, just the single 1-year appropriation?

Dr. STEWART. No. H.R. 18231 authorizes \$9 million for the planning grants, 1967; \$15 million in 1968, and \$20 million in 1969 to the planning grants. But the formula grants, there is nothing in 1967, \$62.5 million for each of 1968 and 1969, and the same with the project grants.

Then there is another element to this, the grants to the schools of public health which would continue an authorization they already have of \$5 million. This would be what 18231 would authorize.

Our feeling is, as I have expressed, that to establish the idea of the planning program and the principle of more flexibility for the State and local health departments, it is a terribly important thing to get underway, and while we would much have preferred 13197, we recognize the shortness of the session yet to remain and the inability of time to really examine the authorized amounts, and we intend to come back to those next year.

Mr. WATSON. Now, one final question. Am I to understand that the State or local health agency would be prohibited from using any of these grants for planning mental retardation?

Dr. STEWART. No, sir.

Mr. WATSON. They would not?

Dr. STEWART. No, sir.

Mr. WATSON. The reason that that question is prompted is because I see a specific breakdown of \$1 million for mental retardation services and \$9 million for planning grants under the Senate bill, but I do not see such a breakdown under the House bill.

Dr. STEWART. The Senate amended S. 3008 to add the beginning of the staffing of the mental retardation clinics, and the \$1 million was for that purpose in 1967.

Mr. PICKLE. Will the gentleman yield?

Mr. WATSON. Yes; I will yield.

Mr. PICKLE. There would be no prohibition of our State health commission to use planning funds for mental retardation.

Dr. STEWART. That is correct.

Mr. PICKLE. This would be for mental retardation planning and not for staffing. At what point, at what level, could the State do this under 18231?

Dr. STEWART. Could they use the money for staffing?

Mr. PICKLE. Use the funds appropriated for mental retardation staffing?

Dr. STEWART. Well, there is no specific provision within 18231 for the staffing of the mental retardation clinics as this was amended in the Senate.

Mr. PICKLE. I understand it, "not specifically."

Dr. STEWART. That is correct.

Mr. PICKLE. But just in the general sense, whether it would be for that program, mental retardation, or whether it would be for tuberculosis.

Dr. STEWART. It would be possible for the State health department within the \$62.5 million authorized in 1968 to use some of that money within their plan for a mental retardation clinic if they so chose.

Mr. PICKLE. This would be the fiscal year, I assume.

Dr. STEWART. In 1968.

Mr. PICKLE. Thank you.

Mr. WATSON. The gentleman has prompted another question on my part, Doctor.

As I understand it now, this is going to be a single formula grant to the States and they will have the discretion of using this planning money as they see fit, in accordance with their health needs.

Dr. STEWART. That is correct.

Mr. WATSON. That is correct?

Dr. STEWART. That is correct, sir.

Mr. WATSON. You do not anticipate the issuance of any regulations or guidelines so as to put restrictions upon the making of these grants?

Dr. STEWART. Well, when the State health planning agency is operational, we would assume that the State plan, which is going to spend the formula grant money would be related to that State health plan that has been developed by the State health planning agency, and we would review this within the Public Health Service, within very broad guidelines, and I think, as we do now, there would be discussion and debate as to how they see their priorities, and—

Mr. WATSON. But the final decision will be with the States. You know we have been a little concerned—

Dr. STEWART. The State plan must be approved by the Surgeon General.

Mr. WATSON. Yes. But, of course, your overall guidelines will place primary emphasis upon the needs of the State—

Dr. STEWART. Definitely.

Mr. WATSON. Rather than those needs as determined by the Surgeon General, as you have said.

Dr. STEWART. I think we are all trying to do the same thing.

Mr. WATSON. I am sure of that.

Dr. STEWART. We are all trying to get services out to the people, and if there is any debate at all it is a question of which one is a little more important than the other in getting it to the people.

Mr. ROGERS of Florida. Will the gentleman yield?

Mr. WATSON. Yes.

Mr. ROGERS of Florida. The main purpose of this and the thrust of this is to allow flexibility to the State, that is the whole reason why we are doing it.

Dr. STEWART. That is correct.

Mr. ROGERS of Florida. And so I think the gentleman is correct, that this is to give the States the right to spend this money in those areas that they feel is necessary within those State borders. This is basically what we are trying to do.

Dr. STEWART. Is to give them flexibility within the formula grant to mold it to the priorities, as they see it through the State planning agency to work on it.

Mr. NELSEN. Will the gentleman yield?

Mr. WATSON. Yes.

Mr. NELSEN. I noted in your statement, with reference to the Senate bill, that the bill provided that by amendment grants to assist the staffing of a mental retardation facility—is this on a matching basis, the Senate bill?

Dr. STEWART. Yes. It is similar to the staffing grant provision in the mental health, where it is a decreasing amount.

Mr. NELSEN. Yes.

Dr. STEWART. I have forgotten what the matching formula is.

Mr. NELSEN. It does not really matter. The point is it is on a matching basis.

Dr. STEWART. Yes.

Mr. NELSEN. Now, what is the position of HEW relative to the Senate amendments?

Did you take a position for—or was there no position taken on the amendments?

Dr. STEWART. I think the position is the one that I stated in my opening statement, that we are not opposed to them.

Mr. NELSEN. Yes.

Dr. STEWART. But with these various committee reports coming along, we would rather look at those first.

Mr. NELSEN. In reference to the flexibility that Congressman Rogers mentioned, I recall the White House Conference early in the session where the direction we seemed to be moving toward is more flexibility, because circumstances may vary in many States where there is more serious need than in another, there may be some local activity that has met one need and not met another.

So I think there is great merit in flexibility and State determination in spite of what I said earlier.

Thank you.

Mr. WATSON. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Jarman.

Mr. JARMAN. I have one or two questions, Mr. Chairman.

Doctor, let me join in welcoming you and your colleagues, your associates who are here this morning. We appreciate the information you have given to us.

I am certainly in agreement and support of the overall objectives of the bill before us, the need for an effective working partnership at all levels in the health field.

The concern that I have is over expenditures, over costs, particularly in view of the costs of so many other things that our Federal Government is trying to do.

Let me ask—and perhaps you have covered this, but let me ask you this: I notice in the Senate committee report that accompanied the Senate bill that the figure given for fiscal 1970 was \$507.1 million. Then, in a comparative listing which you have given us, a comparison of the two bills, the S. 3008 figure shown is \$392 million.

Was that figure reduced on the floor of the Senate when the bill was considered in the Senate?

Dr. STEWART. Yes, it was.

Mr. JARMAN. As I say, you may have covered this, but what was deleted, what was cut out, in the Senate?

Dr. STEWART. They took 1971 and 1972 off, and they put the 1970 at the 1969 level, except for the planning. Does that explain it?

Mr. JARMAN. They put 1970 at the 1969 level except for the planning money?

Dr. STEWART. That is right.

Mr. JARMAN. Well, I will not go into this in any great detail in our short hearing this morning, although I will be interested in much more detail when we go into it with you next year.

Let me ask you this: As originally requested in what was an original request by the administration for a 6-year program, as I understand it, it would cost approximately \$2.4 billion over that period.

Dr. STEWART. That was the approximate figure we supplied the Senate; yes, sir.

Mr. JARMAN. In that request, the 1970 figure was a little over \$500 million in total—\$507 million. The 1971 figure was \$557 million; the 1972 figure was \$545 million.

I do know, of course, that in the hearings in the other body, that Secretary Cohen did indicate, in response to questions, that these are your Department's best estimates of what will be needed.

Dr. STEWART. That is correct.

Mr. JARMAN. Let me ask just one more question then.

Do you anticipate, as we get into this program of Federal-State cooperation going ahead with the legislation that is requested here—do you anticipate then the spending of the Federal share is going to run somewhere in the neighborhood of \$500 million a year, or do you anticipate that beyond that 5- or 6-year period the cost is going to mount and mount, as so many Federal programs do?

Dr. STEWART. Mr. Jarman, I think, in order to accomplish the programs that we visualize as being necessary, controlling the diseases that can be controlled and providing the services that need to be provided, and doing something about drug abuse, doing something about alcoholism and family planning and so on, a long, long list, of building a structure in the country of State and local health departments that can do these things responsibly, efficiently and economically, it is going to take that kind of money.

Mr. JARMAN. By "that kind," do you think Federal expenditures will be held to that level?

Dr. STEWART. I do not think I can predict that far in advance, Mr. Jarman. I think that we estimate at the present time, as we provided here—Mr. Cohen gave the figures—that this would be a level which we could be providing the kinds of services that the people need.

Beyond 1972, I think we would have to have some experience with an increasing amount of funds to know whether there will be needs for more or whether there will not. But I think that this was in rough estimate as to what it really will take.

We have at the present time \$55 million in the formula grants for the entire Nation for all of these various activities, and the needs grow every day. But this is the subject I am sure we will go into in greater depth this coming year.

Dr. LEE. Mr. Jarman, if I could just add a word. Some of these programs, I think, do not just cost money, they save money; and I think, if we just take one example of a program, such as family planning with effective programs making services available to people who currently do not have the services available, can result not only in savings in terms of preventing things like mental retardation, reduc-

ing infant mortality and maternal mortality, but reducing costs, for example, for school construction and a variety of other welfare costs through these programs. So that, they can, in fact, be investments as well as expenditures.

Mr. JARMAN. We certainly hope for those long-range results.

I might add this: I am certainly not for a minute commenting in opposition to the objectives of the program. I think this is an area in which we should be participating, and I think it is unfortunate that we have so many other programs of high cost that it makes it necessary to look very carefully at any new program in terms of whether we can justify it as additional costs for the Federal Government.

Thank you, Mr. Chairman.

Mr. Friedel?

Mr. FRIEDEL. First, I want to say that I am sorry I missed your opening statement.

I have two questions to ask, and each one has a three-part question. You might have answered these questions, I do not know, but these relate to the use of funds for voluntary family planning programs.

For the Health Service formula grants, can the States use Health Service formula grants for voluntary family planning under this program?

Dr. STEWART. That is good.

Mr. FRIEDEL. Does HEW believe that voluntary family planning health services are properly part of a comprehensive State health program?

Dr. STEWART. Yes.

Mr. FRIEDEL. Would HEW encourage the States to include such services in their comprehensive State plans?

Dr. STEWART. Yes; they would.

Mr. FRIEDEL. Thank you very much.

Now, the other one is the Health Service project grants. Can Health Service project grants be used for voluntary family planning programs?

Dr. STEWART. Yes; they could be.

Mr. FRIEDEL. Can an application for such funds be made by a local government agency or a qualified private nonprofit corporation?

Is the approval of the State health department required?

Dr. STEWART. That is right.

Mr. FRIEDEL. Do your potential needs for probable allocation of project grant funds include funds for voluntary family planning?

Dr. STEWART. I do not quite understand that question.

Mr. FRIEDEL. Does it include—

Dr. STEWART. There is no allocation of funds under the project money. This would be competitive within various projects.

Mr. FRIEDEL. It would be.

Dr. STEWART. But it certainly would compete just like anything else would compete.

Mr. FRIEDEL. At what level of expenditures do you anticipate for voluntary family planning purposes for this fiscal year, 1968 through 1970? Do you have any plans for that, what level of expenditures?

Dr. STEWART. Well, no. As I stated earlier, recognizing why the authorized ceilings that are provided in the bill are the way they

are, that this will give us very little flexibility and very little expansion into the family planning programs next year, but we do intend to come up next year with a new look at the authorized ceilings.

There is considerably more expenditures for family planning within the Department, though: The Child Health Institute in research, the Children's Bureau programs in maternal and infant care, the MCH money that is being used by State health departments for family planning, the Office of Economic Opportunity title 19, and you can go down several others that I probably forgot.

Mr. FRIEDEL. Thank you for the straightforward answers. I think it cleared up the record, so far as I am concerned.

Dr. LEE. I might just add one thing on that, Mr. Friedel, in terms of the Department's estimates of additional funds required for family planning services in 1968.

We have estimated, and these are very preliminary, that about \$15 million additional funds would be required based on the estimates that we have in from various States and local family planning organizations and other people that we are working with, both in terms of the Children's Bureau and other programs.

Mr. FRIEDEL. Would that be on a matching basis?

Dr. LEE. These are on a matching basis.

Mr. FRIEDEL. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Satterfield.

Mr. SATTERFIELD. No questions, Mr. Chairman.

The CHAIRMAN. Dr. Carter.

Mr. CARTER. You do not mean that this bill at the present time does include funds for family planning; is that true?

Dr. STEWART. It does not have funds specifically earmarked for family planning, but the formula grant money that would be authorized for 1968, and the project grant money could be used for family planning; yes.

Mr. CARTER. Would it be used for family planning?

Dr. STEWART. I am sure it will be, if it is within the State's or the locality's plans to use it that way.

Mr. CARTER. It is up to the States to do that.

Dr. STEWART. That is correct.

Mr. CARTER. You are just a little bit hesitant about promulgating this at the present time; is that true?

Dr. STEWART. No. I think we would try to encourage the States in the appropriate setting and the appropriate place to do family planning.

Mr. CARTER. Certainly, this is something we should go into, I feel, and go into at once. It is quite a problem, as you know, and if this bill comes to committee for final consideration, I aim to place an amendment in for family planning beginning with this year. I believe it is necessary, because I do not think—I think we should go boldly into this field without hesitancy.

Dr. STEWART. Dr. Carter, I did not want to imply any hesitancy on our part. We will do everything we could, as I answered before, to encourage the States; the States can use the funds, and we will be trying to encourage them to.

Mr. CARTER. Yes, sir. Thank you very much.

That is all, Mr. Chairman.

The CHAIRMAN. Thank you very kindly, Dr. Stewart, and all of your colleagues here. We appreciate your coming up and giving us your views, and we are hopeful that we can get this bill out today. If we do not, it does not have much of a chance, I can tell you that, if it does not get out today.

Thank you.

We will go along with our next witness, if it is all right with you.

Dr. STEWART. Thank you, Mr. Chairman.

The CHAIRMAN. I will call on our colleague, the Honorable James Mackay, to introduce the next witness. I believe he comes from his area of the country. He will have the privilege of introducing him.

Mr. MACKAY. Thank you, Mr. Chairman.

It is a particular pleasure for me to present Dr. John Venable, who is director of the Georgia Department of Health and who is also president-elect of the Association of State and Territorial Health Officers.

I know you have a way of complimenting us to our constituents, but I do not think it will do any good, because Dr. Venable has been knowing me since I was about 14 years old, so I think anything you might say favorable to me would change his opinion which, I hope, is good.

But in any case, Dr. Venable is a graduate of Emory University, and he was on the faculty for 21 years, and he has been the highly respected head of our State health department, which we think is one of the best in the Nation.

I might say that the General Assembly of Georgia, which is capable of being critical of every part of the executive branch of our State government, regards this as one of the best administered departments in our State, and Dr. Venable has certainly been helpful to me since I have been a member of this committee in interpreting to me the Federal, State, local, public-private relationships, and I take particular pride in presenting this outstanding Georgian, who is speaking for the State of Georgia and also for the association. Thank you.

The CHAIRMAN. Dr. Venable, I just want to say you can be proud, too, of your Representative here in Washington. He does a good job on this committee as, I think, every member of the committee does, but he has done an outstanding job.

At this time, I would like to call on Mr. Pickle, our colleague from Texas, to introduce, I believe, the gentleman who is with you, Dr. Peavy.

Mr. Pickle?

Mr. PICKLE. Mr. Chairman, at the witness table is Dr. James Peavy, who is Commissioner of Health of the State of Texas. I have not known him as long as Dr. Venable has our colleague, Mr. Mackay, but almost, because we served together in the State of Texas on many committees.

At one time, I was part of the official State government family, and Dr. Peavy is a career public health official in the finest sense of the word, and he made a real contribution to the health needs of our State and gave us leadership on a national basis. So, I welcome the chance, also, to present him to this committee.

The CHAIRMAN. I might say, as I did about Mr. Mackay, Dr. Peavy, that you can be proud of Jake Pickle. He is one of our outstanding members, and we have 33 outstanding members—32, not counting myself—on this committee.

So, Dr. Venable, if you will begin your presentation—I might say to you as I said to Dr. Stewart, we are trying to get through with this legislation today; so, if you have a long statement, if you will put it in the record, it will appear there, and you can summarize it.

**STATEMENT OF DR. JOHN H. VENABLE, DIRECTOR, GEORGIA DEPARTMENT OF HEALTH, REPRESENTING THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS; ACCOMPANIED BY DR. JAMES E. PEAVY, COMMISSIONER OF HEALTH, STATE OF TEXAS**

Dr. VENABLE. Thank you, Mr. Chairman and Mr. Mackay. I have a very short statement.

I appear today representing both the State of Georgia and the Association of State and Territorial Health Officers of which I am the president-elect. On behalf of all your States' health officers, may I express our appreciation for this opportunity to meet with you today.

It will not be news to any member of this committee when I say that all your State health officers are deeply interested in the legislation being considered. Many of us have spoken with our own Congressman Members—all of you have received communications from your home State explaining the reasons for our support of this remedial legislation. We regret that your heavy schedule of responsibilities precluded full hearing on H.R. 13197 and S. 3008. Assurance by Chairman Staggers that full consideration will be scheduled early next year is most gratifying. We believe it indicates the fact that you have concern, and we look forward to the opportunity to present to you the results of our studies over the past 4 years, during which time we have worked very closely with officials of the Public Health Service and the Secretary's Office, Department of Health, Education, and Welfare.

We are aware, Mr. Chairman, of the situation presently confronting this committee in these closing days of the 89th Congress. I deeply appreciate the extraordinary efforts that you and your committee are making to resolve temporarily the precarious situation of the moment. As requested, these comments and recommendations are addressed to the identical bills, H.R. 18231 and H.R. 18232, introduced by Chairman Staggers and Congressman Rogers of Florida.

This new provision—the expression of Federal willingness to become a full partner in developing practical health plans, utilizing the joint efforts of all States health interests—is extremely important. It is essential if we are to bring to those who need them the fruits of new medical knowledge in the most orderly, least confused fashion, utilizing to the optimum scarce available health personnel. These funds will enable each State to assess all its health needs, plan to meet them and continue an intelligent, realistic appraisal of progress and shifting priorities. We stanchly support this provision in the bills.

Current authority for the Federal formula categorical grants in section 314(c) and section 316 expires June 30, 1967. H.R. 18231 would extend this authority through June 30, 1969, and would eliminate the disease categories presently included as was proposed in H.R. 13197 and S. 3008.

We support this new approach to assisting State and local health departments which would allow to each sufficient latitude to meet their most serious health problems. We must, in candor, point out respectfully that removing the structures on the appropriations will only help solve our problem. The amount of funds provided must be increased significantly if the Federal Government is to become a partner in fact. The increase of but \$6.5 million over present appropriations, distributed among 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands will mean we can make no appreciable impact on greatly needed programs such as family planning, alcoholism, renal dialysis, home and traffic safety, retarded children and a host of others. In view of the obvious needs, we recommend that the authorization for formula health grants to States for 1968 be increased to \$100 million and, because the committee will be making a thorough study of this problem in January 1967 that there is no apparent or compelling need for an authorization for fiscal 1969.

You are familiar with the purpose of the project health grant—to more adequately deal with specific disease or health problems of unusual proportions in delineated geographical areas—so I shall not be repetitious. Our views here reasonably parallel those attendant to the formula grants, namely, that they be authorized for 1968 at a level of approximately 50 percent higher than at the present—\$75 million.

We earnestly request your serious consideration of these views. Authorization to continue our collective efforts next year is vital to continued progress. Our recommended, temperate increases would elevate the rate of progress.

Thank you for this opportunity to appear before you.

Mr. FRIEDEL (presiding). Thank you for your very fine statement.

Are there any questions?

Dr. Carter?

Mr. CARTER. In your State, you have a program at the present time for family planning?

Dr. VENABLE. Yes, sir, we do.

Mr. CARTER. Have you had any difficulty with that program?

Dr. VENABLE. Any program includes difficulties. We, I think, have a major difficulty of not sufficient funds to provide the materials necessary for the needs that people are demanding be met.

Mr. CARTER. Is it widely accepted there?

Dr. VENABLE. It is widely accepted, and we are currently training counselors in the local welfare departments to counsel in this area and refer.

Mr. CARTER. I want to congratulate you on that.

What about renal dialysis, your program for that at the present time?

Dr. VENABLE. Renal dialysis is just starting under a grant in Atlanta in the city hospital. It is just off the ground. I am not sure whether they have had their first patient at this moment, or not, but they will very shortly if they have not already done so.

Mr. CARTER. The mechanism for performing this, I understand, has become less complicated and less expensive, and could be of great help.

Dr. VENABLE. One of the built-in features of this particular project is to try to further a cheaper and mobile method that will enable this procedure to be done at home.

Mr. CARTER. Thank you very kindly.

Mr. FRIEDEL. Mr. Pickle?

Mr. PICKLE. Thank you, Mr. Chairman.

Dr. Peavy, I assume you are in general agreement with the statement which has been made by Dr. Venable?

Dr. PEAVY. Yes, sir. We are in complete harmony all the way through.

Mr. CARTER. That is all, Mr. Chairman.

Mr. FRIEDEL. Thank you.

Mr. WATSON. Doctor, we appreciate your statement. There is only one thing that disturbs me about it. You state on page 3:

The increase of but \$6.5 million over present appropriations, distributed among 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands will mean we can make no appreciable impact on greatly needed programs such as—

and then you enumerate some of the programs.

The thing that concerns me, I agree with you that it will not make an appreciable impact, but yet in your statement you say this will give the Federal Government full partnership. I do not believe in giving them partnership in such a meager amount. I appreciate your statement.

Dr. VENABLE. Thank you, sir.

Mr. FRIEDEL. If there are no further questions, I want to thank you both.

Dr. VENABLE. Thank you.

Dr. PEAVY. We appreciate the opportunity very much.

Mr. FRIEDEL. Dr. Charles Hudson, president of the American Medical Association, accompanied by Mr. Harry Peterson and Mr. Paul Donelan.

Dr. Hudson if you want to briefly summarize your statement, your whole statement will be included in the record. We want to try to get all the witnesses in today.

**STATEMENT OF DR. CHARLES L. HUDSON, PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY PAUL R. M. DONELAN AND HARRY N. PETERSON, ATTORNEYS, LEGISLATIVE DEPARTMENT STAFF, AMERICAN MEDICAL ASSOCIATION**

Dr. HUDSON. Thank you, Mr. Chairman and members of the committee.

I am Dr. Charles L. Hudson, president of the American Medical Association and a practicing physician from Cleveland, Ohio, where I have been in the practice of internal medicine for over 25 years.

Those accompanying me have already been introduced by you, Mr. Chairman.

I would like to abbreviate my report in the hopes that it will be recorded in full, including the summary and the recommendations at the end.

Mr. FRIEDEL. Yes.

Dr. HUDSON. The legislation, insofar as it is intended to provide for greater use of available facilities and manpower, avoid overlapping of existing programs and provide coordination among various programs, and permit greater flexibility of public health grants to meet the particular problems in a State, has the support of the American Medical Association. However, we would like to consider the various parts of the bills separately, inasmuch as we believe that the legislation requires certain modifications.

One section of H.R. 13197 would provide a 6-year program of formula grants for comprehensive planning within the State for health services, both private and public, and including facilities and manpower. Since duplication and overlapping of programs can be costly in terms of health resources, including scarce manpower, the AMA would endorse the concept of comprehensive planning. However, we recommend that certain changes be made:

(1) We believe that the legislation, being concerned as it is with health problems in a State, should provide for the administration of the plan by the State health authority or by an interagency commission composed of representatives of State agencies or departments concerned with health and related activities.

(2) We recommend that the legislation require the membership of the State health planning council to include representatives of the State medical society, with the majority of the council being physicians, including those in the private practice of medicine.

(3) We also believe that such a planning council should be more than advisory and, as in the case of the advisory councils under the heart disease, cancer, and stroke program, the State plan should be approved by the planning council. Further, where the legislation requires a review of the State plan, we believe that this review should be made in consultation with the planning council and that any modifications of the State plan should be approved by the council.

The significance of this legislation cannot be overstated as it will, if enacted, have far-reaching effects on the provision of health care to the citizens within a State. We believe that the above suggested amendments would strengthen the legislation in assuring the continued provision of adequate health services, and with these amendments the AMA supports the program of comprehensive State health planning.

The AMA has endorsed areawide planning on a voluntary basis, and we believe that the legislation would encourage voluntary private agencies to play a substantial role in planning activities. Accordingly, we support the provisions of the legislation for areawide planning.

The comprehensive public health services portion of H.R. 13197 would provide for a 5-year program of formula grants for comprehensive public health services. The section embodies one of the principal objectives of this legislation. At the present time, financial assistance is made available under the Public Health Service Act to States and communities, to assist them in developing and providing public health services. This assistance usually takes the form of separate categorical grants, either formula or project, earmarked for use in meeting a specific disease problem. Grants are presently made for such programs as general public health services, tuberculosis control, chronic disease services, heart disease control, cancer control, mental

health services, dental health services, radiological services, home health services, and also venereal disease control.

As a characterization of the type of services envisioned under this legislation, it was stated in the Senate hearings on S. 3008 that the Federal grant funds would be available to States on a noncategorical basis for the provision of "comprehensive public health services" which are focused on individuals and on families in their communities rather than on separate disease conditions. Dr. Leo J. Gehrig, Deputy Surgeon General, Public Health Service, told the Senate committee:

Through this flexible grant structure comprehensive public health services will be developed, expanded, and supported to maintain physical and mental health; to detect, prevent, control, or reduce the impact of diseases, injuries, and disabilities; to maintain a healthful environment; and, generally, to make available to all persons within the State a continuum of public health services based on the most up-to-date scientific knowledge and techniques.

The testimony of administration witnesses has made it clear that the term "public health services" has little restrictive meaning, if any. The increase in project appropriations indicates a greatly increased program, with no stated limitation as to the kind of services to be supported. The American Medical Association would support programs providing "public health services," which for the most part have been represented in the existing categorical grants, such as for venereal disease, tuberculosis control, radiological health grants, et cetera. We believe that this legislation, in the absence of definitive language, could represent a far-reaching departure, or expansion, from the truly public health services with which the Public Health Service has been charged.

The legislation provides what appears to be unlimited health services, focused on individuals and on families rather than on separate disease conditions. It brings within the guise of "public health" services the medical and health services presently being provided by the individual physician to the individual patient.

The American Medical Association believes that this legislation, as described by witnesses at Senate hearings, represents a substantial change in activities of the Public Health Service. We believe that Congress should define "public health services" under this bill, so that its intention as to the functions of the Public Health Service will be clear, and so that public health clinics will not be fostered to replace private medical care. In the absence of any limitation, and where the appropriations are no longer identified on a categorical basis, an unlimited range of activities appears to be the result. This the Congress refused to authorize under the heart disease, cancer, and stroke program, and we believe that the Congress should not authorize a *carte blanche* program merely because it is under the beneficent title of "public health services." Extensions of such a program can have no other effect than to interfere with a system which has provided a high level of medical care. Interference with the private practice of medicine could also result from the provision authorizing the Surgeon General to set standards as to the scope and quality of the services to be provided.

The American Medical Association cannot endorse an undefined program. As an alternative, or until the scope of the program is put in proper "public health" perspective, we would recommend a continua-

tion of the present categorical grants, with the Surgeon General having discretion to permit a State to shift a portion of a categorical grant for use in other of the categorical programs as may be desired by the State. This would achieve the flexibility sought under the proposed legislation.

The section concerning project grants for health services development would provide a 5-year program of project grants to public or nonprofit private agencies to cover part of the cost of:

(1) Providing services to meet the health needs of limited geographical scope or of specialized regional or national significance;

(2) Stimulating and supporting for an initial period new programs of health services; or

(3) Undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services.

These project grants are intended to assist the States with a particular disease or health problem, and as we view it, would in effect retain the system of categorical grants—the elimination of which is one of the intents of the previous section of the bills discussed. Further, it should be noted that this section no longer refers to “public health services” but is concerned with the development and providing of undefined “health services.”

Presently, project grants are made for cancer control, mental retardation activities, neurology and sensory disease activities, and continuing support of venereal disease and tuberculosis control activities, as well as the development of new or improved methods of providing out of hospital community health services.

An administration witness stated at the Senate hearings that project grants could continue under the proposed legislation for these same kinds of programs, as well as for program support, program development, and demonstration purposes in other health program areas such as heart disease control, dental health, injury control, urban health, family planning alcoholism, drug addiction, and rural health development.

Again, there is no limitation stated in the legislation as to the kind of health services which might be provided. The programs could be supported almost wholly by the Federal Government. And the categorical grants would not only be perpetuated but could in fact be increasingly diversified.

The American Medical Association would support grants for existing or new programs having a bearing on the public health. Assistance in proper Public Health activities to attack and control public health problems has unquestionable merit. However, this section of the legislation is vague and needs clarification as to its intent. There is need for definition and limitation of the services to be provided, and in its present form the association cannot support the project grant provisions.

Other provisions of the legislation provide for interchange of personnel with States, grants for support of public health training, and training of personnel for State and local health work. We believe all these provisions to be salutary and recommend your support.

We would further suggest that the legislation should provide for the creation of a National Advisory Council, to the Surgeon General

of the Public Health Service for implementing the provisions of this legislation, which Council would approve grants made to the States and approve changes made from time to time in the State plans. The Council should include representatives of national organizations which are represented on the State planning councils.

As a final addition we believe that a provision should be inserted in the legislation, similar to section 1801 of Public Law 89-97, to the effect that there shall not be any interference with the practice of medicine.

Having noted that I have not read the summary and recommendations, again, I would like to close and thank you for this opportunity to present the views of the American Medical Association on this legislation. We will be pleased to try to answer any questions which you, or the members of the committee, may have.

(The prepared statement submitted by Dr. Hudson follows:)

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION BY CHARLES L. HUDSON, M.D.,  
PRESIDENT

Mr. Chairman and members of the committee, I am Dr. Charles L. Hudson, president of the American Medical Association, and a practicing physician from Cleveland, Ohio, where I have been in the practice of internal medicine for over twenty-five years.

With me are Mr. Paul R. M. Donelan and Mr. Harry N. Peterson, attorneys on the Legislative Department staff of the AMA.

The American Medical Association is pleased to have this opportunity to appear before you and present its views on H.R. 13197 and S. 3008, the Comprehensive Health Planning and Public Health Service Amendments of 1966.

All of us who are active in medicine are aware of the great contribution being made by the Public Health Service in reaching the high level of health care enjoyed in this country. As you know, the American Medical Association has cooperated with the Public Health Service and has supported legislation in the area of public health.

In general, the "Comprehensive Health Planning and Public Health Service Amendments of 1966" has two principal divisions. One would provide grants to the States for comprehensive health planning—statewide, regionally and locally—with respect to all areas of health services, both public and private, and including health facilities and manpower. The second would revise the present grant system under the Public Health Service Act which, at the present time, provides separate categorical grants—both on a formula and project basis—and earmarked for use in meeting a specific disease problem. Under the legislation, certain present categorical grants would be consolidated into a single grant to the State for use in accordance with its State planning. In addition, special project grants would remain available to provide additional assistance to attack special needs of a limited geographic scope or of regional or national significance.

The legislation, insofar as it is intended to provide for greater use of available facilities and manpower, avoid overlapping of existing programs and provide coordination among various programs, and permit greater flexibility of public health grants to meet the particular problems in a State, has the support of the American Medical Association. However, we would like to consider the various parts of the bills separately, inasmuch as we believe that the legislation requires certain modifications.

*Comprehensive State Health Planning*

One section of H.R. 13197 would provide a six-year program of formula grants for comprehensive planning within the State for health services, both private and public, and including facilities and manpower. Since duplication and overlapping of programs can be costly in terms of health resources, including scarce manpower, the AMA would endorse the concept of comprehensive planning. However, we recommend that certain changes should be made:

(1) We believe that the legislation, being concerned as it is with health problems in a State, should provide for the administration of the plan by

the State health authority or by an interagency commission composed of representatives of State agencies or departments concerned with health and related activities.

(2) We recommend that the legislation require the membership of the State Health Planning Council to include representatives of the State Medical Society, with the majority of the Council being physicians, including those in the private practice of medicine.

(3) We also believe that such a Planning Council should be more than advisory and, as in the case of the advisory councils under the Heart Disease, Cancer and Stroke Program, the State plan should be approved by the Planning Council. Further, where the legislation requires a review of the State plan, we believe that this review should be made in consultation with the Planning Council and that any modifications of the State plan should be approved by the Council.

The significance of this legislation cannot be overstated as it will, if enacted, have far-reaching effects on the provision of health care to the citizens within a State. We believe that the above suggested amendments would strengthen the legislation in assuring the continued provision of adequate health services, and with these amendments the AMA supports the program of comprehensive State health planning.

#### *Areawide Planning*

A second section is also concerned with planning, but this time on an areawide basis. Under this portion of H.R. 13197, a six-year program of grants is authorized, under which the Surgeon General may make a grant (with approval of the State agency administering the plan for comprehensive State health planning) to any other public or nonprofit private agency to cover up to 75% of the cost of projects for developing (and for revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for such services.

The AMA has endorsed areawide planning on a voluntary basis, and we believe that the legislation would encourage voluntary private agencies to play a substantial role in planning activities. Accordingly, we support the provisions of the legislation for areawide planning.

#### *Grants for Comprehensive Public Health Services*

The comprehensive public health services portion of H.R. 13197 would provide for a five-year program of formula grants for comprehensive public health services. The section embodies one of the principal objectives of this legislation. At the present time, financial assistance is made available under the Public Health Service Act to States and communities, to assist them in developing and providing Public Health services. This assistance usually takes the form of separate categorical grants, either formula or project, earmarked for use in meeting a specific disease problem. Grants are presently made for such programs as general public health services, tuberculosis control, chronic disease services, heart disease control, cancer control, mental health services, dental health services, radiological services, home health services, and also venereal disease control.

As a characterization of the type of services envisioned under this legislation, it was stated in the Senate hearings on S. 3008 that the federal grant funds would be available to States on a noncategorical basis for the provision of "comprehensive public health services" which are focused on individuals and on families in their communities rather than on separate disease conditions. Dr. Leo J. Gehrig, Deputy Surgeon General, Public Health Service, told the Senate Committee: "Through this flexible grant structure comprehensive public health services will be developed, expanded, and supported to maintain physical and mental health; to detect, prevent, control, or reduce the impact of diseases, injuries, and disabilities; to maintain a healthful environment; and, generally, to make available to all persons within the State a continuum of public health services based on the most up-to-date scientific knowledge and techniques."

The testimony of Administration witnesses has made it clear that the term "public health services" has little restrictive meaning, if any. The increase in projected appropriations indicates a greatly increased program, with no stated limitation as to the kind of services to be supported. The American Medical Association would support programs providing "public health services," which for the most part have been represented in the existing categorical grants, such

as for venereal disease, tuberculosis control, radiological health grants, etc. We believe that this legislation, in the absence of definitive language, could represent a far-reaching departure, or expansion, from the truly public health services with which the Public Health Service has been charged. The legislation provides what appears to be unlimited health services, focused on individuals and on families rather than one separate disease conditions. It brings within the guise of "public health" services the medical and health services presently being provided by the individual physician to the individual patient.

The American Medical Association believes that this legislation, as described by witnesses at Senate hearings, represents a substantial change in activities of the Public Health Service. We believe that Congress should define "public health services" under this bill, so that its intention as to the functions of the Public Health Service will be clear, and so that Public Health clinics will not be fostered to replace private medical care. In the absence of any limitation, and where the appropriations are no longer identified on a categorical basis, an unlimited range of activities appears to be the result. This the Congress refused to authorize under the Heart Disease, Cancer and Stroke Program, and we believe that the Congress should not authorize a *carte blanche* program merely because it is under the beneficent title of "public health services." Extensions of such a program can have no other effect than to interfere with a system which has provided a high level of medical care. Interference with the private practice of medicine could also result from the provision authorizing the Surgeon General to set standards as to the scope and quality of the services to be provided.

The American Medical Association cannot endorse an undefined program. As an alternative, or until the scope of the program is put in proper "public health" perspective, we would recommend a continuation of the present categorical grants, with the Surgeon General having discretion to permit a State to shift a portion of a categorical grant for use in other of the categorical programs as may be desired by the State. This would achieve the flexibility sought under the proposed legislation.

#### *Project Grants for Health Services Development*

The section concerning project grants for health services development would provide a five-year program of project grants to public or nonprofit private agencies to cover part of the cost of: (1) providing services to meet the health needs of limited geographic scope or of specialized regional or national significance; (2) stimulating and supporting for an initial period new programs of health services; or (3) undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services. These project grants are intended to assist the States with a particular disease or health problem, and as we view it, would in effect retain the system of categorical grants—the elimination of which is one of the intents of the previous section of the bills discussed. Further, it should be noted that this section no longer refers to "public health services" but is concerned with the development and providing of undefined "health services".

Presently, project grants are made for cancer control, mental retardation activities, neurology and sensory disease activities, and continuing support of venereal disease and tuberculosis control activities, as well as the development of new or improved methods of providing out of hospital community health services. An Administration witness stated at the Senate hearings that project grants could continue under the proposed legislation for these same kinds of programs, as well as for program support, program development, and demonstration purposes in other health program areas such as heart disease control, dental health, injury control, urban health, family planning, alcoholism, drug addiction, and rural health development.

Again, there is no limitation stated in the legislation as to the kind of health services which might be provided. The programs could be supported almost wholly by the Federal government. And the categorical grants would not only be perpetuated but could in fact be increasingly diversified.

The American Medical Association would support grants for existing or new programs having a bearing on the public health. Assistance in proper Public Health activities to attack and control public health problems has unquestionable merit. However, this section of the legislation is vague and needs clarification as to its intent. There is need for definition and limitation of the services to be provided, and in its present form the Association cannot support the project grant provisions.

*Other Provisions*

Other provisions of the legislation provide for interchange of personnel with States, grants for support of Public Health training, and training of personnel for State and local health work. We believe all these provisions to be salutary and recommend your support. We would further suggest that the legislation should provide for the creation of a National Advisory Council to the Surgeon General of the Public Health Service for implementing the provisions of this legislation, which Council would approve grants made to the States and approve changes made from time to time in the State plans. The Council should include representatives of national organizations which are represented on the State Planning Councils.

As a final addition we believe that a provision should be inserted in the legislation, similar to Section 1801 of P.L. 89-97, to the effect that there shall not be an interference with the practice of medicine.

*Summary*

In summary, Mr. Chairman and members of the Committee, the American Medical Association is keenly aware of the great contribution to the public health made by the Public Health Service. The proposed legislation would broaden the activities of the Public Health Service, and insofar as it would provide for greater use of existing facilities and manpower, avoid overlapping of programs, and provide greater flexibility of public health grants, it has our support. However, we have directed the Committee's attention to the specific provisions of the bill:

A. We recommend that the Committee support the comprehensive State health planning provision provided that (1) the administration of the plan be by the State health authority or by an interagency commission composed of representatives of State agencies or departments concerned with health and related activities; (2) the membership of the Planning Council include representatives of the State Medical Society, with the majority of the Council being physicians, including those in the private practice of medicine; and (3) the Planning Council should approve a State plan, the review of the plan should be made in consultation with the Planning Council, and any modifications of the plan should be approved by the Planning Council.

B. We recommend your support of the areawide planning provisions and the encouragement of voluntary agencies to play a substantive role.

C. We urge you to oppose the provisions, as now contained in the legislation, for Comprehensive Public Health Services, inasmuch as they apparently could provide for a far-reaching departure from truly Public Health Services.

D. Similarly, we ask you to reject the section on Project Grants for Health Services Development, since what appears to be planned is a program for the development and the providing of a group of undefined "health services."

E. We recommend that you approve of those sections which provide for interchange of personnel with States, grants for support of Public Health training, and training of personnel for State and local health work.

F. Finally, we ask that the bill include provision for a National Advisory Council, include a prohibitory clause stating that there shall be no interference with the practice of medicine, and delete the provision presently in the legislation, out of which interference could arise, that the regulations prescribe the scope and quality of the health services under a State's plan.

For your consideration, we suggest the following modifications to the legislation:

- (1) In the section concerning Comprehensive State Health Planning:
  - (a) provide that the single State agency shall be the State health authority or an interagency commission composed of representatives of State agencies or departments concerned with health and related activities;
  - (b) provide that a State Health Planning Council shall include representatives of a State Medical Society, with the majority of the Council being physicians, including those in the private practice of medicine;
  - (c) provide that a State plan must be approved by the Planning Council, that the review of the plan be made in consultation with the Council, and modifications be approved by the Council.
- (2) Clarify the scope of any health services to be provided by:
  - (a) Adding a definition of "public health services" to indicate that public health is the art and science of maintaining, protecting, and im-

proving the health through organized community efforts. Public health services could include: vital statistics; public health education; environmental sanitation; public health laboratories (if private facilities are unavailable); and hygiene of maternity, infancy and childhood, if private facilities are unavailable.

As an alternative to the provision for comprehensive public health services, permit the Surgeon General to allow, under the existing categorical grant programs, a State to shift a portion of a categorical grant for use in other of the categorical programs as may be desired by the State. This would achieve the flexibility which is sought under the proposed legislation.

(b) Clarifying the program of project grants for health services development, by changing it to one relating to Public Health within the concept of the preceding paragraph (a).

(3) Provide for the creation of a National Advisory Council to the Surgeon General of the Public Health Service, for implementing the provisions of this legislation. This change should provide that the Council would approve grants made to the States and approve changes made from time to time in the State plans, and that the Council should include representatives of national organizations which are represented on the State Planning Councils (as constituted in conformity with our recommendations for membership of the State Planning Councils).

(4) Insert a provision in the legislation, similar to Section 1801 of P.L. 89-97, which indicates that there shall not be any interference with the practice of medicine.

(5) Delete in the section concerning comprehensive public health services the provision that the services be according to standards set by regulations, including standards as to the scope and quality of such services.

Mr. Chairman, in closing we thank you for this opportunity to present the views of the American Medical Association on this legislation. We will be pleased to try to answer any question which you or members of the Committee may have.

Mr. FRIEDEL. Thank you very much for your cooperation.

Are there any questions?

Mr. Younger?

Mr. YOUNGER. Doctor, on your recommendations beginning on page 8 where you are opposed to provisions contained in the legislation, are you referring to the bill on page 9, beginning with line 18?

Dr. HUDSON. May I look-see? Which bill number, sir?

Mr. YOUNGER. Well, the one we are considering.

Mr. DONELAN. I am Mr. Donelan.

Mr. YOUNGER. The bill we are considering, 18231.

Mr. DONELAN. The problem, sir, was Dr. Hudson was not able to get a copy of 18231, nor was the association, and his comments refer to 13197 which contains similar provisions, but they may be in a different part of the bill.

Mr. YOUNGER. Well, I think the provisions probably are similar except in the amount of authorization.

Mr. DONELAN. Generally, that is true, sir.

Mr. YOUNGER. But under the heading "Grants for Comprehensive Public Health Services," that is the provision that you are referring to there?

Mr. DONELAN. That would be the provision.

Mr. YOUNGER. That would be the provision that you oppose.

Mr. DONELAN. That is correct, sir.

Mr. YOUNGER. Now, on (D), you say the "Project grants". Can you tell me what section of the bill you are referring to there? I do not, offhand —

Mr. DONELAN. That would be page 14, sir, line 20.

Mr. YOUNGER. That is the allocation of funds within the states?

Mr. DONELAN. No; project grants for health services development.

Mr. YOUNGER. For which?

Mr. DONELAN. Yes; health services development.

Mr. YOUNGER. Project grants for health services development.

Mr. DONELAN. Yes, sir.

Mr. YOUNGER. It is that provision there that you—

Mr. DONELAN. (e).

Mr. YOUNGER. That you object to.

But you do agree with the Department that the question of family planning ought to be included in this whole package.

Dr. HUDSON. It certainly would not be excluded in view of the fact that this activity now goes on.

Mr. YOUNGER. That is all, Mr. Chairman.

Mr. FRIEDEL. Mr. Van Deerlin.

Mr. VAN DEERLIN. Dr. Hudson, do you call for a majority of physicians to be represented on both the State and the National health planning councils? Do you intend by this recommendation to convey the idea that the planning councils involved in Hill-Burton legislation have been handicapped by the equal representation they have given to nonprofessional members?

Dr. HUDSON. No, there is no reference to any of the council nor should you make inferences of that nature.

Mr. VAN DEERLIN. There would be, however, would there not, a similarity in the problems in the area of the purview of these respective councils, and that they are both related to comprehensive health planning?

Dr. HUDSON. I would think in the Hill-Burton perhaps there would be a wider range for diversity. But in the field of providing health services, and, as I interpret this personal health services, in many instances we do feel that we are expert in this particular field, traditionally have been carrying this out for many years.

Mr. VAN DEERLIN. Thank you.

Mr. FRIEDEL. Mr. Younger.

Mr. YOUNGER. Would the gentleman yield? I think we have a provision in there, in one of the previous bills, that at least a majority should be composed of nongovernmental groups. Would you subscribe to that same theory that we have put into one other bill?

Dr. HUDSON. I would be more or less obliged to refer to my statement, sir.

Mr. YOUNGER. To the effect of what? Repeat it.

Dr. HUDSON. That we would like to have a majority of physicians.

Mr. YOUNGER. A majority of physicians.

Dr. HUDSON. Including those in private practice.

Mr. YOUNGER. Thank you, Mr. Chairman.

Mr. FRIEDEL. Dr. Carter.

Mr. CARTER. Dr. Hudson, I take it that one of your objections, main objections, to this bill is that in place of categorical grants they want just general grants and that their authority might invade the private practice of medicine; is that not true?

Dr. HUDSON. This is a possibility.

Mr. CARTER. Yes, sir.

Dr. HUDSON. Our recommendation was that the flexibility could occur within the listed categorical grants. This would be an acceptable solution to the problem.

Mr. CARTER. That could be done through the Surgeon General's approval or change in categorical grants; is that not true?

Dr. HUDSON. The difficulty, if I could summarize it, is that we are uncertain as to what this means as one moves from listed categorical grant activity into an open field, and then I suppose, from then on, it is subject to individual interpretation as to what that means. But I feel that in all of the interests of the health of the country, we would be better off if that were defined.

Mr. FRIEDEL. Doctor, would you yield?

Mr. CARTER. Yes.

Mr. FRIEDEL. In H.R. 18231, on page 1, under "Findings and Declaration of Purpose," and then you will notice on page 2, line 9:

To assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.

Isn't that clear enough there, Doctor?

Dr. HUDSON. I think that is quite clear, personally, but the feeling of our counsel was that the recommendation we made was even more clear and more definitive.

Mr. CARTER. Doctor, public health as we generally think of it is that branch of medicine which has to do with prevention of disease. You would have no objection to these rather general diseases, but what you are objecting to is that they might enter into the practice of medicine, and so on; is that not true?

Dr. HUDSON. Prevention of disease, however, is not the exclusive prerogative of any departments, so far as I know. It is a part of the general practice of medicine.

I think that the easiest and most comfortable definition of "public health" has to do with environmental safety. If prevention of disease occurs under this connotation, yes, I think that is a proper function of the Public Health Service.

We pick up bits here and there, hence: We would just like to have a better definition of the intent of the expansion or of this kind of activity. It is not that we are opposed to it in its proper sphere. We are accustomed to it, and we support it and collaborate with it, but it is just the uncertainty of the language of this bill that makes us feel it should not be passed in its present form but possibly could be with better definition.

Mr. CARTER. Doctor, for my part, I think I understand, and certainly I would like to see the bill more clearly delineated. Thank you, sir.

Mr. FRIEDEL. Any other questions?

Mr. PICKLE. I would like to ask Dr. Hudson a question or two.

If I understand your testimony here, you would like the language to have more clear-cut definition as to what would be public health services; that is about it.

Now, when you make reference on page 8 in your testimony as to section—first, at the top of the page you say:

Comprehensive public health services is a far-reaching departure from truly public health services.

I do not quite understand what you mean there. That is a mighty fine-cut difference.

Are you saying that your idea of the difference would be on page 9 of what you attempt to give the definition of what would be public health services?

Dr. HUDSON. Well, the word "comprehensive" is a very elusive word, in the first place, and I would not claim to know what the word "truly" means in this particular context because I do think it needs definition.

I think almost everyone has a different opinion as to what it should include and, as we heard earlier a statement to the effect that we need to do something to the structure of the Public Health Service, I think there, too, we need to define and to make an evaluation of this alleged need, to make an evaluation of what we have already in the various fields that might be covered.

Mr. PICKLE. Dr. Hudson, perhaps we are in general agreement. You are apprehensive about the word, "comprehensive", and you suggest that we use the word "truly." We are not any closer to a solution, are we? So we are trying to arrive at what would be a protection to the medical association.

Now, I assume when you make reference to, in the middle of the page, that there shall be no interference with the practice of medicine, that you are talking about the private practice of medicine?

Dr. HUDSON. Yes, sir.

Mr. PICKLE. And you also make reference that you are talking about public health service definition that it could include these things you list, and when you say, "if private facilities are unavailable," you are talking about private medical facilities or private practitioners are not available. What you really want to be sure of is what we do is in no way interfering with the private practice of medicine.

If you look at the bill, in both the bill that is S. 3008, and also this H.R. 18231, you will notice on page 2 in the purpose and intent, line 10, that it says, "but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts," which, I assume, would be optometry and all the healing professions.

Does this satisfy you or the Medical Association on page 2 about the intent?

Dr. HUDSON. Well, the line of the question makes it appear that we are extremely selfish, an extremely selfish profession, and what I would like to say, as an alternative answer to you, is that we now have the Public Health Service and the private sector working in good, harmonious relationships.

It seems to me the burden is on someone who proposes to change it, and so since the definition is lacking as to what health services, public health services are, a sort of open-end recommendation to be determined, perhaps, by the Surgeon General, using the words, "scope and quality" we feel that there is an opportunity to disturb the present relationships, not just our own private practice, but the whole system of providing good, high quality care for the people of the country, and this is the context I would like to leave it rather than I am fearful that my own operation will be disturbed and injured.

Mr. PICKLE. Dr. Hudson, I think—I, for one, and I am sure the members of this committee comparably, do not want to pass any meas-

ure that would interfere with the private practice of medicine as we know it because this is the greatest in the world.

But I assume that you are speaking as a representative of the AMA, and that as such you do not necessarily attempt to speak for every State. I say that because I have a feeling that in my State the physicians within my State are in general accord with the language and objectives of this H.R. 18231 as proposed, and if you have different information than that which respect to my State or other States, why, then, I think you ought to say so. But you are speaking in the general sense when you say you are representing the AMA. I do not think you necessarily represent the Texas view.

Mr. DONELAN. Mr. Pickle, if I may add to what Dr. Hudson indicated earlier with respect to this language on page 2, lines 10, 11, and 12, that was in the Senate reported version, S. 3008.

Also in that reported Senate version of S. 3008, there was language which gave us considerable concern. In the State plan for comprehensive public health services there was a requirement that the State would have to provide public health services for all individuals within the State regardless of income or resources, age, or place of residence.

Now, here again public health services were undefined. But you can only do so much for everybody without intending the definition of public health services to be much greater than is currently accepted. This is why we have our basic point, which is that, and we feel that in this particular point we are representing the overwhelming majority of physicians, that the definition of public health service would do much to clear up any confusion.

Dr. HUDSON. Mr. Chairman, may I—

Mr. PICKLE. I believe two sections in S. 3008 have been eliminated.

Mr. DONELAN. This provision that I mentioned was eliminated as soon as it came up on the Senate floor.

Mr. PICKLE. On page 11 of S. 3008, they have deleted on line 11 all that follows, from lines 11 to 14, "public health services under the plan will be established and maintained for individuals confined to institutions for the mentally ill and mentally retarded," and also on page 18 through page 21.

When you talk about the State plans, that has been eliminated. So that—

Mr. DONELAN. That was eliminated. Our fear though, sir, was that this testimony was drafted at a time when this was the bill that was before us.

Mr. PICKLE. I see. That is all, Mr. Chairman.

Mr. FRIEDEL. Mr. Watson.

Mr. WATSON. Thank you, Mr. Chairman.

Dr. Hudson, I should like to commend you and the American Medical Association for your helpfulness on this legislation.

Now, I notice that your statement is aimed directly at your observations and recommendations relative to H.R. 13197; and, of course, I am sure there would have been some modification if you had had the opportunity to study 18231, which is probably the bill which would come out of this committee, if any does.

I certainly agree with you on page 7 of your statement that we should add some provisions such as section 1801 of Public Law 89-97 that there shall be no interference with the practice of medicine.

But one particular thing that I noticed on page 2, you recommend that a majority of the council of State health planning be physicians; and, frankly, it appeals to me that you recommend on page 6 that we create a national advisory council to the Surgeon General of the Public Health Service for the implementation of the provisions of this legislation. However, you do not recommend there that a majority of the Council be members of the profession. I assumed that would be your recommendation; is that correct?

Dr. HUDSON. I would have to revert to the statement. I could amplify it.

Mr. WATSON. Well, your statement then—if you want to revert to that—your statement is the Council should include representatives of national organizations which are represented on the State planning councils. So we can naturally assume and conclude from that that your specific recommendation is that this National Council not include a majority of physicians.

Dr. HUDSON. That is correct.

Mr. WATSON. Thank you.

Thank you very much, Doctor, for your contribution.

Mr. FRIEDEL. Mr. Mackay.

Mr. MACKAY. Thank you very much, Mr. Chairman.

Dr. HUDSON, the nub of the problem, as I see it, and it would appear from your testimony, is your concern about who actually determines priorities. I am looking at S. 3008, page 4, starting on page 3, where it says:

In order to be approved for purposes of this subsection, a State plan for comprehensive State Health planning must (a) designate, or provide for the establishment of, a single State agency, which may be an interdepartmental agency, as the sole agency for administering or for supervising the administration of the State's health planning function under this plan.

We have our State director, and I would just assume that it would be the State board of health.

Dr. HUDSON. I felt that it was not precise and specific enough in its language, and that we would like to have that—

Mr. MACKAY. It is left up to the State though; is it not? I do not construe this to give the Surgeon General the power to say that you have got to configure the thing in a certain way.

Dr. HUDSON. No; that is right.

Mr. MACKAY. And it seems to me that our common view would be that the State ought to have this authority to determine it.

Dr. HUDSON. Yes.

Mr. MACKAY. On the other hand, if you go further, I supported in the Georgia Legislature the position that the majority of the board of health ought to be professional people, not necessarily physicians, because we find veterinarians and many other people want to get into discussions of health policy.

For the Congress of the United States to say that a State has got to put a majority of physicians on there is a pretty stern use of congressional power in determining what we do at the State level, would you not say?

Dr. HUDSON. Yes.

Mr. MACKAY. Well, I just recall working very pleasantly with the AMA on the heart, stroke, and cancer program in which we explicitly

provided for participation by the practicing physicians, and I want to report to you that you are certainly accurate when you said there was a division of opinion in your ranks, because I have been receiving splendid material from AMPAC on how to get reelected, and AMPAC is raising money to beat me, so I am really confused. Thank you.

Mr. FRIEDEL. Any other questions?

Mr. ADAMS. I have just one, Mr. Chairman.

Doctor, I gathered from your statement and from your testimony that you, representing the AMA, have no objection to the manner or the amount of funding as set forth in this bill, is that correct?

Dr. HUDSON. I think I have not touched on it in my statement.

Mr. ADAMS. I noticed there was nothing in it, but I gather from it that, therefore, that you have no opposition to the manner or the method of funding as is proposed in the bill?

Dr. HUDSON. Let me refer to my compatriot here.

Well, your observation is correct, that we have not made any reference to it, and so any answer I think would have to be general. Our opposition is largely to the substance, that is, the lack of definition of what is being proposed, and then amounts of funds, of course, relate to that subject.

If you have a project that is excellent, there cannot be a great argument against putting more funds into a good project. But we cannot discuss funding when we are uncertain as to what this proposition is.

Mr. ADAMS. I have no further questions.

Mr. MACKAY. I have one further question. I want to say that I was being a little facetious a while ago, and because I am in a campaign, I am not quite rational at this point, but I hope we can, particularly those of us on the Subcommittee on Health can, get into some real deep discussions of what we do mean by public health and where the lines of demarcation are.

But right in the area of Metropolitan Atlanta, where I am told the birth rate of the indigent poor, both white and Negro is nearly as great as that in India, we have a planned parenthood program that is being carried out down there by Dr. Thompson at Grady Hospital, which is one of the most fascinating and important activities that I know about in public health.

Yet, would you call an actual planned parenthood program an environmental program, or would you call that the practice of medicine, private medicine?

Dr. HUDSON. I think it has to do with the total community. It is always presented that way.

Mr. MACKAY. I am sure the environment helps create the problems.

Dr. HUDSON. Yes; and the effects of the population explosion are on the total community, also.

Mr. MACKAY. But I would just like to stress this, take this opportunity to stress to you, that I certainly do not have any doctrinaire views about what is public health and what is private medicine, and I need help in this area, and any information that the American Medical Association can furnish me will be appreciated and studied with great care.

Dr. HUDSON. I would like, Mr. Chairman, to be permitted to add something that is, perhaps, tenuously related to the question.

I served on the National Commission for Community Health Services, and in its task force that tried to describe what comprehensive personal health services would be and how they might be organized within a community. I found it very difficult to do it at the local level, and I would think that to make this definition in an ascending scale to State and national levels would be increasingly difficult.

When I mention this, I mention the problem of fitting the Public Health Service into the total resources of a community and trying to define what their role would be, and some of my hesitancy is personal in that I feel with this knowledge, the difficulty of describing it locally right where the people are, becomes increasingly difficult and makes the problem not only more difficult but more urgent at the national level that we make this definition.

Mr. MACKAY. Thank you. No further questions.

Mr. FRIEDEL. Thank you.

Any other questions? I want to thank you, Dr. Hudson, and your two colleagues there.

Dr. HUDSON. Thank you, sir.

Mr. ADAMS. Mr. Chairman, just prior to the testimony of the next witness, I wonder if I might be permitted to make a unanimous-consent request. I have here the statement from Dr. Bucove, who is the president of the Association of State and Territorial Health Officers. He also happens to be the head of the Washington State Public Health Service, and I would like to include a statement by him which is in support, on behalf of his organization and of the Washington State Medical Association, of H.R. 13197, and the succeeding bill, 18231, and I ask unanimous consent that his statement might be included in the record at this point.

Mr. FRIEDEL. If there is no objection it will be included in the record at this point.

(The statement of Dr. Bernard Bucove follows:)

STATEMENT OF BERNARD BUCOVE, M.D., PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

I wish to express my own and our Association's thanks to the House Commerce Committee, and especially to Chairman Staggers, for your favorable response to our pleas for action to continue Federal grants for public health programs. Dr. Venable has shared with me the statement which he is presenting, and I subscribe to it fully. I have every confidence he will be able to supply further information through answers to questions which the Committee may have.

I have polled our Executive Committee, and our recommendations are unanimous. They are:

(a) Support of the planning grants provisions of H.R. 18231 for 1967, 1968, and 1969.

(b) As the *minimum*, support of the formula and project health grants at the level of \$62.5 million for 1968 only. The modest increase suggested by Dr. Venable is, in our view, more than justified.

(c) We are not able to discern any reason to authorize formula and project grants for 1969 in the amount proposed in H.R. 18231.

(d) Complete hearings on the basic proposal contained in H.R. 13197.

The new challenges to the health of our nation's people require new vital programs, more highly trained personnel and adequate financial support. Much definitive information will result from next January's hearing. Our four-year study of how best to meet the public health problems of today and of tomorrow convinces me that ultimately a proposal similar to H.R. 13197—S. 3008 will be enacted. It is needed—it is practical—it is acceptable. Washington's State Medical Society, as was the case with other state medical societies, had endorsed the proposal. Your continued interest is essential to the health of the nation.

Thank you.

Mr. FRIEDEL. Our next witness will be Mr. James Brindle, president of the Health Insurance Plan of Greater New York.

**STATEMENT OF JAMES O. BRINDLE, PRESIDENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK**

Mr. BRINDLE. Thank you, Mr. Chairman.

Mr. FRIEDEL. You may proceed.

Mr. BRINDLE. I have a written statement which I would like included in the record, Mr. Chairman, if possible.

Mr. FRIEDEL. Your statement will be included in the record.

Mr. BRINDLE. I would like to make just a few brief remarks about it. The Health Insurance Plan, of which I am president, conducts a comprehensive group practice care program in New York. It covers approximately 700,000 persons. There are other programs of this kind, notably the largest one in the country, the Kaiser Health Plan of California.

These programs over a period of years have been in competition with the most common method of furnishing personal health services in this country. The general practice is a fee for service basis. They have organizations which are in competition with them, and it is not an exclusive program, and I would say they have certain economic and medical advantages.

Now, we are generally in favor, not only these two programs I mentioned, but with the Group Health Association of America which represents a large number of such plans—we are generally in favor of the bills under consideration here, and we have, because of our experience in opposition to, in a free-enterprise economy to, the type of organizations we represent, we have several specific suggestions.

One of them is precisely the opposite from that one just recommended by the American Medical Association.

We think, as a matter of fact, that the proposal should include a majority of representatives on these statewide planning councils to represent the public rather than the professions which are at interest in this, and this we have specific language which we suggest be included to this end.

The other point is since planning often really intrudes and prevents experimentation, we would suggest that some general language be included, and again we have specific suggestions, which would encourage the development of effective approaches to the organization delivery of health services with view extension to experimental approaches and alternatives.

I think to say we have excellent personal medical services in the United States is really almost irrelevant. However good they are, and there are comparisons with other systems, and there are tremendous differences inside them, we can all agree they must be improved, and what we are suggesting is the fact that we want to see flexibility toward experimentation, and we want to see these planning councils dominated not by those who provide service but by those who are representing the general public.

What we are really trying to get to here is to take every possible effective action to see that we get improvement, however the level of services are, that we get improvement, and we try various methods

by which we can further improve, no matter how excellent we are in personal health services in the United States, and that there is always room for improvement. Thank you, Mr. Chairman. I will be glad to answer any questions.

(The prepared statement of Mr. Brindle follows:)

STATEMENT OF JAMES O. BRINDLE, PRESIDENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK

Mr. Chairman and members of the committee, my name is James O. Brindle, president of the Health Insurance Plan of Greater New York, which conducts one of the largest prepaid comprehensive group practice health care programs in the United States. At present our program provides most of the professional services for approximately 700,000 persons in the metropolitan New York area.

The regional planning concept was written into the Hill-Burton law. The substantial and significant benefits which have flowed from Hill-Burton are well known and widely praised, but the regional planning concept has not been successfully implemented.

Health facilities and services in this country have continued to develop in a random and disorganized manner. We share the increasing concern with patchwork patterns of health services and facility distribution—patterns which to some extent are responsible for our failure to attain optimum utilization of resources devoted to health services. Failures in achieving optimum distribution of health facilities and services have occurred in the past and will continue in the future if diverse interests independently pursue their various objectives in an uncoordinated and uncooperative manner. We strongly support efforts to foster rational planning.

People who own and operate health facilities have a vested interest if not in maintaining the status quo, at least in assuring that future developments will permit them to maintain their relative position in the health care economy. Consequently, we are concerned about attempts to impose order on existing patterns which may lead to the congealing of these patterns.

Planning, although it offers the hope of coherent development and optimum organization in the distribution of health services, also poses a very real threat of antagonism and resistance to innovation and development of alternative means of organizing and distributing health care services. Thus we believe that any legislation having to do with hospital and health facility and service planning should contain at least the following safeguards:

1. The principal decision-making role should be reserved to people who truly represent the general public as consumers of health services, rather than people who might be expected to have more parochial views of planning. Ultimate responsibility for resolution of broad questions of social policy should remain free from identification with the limited and sometimes specialized interest of any particular health profession or the prevailing philosophy in the hospital "industry".

2. Any planning program should assure that promising alternatives to the dominant methods for organizing and distributing health care services are given an opportunity for a fair trial, and, if they succeed, for continued growth.

THE IMPORTANCE OF ALTERNATIVES

The traditional and prevailing method of medical practice in this country always has been fee-for-service. This method of providing physicians' services is as random and disorganized as the present lack of system in distributing hospital services. This state of affairs has long been recognized.

In 1951 President Truman appointed a Commission to study and report on the health care needs of the nation. In its 1952 report entitled "Building America's Health" the Commission observed:

"The genius for organization, so characteristic of American life in general, is conspicuous in health services by its absence. By organization is meant the process of putting together people and facilities, and utilizing them in the most efficient manner \* \* \*.

"In reality most of the American people grope their way through a haphazard array of health services \* \* \*."

The stimulus for planning stems from a belief that the present system (or lack of system) for organizing and distributing health care services does not repre-

sent the best approach. Hence any planning program, if it is to result in improving present conditions, must assure a significant measure of flexibility by encouraging alternatives to the patterns whose inadequacies have stimulated the demand for planning. In 1959 the American Medical Association's Commission on Medical Care Plans concluded that:

"The medical profession should assume a judicious, tolerant, and progressive attitude toward developments in the medical care field. The need for continued experimentation is recognized, and the profession should undertake, and actively participate in, the study and development of various mechanisms for the provision of medical care of high quality."

However, if planning is left to people and institutions representing the traditional approach to organizing and distributing health care services, we fear that opportunities for experimentation and innovation may be severely restricted.

Group practice prepayment plans represent one alternative to the principal method of distributing health care services. Certainly this is not the only alternative and others may be developed in the future. Our belief in the importance of maintaining flexibility and providing opportunities for developing new techniques of organizing and distributing health care services would extend to any responsible approach.

Among possible alternatives, we are, of course, most familiar with the approach of our plan, which is a product of experimentation of the kind advocated by the American Medical Association's Commission on Medical Care Plans. We believe that our plan represents a significant and proven alternative to the dominant patterns of organizing and providing care, and the following discussion is offered not as a special plea for our approach, but only as illustrating the usefulness, and, if substantial progress in distributing health care services is to be realized, the necessity, of assuring opportunity for experimentation and innovation.

#### ONE ALTERNATIVE: DIRECT-SERVICE, GROUP PRACTICE PREPAYMENT PLANS

A direct service plan receives dues from its membership and assumes direct responsibility for arranging health services for a fixed payment per member per month. Contrary to the prevailing system, which lacks any overall concern with organization, direct-service plans undertake to unite and coordinate the health care resources necessary to provide the patient with the care he needs. Direct-service plans have built-in incentives for holding down costs and avoiding both unnecessary duplication of facilities and inappropriate utilization of services. These plans also provide a potential for significant economies by stressing preventive care and early disease detection.

The organization with which I am affiliated organizes prepaid medical care services for some 700,000 persons who reside in the greater New York area. These services are provided by 31 medical groups based at outpatient centers throughout the area. The major specialties of medicine, along with general practitioners, are represented in each of these groups. Community hospitals have been used to provide hospital care to the membership. Throughout the 20 year history of our organization, we have found a persistent obstacle to fulfilling our commitment to provide comprehensive health services; namely, the physicians in the medical groups do not have free access to needed hospital beds. Furthermore, because the physicians in each medical group are unable to hospitalize their patients in the same hospital, it is difficult, and in many instances impossible, to focus all the talents of the group on a sick patient during the very period of his illness when consultation of physicians in different specialties is frequently most important.

Until this year HIP was not permitted under New York law to own and operate hospitals. The law was amended this year and we are now permitted to round out our program by developing a network of hospitals for our present and future members. We believe that any significant planning effort should permit and encourage organizations such as the one I represent to implement the goal of providing comprehensive health services for a significant segment of the population which has demonstrated a desire to receive services through this type of program.

On the West Coast the Kaiser Program, which is similar to HIP in many respects, has always owned and operated its own hospitals. It has demonstrated the effectiveness of coordinated planning of health care services and facilities and is now providing health services to 1,400,000 people in California, Oregon, Washington, and Hawaii.

A number of observers have noted the advantages, both in cost-savings and in quality, that group practice can produce, particularly when it is coupled with prepayment.

The first large-scale systematic appraisal of the organization of medical care services in the United States was conducted by the Committee of the Costs of Medical Care, which represented leading physicians, economists, hospital experts and allied professionals. In October of 1932 this Committee issued the 28th and last volume of its landmark study. The Committee's first recommendation was that medical service "should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel". In 1947 the American Hospital Association's Commission on Hospital Care stated: "It is generally recognized that the coordinated effort of a group of physicians can provide the individual patient more readily with medical care of higher caliber than can equally skilled physicians working separately." President Truman's Commission on the Health Needs of the Nation concluded that "When group medicine is practiced in accordance with the highest standards, it provides excellent medical care at the lowest cost to the patient and the community." The President's Commission also approved formation of groups rendering prepaid comprehensive service. Both Presidents Kennedy and Johnson advocated group practice of medicine in messages to Congress and the American Medical Association's Commission on Medical Care Plans concluded that "good medical care is being provided, within the scope of services offered", by direct-service plans. Others who have studied the subject have reached similar conclusions.

Again, we wish to make it clear that we refer to our plan, and to direct-service prepayment plans in general, not with a view to seeking preferential treatment, but only to indicate that there are meaningful alternatives to the prevailing methods for organizing and distributing health care services, and in support of our belief that any approach to planning should assure that this and other alternate approaches are provided an opportunity to develop so that each individual is secured the right to choose from among significantly different approaches to distributing health care services.

#### SUMMARY

(1) We suggest that the dominant role in the planning process should be left to people representing the public as consumers of health care services. Adequate representation for special-interest groups should be provided, but health professionals should be in a minority.

(2) We believe that assuring the highest level of health attainable for every person will most likely be achieved through encouragement of flexibility and experimentation in the development of alternative approaches to the provision of health services.

#### PROPOSED AMENDMENTS TO S. 3008, SUBMITTED BY THE HEALTH INSURANCE PLAN OF GREATER NEW YORK

1. Sec. 2(a), page 2, line 5, following the words "of individuals and organizations," insert the following: "*that such collaborative effort should be directed toward encouraging and supporting effective means of organizing and delivering health services, and should foster flexibility and experimentation in the development of alternative approaches to the provision of health services;*"

2. Sec. 314(a)(2)(B), page 3, line 15, following the word "and" at the end of line 15, insert the words "*at least a majority comprised*".

3. Sec. 314(a)(2)(C), page 3, line 22 following the words "(both public and private)", insert the following: "*and to encourage development of effective approaches to the organization and delivery of health services (with due attention to experimental approaches and alternatives)*"

Mr. FRIEDEL. Any questions? Mr. Younger.

Mr. YOUNGER. In regard to your recommendation about the majority of the council, are you familiar with or do you have before you 18231?

Mr. BRINDLE. I have a copy of the Senate bill 3008. I think its contents are approximately the same.

Mr. YOUNGER. I guess it is the same. I have not compared them.

The bill we are considering is 18231 and, as I understand before, in response to recommendations of the various health plans all over the country, we did include the expression that at least a majority composed of. Where would you put that expression in the bill, do you know, or can you advise us?

Mr. BRINDLE. Well, we have a specific proposal which would put it in again—let me see if I can find it here—on page 4 in 2 (B) we would suggest that this be—and that is the same as the Senate version, right after line 13 “and” we would suggest the insertion “at least a majority comprised.”

Mr. YOUNGER. Of the group concerned with health, is that what you would recommend?

Mr. BRINDLE. Yes, sir; and it would follow that line 13, and it would run “and at least a majority comprised of consumers of health services,” following line 13, between lines 13 and 14.

Mr. YOUNGER. It is similar to the recommendation that the committee put in a previous bill.

Mr. BRINDLE. I think it is, sir.

Mr. YOUNGER. Except we got a little confused, as I recall now, with the language. But—

Mr. BRINDLE. Well, this is—

Mr. YOUNGER. The principle is the same.

Mr. BRINDLE. Yes, sir.

Mr. YOUNGER. And in this council—

Mr. BRINDLE. A majority to represent the consumers.

Mr. YOUNGER. That a majority be composed of those that need or use the health services rather than the practitioners.

Mr. BRINDLE. Rather than those who furnish it; yes, sir.

Mr. YOUNGER. That is your recommendation, and it would come in this section (B).

Mr. BRINDLE. Section (B) on page 4 after line 13.

Mr. YOUNGER. On page 4?

Mr. BRINDLE. Yes.

Mr. YOUNGER. Thank you very much.

Mr. FRIEDEL. Mr. Van Deerlin.

Mr. VAN DEERLIN. Thank you, Mr. Chairman.

Mr. Brindle, has your organization which represents, I take it, group care and prepayment plans, had some experiences that are unpleasant with what we might call the medical establishment?

Mr. BRINDLE. Well, I would say, I have to say, in all justice in the recent 3 or 4 years it has been much improved in New York. But over the history of the Health Insurance Plan, and I think from my involvement with other group practice prepayment plans like Kaiser Plan and those represented by the Group Health Organization, there has been consistent opposition to this plan on the part of the standard medical establishment. In New York it was necessary to go to the State and get a law passed to keep the hospitals from excluding physicians who were engaged in group practice from getting hospital privileges.

This last year we had to go for legislation to get permission for the Health Insurance Plan to move in the hospital field.

Lately, the hospital council which, in New York now must have a substantial representation from the consumers rather than the purveyors of services, will have to be more sympathetic.

I say lately the hospital planning council of both State and local in New York have been much more sympathetic, but still generally around the country you find opposition from these organizations which do represent hospitals and the established medical organizations, you find opposition from these groups to the group practice prepayment plans.

Mr. VAN DEERLIN. I see you put in a statement exclusion from established hospitals, I presume doctors who are associated with these plans?

Mr. BRINDLE. Yes, sir.

Mr. VAN DEERLIN. Not patients. Patients are not excluded as such, except you cannot take your own doctor in; is that the idea?

Mr. BRINDLE. Well, a doctor has to admit a patient to a hospital. So if you blocked physicians out you effectively block their patient or force these patients to transfer to another physician.

Mr. VAN DEERLIN. How are these staffs accredited? Is this through membership in the State medical society, or licensed physicians? These are always licensed physicians we are talking about, are they not?

Mr. BRINDLE. These are licensed physicians, but the appointment to hospital staffs is controlled by the board of trustees of a hospital, and they act on the advice of the physicians on the staff there. Staffs customarily are organized into a medical board which appoints, recommends the appointment of physicians, and physicians are appointed to hospital staffs by the board of trustees of a hospital.

I do want to say the situation has improved in New York. But in many places you still find this discrimination against physicians in group practice prepayment plans on the part of local institutions and local agencies.

Mr. VAN DEERLIN. What about the Kaiser organization that you referred to in your statement?

Mr. BRINDLE. Well, the Kaiser organization has gotten around this difficulty by developing its own hospitals. But you find there that they have had experiences where even in the planning and erection of new hospitals they have had opposition from the establishment which, for instance, has dominated the planning programs, and so on.

In most areas you find these organizations that represent hospitals and physicians generally blocking the development, perhaps, of new institutions, new agencies or influencing negatively grants of money, money grants, toward the group practice plans.

Mr. VAN DEERLIN. This matter of admission to hospital staffs; is there any legal recourse that is possible?

Mr. BRINDLE. Well, yes; but it is extremely difficult, and you have to understand the problem of a good hospital. They want to restrict their staff to persons who are well qualified, and so it is extremely difficult, and some of the time the opposition and the blocking gets pretty subtle.

They also have the problem, most hospitals do, of pressure on beds, and when they run out of beds for their staff it is hard to get new people on, so you know you cannot define this precisely.

In New York it was so open and flagrant that we had a State law passed. Now this has not been resorted to in other places and, fortunately, Kaiser, with its resources of the Foundation Health Plan has been able to develop its own institutions.

Mr. VAN DEERLIN. Normally, would not a physician's State license attest to his qualifications?

Mr. BRINDLE. No. There are many other qualifications taken into consideration.

For instance, by a health plan like ours or the Kaiser Plan or others or good hospitals, in determining who could practice in a hospital, and it would depend on the extent of practice.

For instance, many hospitals, quite properly, and agencies like ourselves, require much higher qualifications for training, for certain procedures. You cannot accept, for instance, the fact that a man is licensed, and bring him into an institution and let him do neurosurgery and do heart work. There are many gradations which are quite properly applied, and many other determinants of qualifications of a physician. So, you see, there is opportunity to be quite discriminatory, sometimes properly and sometimes improperly, and in granting hospital privileges.

Mr. VAN DEERLIN. I note that in your summary recommendations, the second one you ask for a majority on the State planning councils, of consumer, nonprofessionals.

Would you settle for half and half such as we have in Hill-Burton?

Mr. BRINDLE. I think that is an improvement, but I really believe that the majority would be a better solution to it.

Mr. VAN DEERLIN. That is a precedent.

Mr. BRINDLE. That would be an improvement over the present language. I would urge that the majority be receivers, rather than the purveyors of services.

Mr. VAN DEERLIN. I see the chairman is getting ready to use his gavel.

Mr. FRIEDEL. Dr. Carter.

Mr. CARTER. Mr. Brindle, would you give me a little resume of your background, please, sir.

Mr. BRINDLE. Yes, sir. I am president of the Health Insurance Plan of Greater New York. Prior to that I was director of the Social Security Department of the United Auto Workers, and I helped to develop a prepayment group, practice plan in Detroit there.

Before that, with the exception of 4 years in the armed services, during World War II, I was director of public assistance in Pennsylvania, and there supervised the administration of welfare medical care in that State.

Mr. CARTER. Have you had professional training in this capacity?

Mr. BRINDLE. Not as a physician, no, sir.

Mr. CARTER. Well, as an administrator or supervisor, have you had college training along those lines?

Mr. BRINDLE. Yes, I have had college training and my professional background was in social work.

Mr. CARTER. Social work.

Mr. BRINDLE. Yes, sir.

Mr. CARTER. Would you feel differently then if these councils should be composed principally of consumers, that they should direct the health departments; is that true?

Mr. BRINDLE. I do not think these councils should direct the health department. There are many technical areas in which you obviously need professionals and, as I indicated, I think the professions ought

to be represented, but just as I think you gentlemen must decide many important overall policy decisions concerning operations of our health, and since we are primarily interested in the health of the people, not in the operation of the professions, I think it is perfectly proper to have an overall planning agency dominated by those who have the primary interests, the public interests.

Mr. CARTER. You do not think the medical profession then has the primary interest in public welfare?

Mr. BRINDLE. I think it has a great interest in the public welfare, but I think—

Mr. CARTER. Yes, sir; I agree with you.

Mr. BRINDLE. But I would not say its primary interest—well, its primary interest is in health care and providing it, but I would say that, as in other providers of service, it may have a little different approach and a little different objective from those who are receiving the care or those who are kind of neutral or disinterested therein.

Mr. CARTER. Do you consider yourself better qualified to judge on capacities of physicians or as to what they should do in States and State departments of health rather than what the physicians themselves should decide should be done; is that true?

Mr. BRINDLE. I do not know how you make the comparisons. There are many areas in professional and in administrative policy, although I would not think of trying to proceed without the advice and help of a physician, but I do not think that it is necessary at all to have an organization of physicians be the persons who have voting control of a planning agency.

Mr. CARTER. Yes, sir.

Would you say you were a member of the Automobile Workers Union; is that right?

Mr. BRINDLE. No, sir, not a member. I was head of their Social Security Department. I came on there as an expert to deal with pensions and health insurance, and programs like that.

Mr. CARTER. Yes, sir. And experts on pensions were in your group; is that right?

Mr. BRINDLE. Yes, sir. We had actuaries in the group.

Mr. CARTER. In this group would you recommend that members of other professions should help decide problems concerning social security?

Mr. BRINDLE. Yes. As a matter of fact, we had physicians in the organization to be concerned with this area. We worked with them.

Mr. CARTER. I suppose they were in the majority then?

Mr. BRINDLE. No, sir; they were not.

Mr. CARTER. They were not?

Mr. BRINDLE. That is right.

Mr. CARTER. I see.

Mr. BRINDLE. We were not dealing primarily with medical affairs either.

Mr. CARTER. Can you advocate that they not be in the majority in something which affects them more greatly than any other group?

Mr. BRINDLE. I would disagree with you that health care affects—

Mr. CARTER. In which they devote their lives to it?

Mr. BRINDLE. I would disagree with you that health care affects physicians more than it affects patients.

Mr. CARTER. Well, I am in agreement with that insofar as the patient is concerned. But that is, of course, the great ideal of the physician is to help those who are ill and who are sick, and most of us, regardless of what people say, are devoted to that ideal of helping. Certainly I think that physicians should be represented on these councils.

Mr. BRINDLE. I do, too. We do not disagree on that. I agree they should be represented.

Mr. CARTER. At least one half of the council should be composed of physicians and, of course, the other half should be extremely intelligent men although, perhaps, from different walks of life.

Mr. BRINDLE. I think we are just differing on the proportion of the people. We would just recognize that the professions must be represented and the public, too.

Mr. CARTER. You have also stated that you worked previously on the situation on which you worked, the majority of the group were the same type as you were, and I should think that positions or councils involving physicians as well as their patients should also have at least equal representation.

Mr. BRINDLE. Well, I do not know what kind of—I do not know how you envisage the place I last worked. I was a staff member, a technical staff member, with a staff of qualified persons. We had a couple of physicians on the staff, actuaries, we had insurance experts, and so on. We were not primarily engaged—when we set up a health plan we put it under the direction of physicians, and when we had substantial representation of these physicians on the health plan, we obviously used physicians. My job was not to work primarily in the health area, and when we were in pensions we had an actuary. We were employees of an organization which hired us. We did not have a council.

Mr. CARTER. Yes, sir. How many were in your group?

Mr. BRINDLE. In the United Auto Workers?

Mr. CARTER. Yes, sir; this group you are talking about.

Mr. BRINDLE. At the time I went there about 1,600,000.

Mr. CARTER. In your council or your commission you said there were two physicians.

Mr. BRINDLE. I had no commission, we had a diagnostic center which was operated by the union.

Mr. CARTER. We are not getting anywhere on this.

Mr. BRINDLE. I had no council.

Mr. CARTER. You were a member of a group, were you not?

Mr. BRINDLE. I was a member of the technical staff of the union.

Mr. CARTER. A member of the technical staff. Now we are getting a little further. How many members were on this technical staff?

Mr. BRINDLE. We had about 11 people.

Mr. CARTER. How many physicians were on this?

Mr. BRINDLE. There were two, but they worked—

Mr. CARTER. Two physicians, all right.

Mr. BRINDLE. But they worked in the health plan.

Mr. CARTER. All right, sir, OK.

Now, this applied to the Automobile Workers, I believe you stated, is that not right?

Mr. BRINDLE. We did the negotiating with the corporations.

Mr. CARTER. All right. Nine of those members were not physicians. Yet in a system which involves physicians directly you want to limit the number of physicians to less than half, whereas on a different commission entirely, on your commission or on your group, they had a representation of only two.

Mr. BRINDLE. We were not primarily concerned with health programs; we were renegotiating pensions.

Mr. CARTER. It all depends on whose ox is gored as to what number you would have on a council, it appears to me. Thank you, sir.

Mr. FRIEDEL. Mr. Mackay.

Mr. MACKAY. Mr. Chairman, I would just like to say this; Mr. Brindle, I will make the same point to you that I made to Dr. Hudson. This law does not say what the State agencies shall be. It leaves this up to the State legislature, and if we had not achieved reapportionment I would be interested more in Congress defining this. But are you not willing to leave it up to the State legislatures to thrash out who shall be the agency?

Mr. BRINDLE. Who should be the agency?

Mr. MACKAY. Yes. In planning, the planning agency. This law does not say.

Mr. BRINDLE. Well, my recommendation was that we have a majority, that Congress act to provide a majority, represent the consumer rather than the provider.

Mr. MACKAY. Do you not think we can contribute to the vitality of the State as a political subdivision if we leave this type of policy question for experimentation and variety?

Mr. BRINDLE. I think that if you leave it you are going to find in most places the majority will be, as in many past such activities will be, dominated by the providers of the services.

The other suggestion made that there be equal numbers would be better, I would think. But I should think I would recommend you put some standards in there on this subject.

Mr. MACKAY. Thank you very much.

Mr. FRIEDEL. Any other questions?

Mr. Pickle.

Mr. PICKLE. Mr. Brindle when you offered to the committee your recommendations, amendments, the first and the third, it seemed to me that your key word was "experimentation."

I assume that in offering these two suggested amendments you are by that wording hoping to put into the measure the intent of the bill to provide for group practice prepayment or group hospitalization that you have in New York?

Mr. BRINDLE. Among other things. I think the experimentation should be broader than that; yes, sir.

Mr. PICKLE. I, for one, do not agree, but I just want to be sure I pinpoint that.

Mr. BRINDLE. I am really speaking on behalf of the group practice prepayment, but I think there can be other possible and useful experiences, experiments.

Mr. PICKLE. That is all.

Mr. FRIEDEL. Any other questions? Well, thank you very, very much, Mr. Brindle.

Our next witness will be Dr. Henry B. Peters, University of California, Berkeley, Calif., for the American Optometric Association. Would you wish to summarize your statement?

**STATEMENT OF DR. HENRY B. PETERS, ASSISTANT DEAN AND DIRECTOR, CLINIC, SCHOOL OF OPTOMETRY, UNIVERSITY OF CALIFORNIA, REPRESENTING THE AMERICAN OPTOMETRIC ASSOCIATION**

DR. PETERS. Thank you, Mr. Chairman.

I am Dr. Henry B. Peters, assistant dean and director of the clinic of the School of Optometry of the University of California in Berkeley.

I am a member of the ad hoc program and review council to the California medical assistance program and, among other things, a member of the American Public Health Association.

It is as a member of the committee on public health and optometric care that I appear here today in behalf of the American Optometric Association.

The American Optometric Association endorses the purposes of this legislation. I particularly want to compliment this committee on its concern for the profession of optometry in past legislation, and I hope that it will extend that concern to this.

It has been my privilege to sit on various planning commissions in the State of California, and I believe they perform a vital function.

It is safe to assume that funds will not be available to provide for the maximum needs or even some of the more urgent ones. It, therefore, will be necessary to curtail or postpone some of the suggested projects.

Vision care has not received the support or interest it merits. There are no project grants, no formula grants to optometry for vision care. Testimony by members of the optometric profession before this committee has outlined the importance of vision care for all people of all ages in all walks of life. Vast unmet needs for vision care exists today. For example, vision screening among preschool and school age children, an area in which I have done considerable research, shows repeatedly that 12 to 20 percent of the children have uncorrected, unrealized vision problems. At every motor vehicle licensing office large numbers of applicants fail because of uncorrected vision problems.

Industrial vision screening programs regularly show that 25 percent or more of those currently employed have vision inadequate for their jobs. Multifaceted screening programs show a higher incidence of uncorrected vision problems than any other health defect except dental disease. The Armed Forces have found that one of the major causes for rejecting men is defective sight. Much of this could have been corrected if proper vision care had been obtained in childhood.

The full cost of neglected vision problems is impossible to calculate. An estimated total must include the costs of highway accidents, industrial injuries, lost production, school retardation, and dropouts. A local upward bound program for students considered potential dropouts by the OEO in our community, found that 52 per-

cent of the children in this program considered potential dropouts had severe uncorrected and undetected vision problems.

Optometry is a national resource for sight conservation. The 17,000 practicing optometrists, the Nation's third largest health profession, want to participate in the planning and implementation of vision care and sight conservation programs. They wish to eliminate the human and material waste caused by inadequate vision services.

But these problems are largely ignored by Federal, State, and local public health officers. Optometry, which serves the vision needs of the vast majority of the Nation's citizens, is not represented in any public health department concerned with health services—state or local. How then may optometry be represented in the health planning program proposed in this legislation?

There are only two ways that we can see, and I would propose for your consideration two amendments. The first relates to the State health planning council, and the second relates to a specific provision for planning for sight conservation.

I compliment the committee on including in section 314 providing consumers on the Health Planning Council. Having served on just such a council under title 19 Medicare, I can assure you that the majority of consumers lends a welcome balance to the governing council.

There is no question that the language in the bill would permit the employment of duly licensed optometrists to the State planning council. But to make certain that Congress intends that representatives of the various health professions be included on these councils, we recommend that on page 3, line 16, after the word "health" there be inserted "duly licensed personnel in sciences related to health".

The term "sciences related to health," has been used in several recent congressional enactments to include medicine, dentistry, optometry, pharmacy, osteopathy, and other health related sciences.

Our profession urges that when reported by this committee, the bill contain a provision which will assure that some of the authorized funds must be used for vision care planning.

Frankly, I am normally opposed to this kind of fragmentation, but it is urgent that the Congress indicate its intent that some of the health planning funds be directed in this direction.

So we have suggested, Mr. Chairman, that at least 2 percent of the State's allotment under this subsection shall be available only to the State vision authority for developing the State planning of optometric and related vision services.

We are grateful for the opportunity, Mr. Chairman, to appear before you today. Our association wholeheartedly endorses the concept of this legislation and urges that the suggested amendments be incorporated into the bill when reported to the House.

If there are any questions, I will endeavor to answer them. If I do not have the information at hand it will be furnished to the committee promptly. Thank you, Mr. Chairman.

(The prepared statement of Dr. Peters follows:)

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION  
PRESENTED BY DR. HENRY B. PETERS, O.D.

Mr. Chairman and Members of the Committee, I am Henry B. Peters, Assistant Dean and Director of the Clinic of the School of Optometry, University of Cali-

fornia, Berkeley, California. In 1938 I graduated from the School of Optometry at Berkeley and subsequently earned a Master's degree in Educational Psychology. I am licensed to practice optometry in California.

Currently I serve as Vice President, Association of Schools and Colleges of Optometry; member, American Academy of Optometry Executive Council; member, American Optometric Association Committee on Public Health and Optometric Care; and member, Ad Hoc Program and Review Council of the California Medical Assistance Program. I served as a Navy line officer during the second world war and currently hold a reserve commission as an optometrist in the Navy Medical Service Corps.

It is as a member of the Committee on Public Health and Optometric Care that I appear here today on behalf of the American Optometric Association. The Association is composed of optometrists duly licensed to practice their profession in one or more of the fifty states and the District of Columbia. Of the 17,000 licensed optometrists in practice today, close to 14,000 hold membership in our Association.

The purpose of H.R. 13197, as I understand it, Mr. Chairman, is to assist in the extension and improvement of comprehensive health planning and public health service as well as to provide a more effective use of available federal funds. When one considers the vast amount of federal monies available to states for public health projects, there can be no question that some money should be allocated for planning. This bill, when enacted into law, will authorize the U.S. Public Health Service Surgeon General to make grants to states which have submitted plans for comprehensive state health planning. The American Optometric Association endorses the purposes of this legislation.

It has been my privilege to serve on various planning commissions in the State of California and I believe they perform a vital function. But in order to fulfill their purpose, funds must be allocated for the planning which should be done by individuals knowledgeable about the needs of the public, the facilities and the personnel available to meet these needs as well as the relative merits of each suggested plan. It is safe to assume that funds will not be available to provide for maximum needs; it therefore will be necessary to curtail or postpone some of the suggested projects. Thus, intelligent planning must be provided to obtain the best results.

Testimony by members of the optometric profession before this Committee has outlined the importance of vision care for people of all ages in all walks of life. Vast unmet needs for vision care exist today. For example, vision screening among pre-school and school age children, an area in which I have done considerable research, shows repeatedly that 12 to 20 percent of the children have uncorrected, unrealized vision problems. At every motor vehicle licensing office large numbers of applicant fail because of uncorrected vision problems. Industrial vision screening programs regularly show that 25 percent or more of those currently employed have vision inadequate for their jobs. Multiphasic screening programs show a higher incidence of uncorrected vision problems than any other health defect except dental disease. The armed forces have found that one of the major causes for rejecting men is defective sight, much of which could have been corrected if proper vision care had been obtained in childhood.

The full cost of neglected vision problems is impossible to calculate. An estimated total must include the costs of highway accidents, industrial injuries, lost production, school retardation and drop-outs. A local upward bound program for students considered potential drop-outs found that 52 percent of the young people had severe uncorrected and undetected vision problems.

President Johnson, in his message to Congress which provided a foundation for this bill stated, "A winning strategy demands wise and well planned use of manpower. It demands coordinated use of all the resources available \* \* \*. I recommend to Congress a program to enable states and communities to plan the better use of manpower, facilities, and financial resources for comprehensive health services \* \* \*."

Vision is an essential factor in both health and education. It plays an important part in the battle against retardation. In days gone by, people referred to the "Three R's—readin', ritin' and 'rithmatic." There is another R commonly used with reading, remedial reading. The remedial might well be applied to "ritin'" and also "'rithmatic". A child with defective vision is almost sure to be retarded in arithmetic and writing as well as in reading.

In his message President Johnson also said, "Few programs have had the visible success of Operation Headstart". The visible success is in part due to

the work of the Volunteers for Vision, sponsored by the Auxiliary to the American Optometric Association.

The Honorable Wilbur J. Cohen, Under Secretary of Health, Education, and Welfare, in his statement before the Senate Committee on Labor and Public Welfare during hearings on the Senate companion bill to H.R. 13197 said, "It is designed to serve as a new legislative basis for expanding the capabilities of states and communities to plan, develop and provide public health services". He went on to say that the principal objectives were: "First to increase the capacity for continuing comprehensive planning for health statewide, regionally and locally, in partnership with the federal government \* \* \*. Second, to redirect the focus of health grant programs to reactivate local and state health efforts and to focus program activities more clearly on bringing services to people".

Optometry is a national resource for sight conservation. The 17,000 practicing optometrists, the nation's third largest health profession, want to participate in the planning and implementation of vision care and sight conservation programs. They wish to eliminate the human and material waste caused by inadequate vision services.

But these problems are largely ignored by federal, state and local public health officers. Optometry, which serves the vision needs of the vast majority of the nation's citizens, is not represented in any public health department concerned with health services—state or local. How then, may optometry be represented in the health planning program proposed in this legislation? There are only two ways that we can see. I would propose for your consideration two amendments. The first relates to the state health planning council and the second relates to a specific provision for planning for sight conservation.

First, section 314(a) (2) (B) requires that a state plan to be approved must provide for the establishment of a State Health Planning Council, which shall include representatives of state and local agencies in nongovernmental organizations and groups concerned with health, and of consumers of health services to advise such state agencies.

There is no question but that the language of the bill would permit the appointment of duly licensed health personnel to a state planning council. But to make certain that Congress intends that representatives of the various health professions be included on these state councils, we recommend that on page 3, line 16, after the word "health" there be inserted "duly licensed personnel in sciences related to health".

The term "sciences related to health" has been used in several recent Congressional enactments, one passed by the first session of this Congress known as the Medical Library Assistance Act of 1965, P.L. 89-291. The House Committee report in referring to the term "sciences related to Health" said, "This means that the disciplines which may receive construction assistance under the health research facilities program are the same disciplines as will be included under the reported bill such as medicine, dentistry, optometry, pharmacy, osteopathy and other health related sciences". At the very least we hope this Committee will see fit to make a similar statement.

Second, one of the provisions of this bill is: "At least 15 per centum of a State allotment shall be available only to the State Mental Health Authority for the provision under the State plan of mental health services". When hearings were held by the Senate Committee on the Senate companion bill, representatives of the dental profession requested that a provision similar to the mental health requirement be incorporated in the bill with a minimum of five per centum for dental health planning.

Our profession urges that when reported by this Committee the bill contain a provision which will assure that some of the authorized funds must be used for vision care planning. We therefore recommend that an additional paragraph be included on page 13 under sub-paragraph 7 as follows: "At least 2 per centum of the State's allotment under this sub-section shall be available only to the State Vision Authority for developing the State planning of optometric and related vision services".

While we are hopeful that the state will utilize more than this minimum, the action of Congress in specifying some amount for vision will call the states' attention to the need for planning of optometric and related vision services.

Mr. Chairman, and Members of the Committee, we are grateful for the opportunity to appear today. Our Association wholeheartedly endorses the concept of this legislation and urges that the suggested amendments be incorporated into the bill when reported to the House.

If there are any questions, I will endeavor to answer them. If I do not have the information at hand, it will be furnished to the Committee promptly.

The CHAIRMAN. Mr. Pickle.

Mr. PICKLE. I assume, Dr. Peters, since no provision has been made for a specific allotment to an individual group other than limitations with respect to mental health, that is, none is given to dentistry, and that you yourself would not prefer this fragmentation, I believe that is what you said there—

Dr. PETERS. That is correct.

Mr. PICKLE (continuing). If the language and the intent were shown that we, through the legislation, were leaving to the States the determination of the distribution of these funds, and that it would be for duly licensed personnel in sciences relating to health, that this would, in general, take care of your concern?

Dr. PETERS. Yes, Mr. Pickle.

Mr. PICKLE. I think it should be, and I think this is the intent of the committee, and it would be better than to ask for an individual allotment. With that understanding, that would be satisfactory, you feel, to you or your group?

Dr. PETERS. Yes, sir.

Mr. PICKLE. All right. Thank you.

The CHAIRMAN. Any further questions?

Mr. SPRINGER. This is the first time I knew this was in the bill, page 14, lines 15 to 19. I do not know how it got in there, but with respect to your first amendment, I think that is all right, and I think it will retain the amendment, if we retain the language of this bill, lines 15 through 19, but I do not like the "friend" system where everybody comes in and they earmark this little special fund, and then this gets to be a habit year after year after year of allocating funds to a certain specific profession. I do not believe that this is a good way to start. I am glad you called it to my attention, because I think that health activities ought to have priority. In Alabama the priority is not going to be the same as in New York City, in my opinion, and there certainly ought to be flexibility, and a great deal of it. But if you are going to earmark 15 percent for this profession, 5 percent for that profession, and 2 percent for anybody else, pretty soon half the money is going to be used up in allocating it to a particular profession.

I do not believe that is a good way to legislate, because I think that your State and local authorities ought to have some discretion here on how they are going to allot the money based on the priorities you need in that community.

But I would say that if we retain this language then you will probably be protected. But I do not think I am going to support that language of allocating any money to any specific profession or any specific illness.

It seems to me that is not the way to legislate.

Dr. PETERS. I agree.

Mr. SPRINGER. The principle of the system has certainly fallen down by its becoming so antiquated over there now that they cannot change it because a profession comes in wanting its percentage, and then this becomes chronic year after year after year and then it is hard to change it. But I understand your situation and I can see why you are in here asking for 2 percent if somebody is in here asking for 15 or 5 percent.

Dr. PETERS. I simply wanted to use this as a means of calling attention of the States to the problems that are involved in the need for vision services. I could not agree with you more, Mr. Springer, about the fragmentation.

Mr. SPRINGER. I worked for years with the Illinois Optometric Association, and I know it is a fact on the school system and on the roads and everywhere else that it surely is a safety factor. But this is just my opinion as of this moment, and I do not think I am going to change it, and if I get a chance to offer any amendment, I will.

The CHAIRMAN. Any further questions? If not, thank you very much.

Dr. PETERS. Thank you.

The CHAIRMAN. Our next witness is Brian O'Connell, executive director, the National Association for Mental Health, Inc.

#### STATEMENT OF BRIAN O'CONNELL, EXECUTIVE DIRECTOR, THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

M. O'CONNELL. Thank you, Mr. Chairman.

The CHAIRMAN. You may proceed.

Mr. O'CONNELL. Mr. Chairman, on behalf of the association there has been distributed a statement and I recognize the severe time limit. Suffice it then to say that the association supports the bill as reported out of the Senate, S. 3008, and would even go so far as to add to the funding for 1972 as originally proposed to the Senate, and as originally included in H.R. 13197, recognizing the advice of the chairman and of the committee of the problem of securing such legislation in the House at this late date, and we, at least, argue strongly for sufficient planning money and grants for 1 year, with the hope of returning early in the next session in order to further discuss the longer term appropriations and legislation.

(The prepared statement of Mr. O'Connell follows:)

#### STATEMENT OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

The National Association for Mental Health is a national voluntary citizens organization directing its efforts to the prevention and reduction of the incidence or impact of mental illness or disability. We favor passage of S. 3008, as passed by the Senate, with the exceptions noted below.

We vigorously support this bill because it would (a) extend to public health programs the concept of comprehensive planning that has been effectively used in the Hill-Burton program; (b) strengthen and improve existing programs of grants-in-aid and public health services; and (c) provide federal assistance for the mentally retarded and other handicapped children.

#### BACKGROUND

The various federal programs for support of public health activities through grants-in-aid, now total 16 in as many categories. It is a matter of increasing concern to States, counties and cities, because of expanding responsibilities of public health, that there is at present a lack of flexibility in the use of public funds, since funds appropriated for each of the above specific categories may not be transferred.

S. 3008 provides for a flexible and responsive program of financial assistance for public health activities aimed primarily at the provision of community health services.

#### COMPREHENSIVE PLANNING

With limited resources of funds and manpower to meet our critical health needs, it is essential that we apply as fully as possible the concept of evaluating

needs and establishing priorities based on the extent of need. During the past 20 years the Hill-Burton program has demonstrated that comprehensive planning is essential to the most effective use of resources. There is no single category which would not benefit from comprehensive Statewide planning, particularly today when the responsibilities of public health departments are expanding.

We believe it essential that this bill be passed so that funds may become immediately available to the States. There can be no delay in meeting the need for coordination resulting from the many different sources of federal support for health programs at the State and local level.

#### COMPREHENSIVE PUBLIC HEALTH SERVICES

The bill embodies a fundamental revision of the health grant structure, by making federal grant funds available to States, and through them to their local communities, on a flexible basis for the provision of comprehensive public health services focused on individuals and on families in their communities rather than on separate disease conditions. Through this flexible structure services will be supported to maintain physical and mental health; detect, prevent, control, or reduce the impact of diseases, injuries, and disabilities; maintain a healthful environment, and generally make available to all persons in a State public health services related to local needs.

The National Association for Mental Health strongly supports this concept. We are particularly interested in the enactment of S. 3008, since it makes available funds, on a more realistic basis compared with known needs, for the development of mental health services in communities. It provides that of a State's allotment for comprehensive health services:

At least 15 percent of all funds allotted to a State must be available to the State mental health authority for State and local community mental health services.

At least 70 percent of all funds available to the State health authority and to the State mental health authority must be used to support services in local communities.

Up to 30 percent of the funds available to the State health authority and to the State mental health authority may be used to strengthen the State health agency or State mental health agency.

We regard it as particularly significant that this provision permits specialized planning by the State mental health authority to meet the mental health needs of the State, and at the same time relates the specialized planning to the comprehensive planning.

Earlier, we stated that NAMH supports S. 3008 as enacted by the Senate with certain exceptions. We urge that there be restored the deletions in the authorizations, made when S. 3008 was passed, so that the program extend through 1972 with a total authorization of 10.0 million for 1967; 304.5 million for 1968; 401.2 million for 1969; 507.1 million for 1970; 57.0 million for 1971; and 545.0 million for 1972.

The NAMH believes S. 3008 to be the single most important health bill to come before the second session of the 89th Congress and, if passed, it would be one of only two major health bills enacted during that session. We believe that delay beyond this session of the Congress in enacting S. 3008 would seriously jeopardize the proposed program for extension and improvement of comprehensive health planning and public health services.

We urge that the House Committee on Interstate and Foreign Commerce report this bill favorably in time for it to be voted on and passed by the 89th Congress.

The CHAIRMAN. I want to thank you very kindly for your statement and your appearance here because, as you say, time is of the essence. We did not mean to keep you that short.

Mr. O'CONNELL. I would want to urge that I would be happy to go on at some length, but I am impressed with your statement that if a bill is not reported out today we may not get anything.

The CHAIRMAN. That is about right; that is about the situation.

Any questions?

Mr. SPRINGER. I have none except on this question of the 15 percent. How did you arrive at that?

Mr. O'CONNELL. This was not a figure that the National Association for Mental Health arrived at. This was a figure included in the original legislation based on consultation with the Department of Health, Education, and Welfare, as a realistic proportion of total health spending which, at a minimum, should go for mental health, mental retardation.

The CHAIRMAN. Thank you again, and your statement will appear in the record in full.

We have one more witness, Mr. Thomas A. Tucker.

**STATEMENT OF MRS. FITZHUGH W. BOGGS, FORMER PRESIDENT,  
NATIONAL ASSOCIATION FOR RETARDED CHILDREN**

Mrs. BOGGS. Mr. Tucker was called to the White House, and I will speak for him, if I may.

The CHAIRMAN. You are Mrs. Boggs and you are representing Mr. Tucker on behalf of the National Association for Retarded Children.

Mrs. BOGGS. I am a past president of the association.

The CHAIRMAN. Well, could you insert your statement in the record, please?

Mrs. BOGGS. I would be delighted if you would. I am attending to your time.

The CHAIRMAN. All right. Thank you.

Mrs. BOGGS. I am Mrs. Fitzhugh W. Boggs. I am representing Mr. Tucker. Mr. Tucker is a member of the President's Committee on Mental Retardation which happened to be meeting today, and when I asked him, to call over, as I thought, the time was running, he told me that the group was just leaving for a meeting at the White House, and he sends his apologies and regrets.

We have presented our views in the testimony which we have given in writing, and I will not read that.

I will use just a minute or two to say that while there is some fund for the services to the mentally retarded included among the project grants of the Public Health Service as presently operated and as would be authorized under 18231, the amount is very small, and there is at the present time an urgent need to expand community facilities for the mentally retarded.

In 1963 the Congress authorized construction legislation for community facilities for the mentally retarded, and also for community mental health centers.

Recognizing the need to augment that with operating funds, the Congress acted in 1965 with respect to community mental health centers, but not with respect to community mental retardation facilities. The Senate, in adding section 8 to the bill S. 3008, has recognized that deficiency.

The Surgeon General has said that the Department prefers to await the recommendation of the new Committee on Mental Retardation appointed by the President last spring. The proposals in S. 3008 which we are espousing are really an outcome of the activities of the President's Panel on Mental Retardation which was appointed in 1961, 1962. We do not believe that there really can be a moratorium on that proceeding in an orderly fashion with the growth of this authorization legislation, and we would strongly urge that the Senate amendments,

as included in section 8 of S. 3008, be included in your bill as you report it out this year.

Failure to do so would cause a delay in the staging of this operation and will accentuate the kind of problem that Mr. Nelsen referred to earlier this morning.

We are also in support of the two additional amendments, section 9 and section 10, which were added in the Senate.

We concur with the view that has been repeatedly expressed here this morning that the authorizations in 18231 can only be regarded as stopgaps and are not adequate to the total program.

Thank you, sir.

(The prepared statement of Mr. Thomas A. Tucker follows:)

STATEMENT OF THOMAS A. TUCKER, PRESIDENT, NATIONAL ASSOCIATION FOR RETARDED CHILDREN

The National Association for Retarded Children supports and urges passage of S. 3008, the Comprehensive Health bill, during this session of Congress. We urge passage of the bill as reported out by the Senate Committee on September 29th.

It is late in the year, but, we contend, not too late for the members of this Committee to review the history of this legislation, its origins in thought and study begun in the early sixties by the State and Territorial Health Officers, the National Commission on Community Health Services and the President's Panel on Mental Retardation of 1961-1962. The documentation published some months ago in the Senate hearings is replete with justification. We urge the Committee, also, to consider the need for timely anticipation of the requirements of state legislatures, state agencies, local governments and non-profit voluntary agencies, to the end that those who will have the responsibility for matching these funds and delivering the various services speedily and efficiently know in advance where they stand. Postponement of this legislation or substitution of an emasculated bill will inevitably reduce its effectiveness.

Contrary to some impressions, this is not a crash program of the Great Society; it is a logical and well staged development, building on existing experience and precedents. The attached table compares the authorized appropriations for S. 3008 with authorizations for the House and Senate passed versions of this year's Anti-Poverty and Elementary and Secondary Education bills. The amount authorized for FY 1967 in S. 3008 is less than one percent of the 1967 authorization for anti-poverty funds and the 1968 authorization is 8.3 percent (Senate) and 8.5 percent (House) of the 1968 authorizations for Elementary and Secondary Education. Thus, we can see that the authorized appropriations are modest when compared with the anti-poverty and education bills. Yet good health is basic to good education as well as for the alleviation of poverty.

*Comparison of authorized appropriations for antipoverty, elementary and secondary education amendments, and public health planning and services bills*

	House authorization (in millions of dollars)		Senate authorization (in millions of dollars)	
	1967	1968	1967	1968
Elementary and secondary education amendments (S. 3046; H.R. 13161).....	2,187	3,553	2,716.5	3,649.7
Antipoverty (S. 3164; H.R. 15111).....	1,750		1,750.0	
Public health planning and services (S. 3008).....			10.0	304.5

We respectfully point out that S. 3008 as it now stands holds the 1967 authorizations to a token amount, \$10 million for all purposes, and that this is what the Administration has already budgeted. The total authorization for 1970 is already below the Administration proposal. The totals authorized for 1968 and

1969 are less than 3% and 4% respectively, more than the Administration recommended.

Our particular interests in this legislation are sixfold:

### 1. *Planning*

As an organization interested in children and adults with a chronic disability, whose needs for health services are extensive, we are especially aware that, in recent years, the growth of public and private health services has not been orderly or planful, nor, indeed, has the approach of the federal government been holistic. This bill enunciates a philosophy which recognizes the changes brought about in the health field as a result of scientific advances and of modifications in our social structure and economy; it recognizes the need for planning, and makes the means available to states to carry out this function more intensely in the next few years. Such planning, if it is indeed comprehensive, must redound to the advantage of the mentally retarded in the same measure as it affects other citizens.

### 2. *Prevention*

The prevention of mental retardation in children yet unborn is a major objective of our organization. Such prevention will require action on many fronts. The proper organization and pursuit of many kinds of public health activities will contribute to this end—the control of certain diseases such as measles, viral encephalitides, and toxoplasmosis, the control of environmental hazards such as lead poisoning, the prevention of accidents resulting in brain injury, the reduction of prematurity through improved prenatal care, the prompt dissemination of new findings relative to causation, and many other activities which are part of a broadly conceived and intelligently administered public health program.

The formidable costs to society of mental retardation are not widely understood. Since mental retardation is generally speaking not "curable" in a medical sense, and usually results in some degree of continuing disability throughout life, the loss to the nation in costs of care and salvaged earning capacity can be realistically estimated as between one-quarter and one-half million dollars for each individual who becomes seriously mentally retarded but who could have been saved by preventive methods. Each year that passes now dooms some 50,000 infants to lives of dependency and distress, because of mental retardation (not counting the milder forms which only reduce productivity). The losses in costs to the taxpayers for care and in potential earning capacity of these retarded citizens who will be born in 1967 is equivalent to 10% of the entire federal budget anticipated for the same year. If through intensification of public health measures, we could prevent only one out of every ten cases of serious mental retardation which will be caused in 1967, the savings in *costs of care alone* could balance the annual expenditures authorized under S. 3008 for all purposes for either 1969 or 1970, the years of maximum authorization. Can we afford to postpone stepping up our activity in prevention for even one year?

### 3. *Public Health Services*

Those who are, unfortunately, already retarded require various general and specialized health services within the framework of generic services. A small beginning has been made in developing this approach under existing authorizations. However, failure to authorize increased appropriations in the years immediately ahead will put a ceiling on efforts in all new or recently activated fields, and especially in the area of services affecting the mentally retarded adult—a group which will be at least 50% larger in the next decade.

### 4. *Services in Community Facilities for the Mentally Retarded*

In addition to the attention which can and should be given to mentally retarded children and adults within the general system of public health, there is at present a special need to provide funds to initiate, expand and improve specialized community services to the retarded which may run the gamut of the continuum of care, (exclusive of those forms of service which are now receiving federal support through education or vocational rehabilitation agencies). Much enthusiasm has been generated throughout the country by the Mental Retardation Facilities Construction amendments. Many communities have not, however, been able to avail themselves of these funds because of lack of capacity to launch the service when the building is ready to open. There is a need to authorize this program now, so as to put mental retardation facilities on a comparable basis with community mental health centers, both in

states where these are being developed in a complementary fashion, and in States or communities where the two programs are separately administered. Section 8 of S. 3008 provides a modest and well thought-out program which will meet this need and at the same time stimulate State, county and local governments to share in these costs. In this same spirit the funding under this section would be available to initiate services in any community facility for the retarded regardless of whether it was constructed with federal funds.

#### 5. *Definition of Construction*

Section 9 of S. 3008 modifies the definition of construction to include acquisition of land and of existing buildings. The language follows that of PL 89-333 covering comparable situations in construction of sheltered workshops. The purpose is to offset the disadvantage now suffered by sponsors of projects in built-up areas, where the most suitable location may be already in use and where the cost of land is a considerable part of the total cost of the project. We understand that the Secretary would prefer not to have the present language of subsection (f) of Section 401 of PL 88-164 deleted. We have no objection to retaining the present language of subsection (f) if the sense indicated above is added.

#### 6. *Physical Education and Recreation for the Handicapped*

The modest authorizations in Section 10 would benefit all categories of physically and mentally handicapped children by stimulating recruitment and training of personnel in an area which has been largely overlooked. This effort will be complimented by a program of demonstration grants, through which new practical knowledge may be gained.

We appreciate the opportunity to be heard on behalf of America's six million mentally retarded citizens and urge your prompt and careful consideration of these matters.

The CHAIRMAN. Thank you, Mrs. Boggs. Well, that is entirely the intention of the committee that this will be just a stop gap piece of legislation, a holdover, and it appeared all of a sudden as an emergency last Saturday a week ago, and we were still in session on some other matters and had two or three packages to come off the floor, and other matters, so we gathered at the last minute here that it is an emergency, and we are trying our best to accommodate it in the time we have.

Mrs. BOGGS. We recognize that both your committee and the Senate committee have been extraordinarily busy this year on various matters. It is unfortunate that health seems to be taking the squeeze.

The CHAIRMAN. I do not know about the Senate committee, but I can assure you that this committee is busy, and some of the members said they liked me all right, but they are getting tired of looking at me, so I guess that is about it.

Mrs. BOGGS. Thank you.

The CHAIRMAN. Just a moment. Are there any questions? If not, we wish to thank you very kindly.

This concludes the hearings, and we will go into executive session on Thursday on this matter.

(The following material was submitted for the record:)

#### STATEMENT BY NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, PRESENTED BY WILLIAM E. SCHUMACHER, M.D., PRESIDENT

Mr. Chairman, I am the director of the Bureau of Mental Health, Dept. of Mental Health and Corrections, State of Maine, and I am the president of the National Association of State Mental Health Program Directors.

It is the position of the members of this association that S. 3008, as amended by the Senate and passed by the body on October 3, will more effectively meet the public health needs of the states than the various alternative proposals.

We have studied the various "Partnership for Health" proposals and have determined that significant improvement in public health administration (including mental health and mental retardation) can be provided only through adoption of the Senate-passed bill.

As Dr. John Venable told your committee this morning, eliminating the disease categories in the present grant program (as the compromise "Staggers bill"—H.R. 18231—does) is only a partial solution of the problem of providing improved public health services.

In addition, what is needed for a strong and effective partnership is a substantial increase in the federal share. We consider the provisions in H.R. 18231 as inadequate.

Government at present has a special responsibility to see that the vastly increased expenditures of tax money and other funds for health services are utilized efficiently with a minimum of dilution by bureaucratic distractions.

S. 3008 as passed by the Senate fully meets this responsibility.

H.R. 18231 does not.

S. 3008 as amended may be considered a serious move by the Congress to require the federal government to get its own public health program in order, providing an effective partnership of the federal government with the states and local resources in providing both leadership and financing of essential health services.

H.R. 18231 is a gesture in the right direction. It is not the full bold move called for.

Our members also support federal assistance for developing staffs in community mental retardation facilities. H.R. 18231 fails to treat this problem.

There is one particular issue, involving both S. 3008 and H.R. 18231, with which we especially want to treat.

It is the matter of allocating a minimum of 15 of the grants for comprehensive public health services for use in state mental health services.

This factor is in both bills and the history of the need for this clear and singular mandate is long and well-known.

Our members have asked me to express to you our strong feeling about the necessity for this provision.

It is our hope that it will not be altered in whatever final version emerges from the Committee.

In connection with this matter, back on August 31 we had occasion, at the request of Congressman Paul Roger's subcommittee staff, to submit to the Investigations Subcommittee some data on the relative size and importance of mental health and mental retardation programs in the total public health picture in the states.

In our August 31 statement we showed a breakdown of total State expenditures for public health in 1965 as: \$3,368,311,309.

Of this amount 69% was expended on mental health and mental retardation programs.

We urge your favorable consideration of S. 3008 as passed by the U.S. Senate.

STATEMENT OF EMIL T. CHANLETT, CHAIRMAN, RADIOLOGICAL HEALTH SECTION, AMERICAN PUBLIC HEALTH ASSOCIATION

Chairman Staggers, on behalf of the Radiological Health Section of the American Public Health Association I am most appreciative of the opportunity to testify on H.R. 13197. As Chairman of the Radiological Health Section, I speak on behalf of a large number of practitioners of radiological health protection working in State and local health departments. Presently there are nearly 1,000 men and women so engaged in the United States. About one-third of the funds for their work comes from a Public Health Service categorical grant to their employing agency. In FY 65, about \$4,000,000 was provided from State and local sources.

My name is Emil T. Chanlett. My home is at 622 Greenwood Road, Chapel Hill, North Carolina, where I am Professor of Sanitary Engineering of the University of North Carolina and Director of the Radiological Hygiene Program. I am a member of the North Carolina Atomic Energy Advisory Committee by gubernatorial appointment.

H.R. 13197 which we fully support provides for formula grants and project grants for planning and services in public health at the State, area-wide, and local level. This bill is of great importance to sustain and to develop environmental health services. This bill is of particular interest to radiological health as it is one of the several categorical grants now made by Public Health Service to States for specific services. Under the bill such categorical provisions with the exception of mental health will be made part of one allotment. For fiscal year 1966, \$2.5 million were provided to the State and Territories to establish and to sustain radiological health services. A determined and inspired effort and effective activities were necessary to reach that high mark of national and state concern for managing the radiation exposure of our people.

The merits of this bill have been clearly delineated by our foremost public health administrators and by the leader of the American Public Health Association. It is not the purpose of this statement to refute, detract or to demur from these sincere and well informed witnesses. The present \$2.5 million for radiological health is slightly over 4% of the total of approximately \$57.5 million for present formula grants to the States and Territories in fiscal year 1966. Perhaps it is the very fact that we are small fish in big ponds that we seek the safe havens of identification before the House Committee. We ask that the record show our support for this bill and our understanding and the Committee's recognition that the extant activities supported by formula grants shall continue to be nurtured under the Comprehensive Planning and Health Services legislation both in its conception and in its implementation. Further, that so long as these activities are worthy of their nurture, these shall be vigorously encouraged to obtain greater support from State tax resources.

It is certain that there is nothing peculiar or special about the present radiological health formula grants. It is only our proximity and dependence upon these which makes it seem so. We are dedicated to protecting each citizen and his surroundings from a cumulative dose and contamination, in minute amounts by irrevocable small actions, beyond easy recall. There are two items that warrant mention.

The existing radiological health formula grants have made it possible for the States to achieve a readiness and competence to meet the challenge the Congress so wisely set before the States to enter into executive agreements for the transfer of the licensing power for radioisotope users from the U.S.A.E.C. to a State. As of July 1966, 13 States have met the issue, a heartening and real reminder that we are a federation of sovereign States bound to one another for the general good. Other than for a limited training activity, the U.S.A.E.C. has no funds for strengthening a State's capability to meet AEC's necessarily demanding criteria for the transfer of its inspectional authority and responsibility to a State. Nor to my knowledge does it wish such funds. But the PHS formula grants are a factual element in the healthy process under way. We look to the day when 50 States have met the unique opportunity to exercise this bit of their sovereignty, lest the scepter rust.

The second item is the reaffirmation that government is a process of men and not administrative schema, however handsome and colorful the organization charts. Men respond to leadership, to friendship, to devotion and pride in their professional calling. The present system of multiple categorical formula grants is a colossal administrative headache and hodge-podge, but it carries the personal identification of a common professional dedication and ambition. Incentives are a powerful American ignition. The broad administrative structure for activating H.R. 13197 must keep the lines of common professional goals strong and wide open. In radiological health these provide the energizing pulse from the top command of the Division of Radiological Health of the PHS to the most distant toter of the "Cutie-pie" and Geiger-Muller counter in the physician's office in some rural village to check an Xray machine or in the field check of a "Hi-Vol" air sample in an urban center. It is not a one-way wire. It carries the intelligence surveillance information to safeguard our people, young, old, and unborn. Large plans and administrative structures must have the human dimension to produce a service to the root of our administrative being, the taxpayer.

We support H.R. 13197. We want the record to recognize the place of radiological health in the present support system. We want the record to show that it is not the intent of this legislation to diminish the place of such activities as radiological health in the overall health protection services of our people.

## STATEMENT OF THE AMERICAN INSTITUTE OF PLANNERS

The American Institute of Planners is the professional society for city and regional planners in the United States. Its 4,500 members account for the professional planning staffs in city, metropolitan and state comprehensive planning agencies, and in many housing and urban renewal agencies. Other members of the Institute, in private practice, serve as consultants to local, state and federal agencies on problems of urban growth. Thus, the profession is well qualified by experience and interest to comment on matters concerning urban development and the federal responsibility.

We heartily endorse the basic principles behind this legislation, which would greatly expand the scope and dollar level of federal aid to the states for public health services, and would broaden and make more flexible the manner in which the funds are expended on the states and local levels.

This trend toward block-grants to state and local agencies for assistance in developing a wide range of planning for services is quite consistent with trends in other federal legislation, and we feel that it will result in a more comprehensive approach in health facilities and services planning.

Our primary suggestion for improving this legislation would be to make specific reference to integrating this health planning program with comprehensive planning underway in nearly all states and metropolitan areas, thus putting health planning in its proper perspective in relation to physical, social and economic goals.

To do this, we would suggest adding as Section (c) (2) (K) of the proposed amendments to Section 314 of the Public Health Service Act, the following language:

"Provides, where comprehensive state-wide planning is being carried on with or without assistance under Section 701 of the Housing Act of 1954, for full coordination between the comprehensive state health planning plan and other state-wide planning programs, and for assurances that such health plans will be in conformity with the general development policy in such state."

This language is similar to that which this and previous Congresses have enacted in such legislation as the Water Resources Planning Act, the Mass Transportation Act, the Land and Water Conservation Act, and the Highway Act of 1962. Its purpose is to relate comprehensive health planning to total development planning for the jurisdiction for which the services and facilities are to be provided.

Section 701 of the Housing Act, as administered by the Department of Housing and Urban Development, is the primary vehicle recognized by the Bureau of the Budget and federal law for coordinating functional plans into total community plans. Several examples will suffice. In the Senate hearings on S. 3008, several state health officers endorsed this legislation as providing more flexibility and comprehensiveness to health planning. An example is Dr. G. D. Carlyle Thompson, Director of Public Health for the Utah State Department of Health, who wrote, "The nature of the work of state health agencies has always required and actually involved planning, especially with the impact of categorized federal grants. But it is generally recognized that planning has been rarely adequate both as to extent or quality." The agency for statewide comprehensive planning in Utah is the State Planning Coordinator in the Office of the Governor, who is authorized to receive and administer 701 grants to coordinate health planning with economic development, recreation, transportation and all the other factors affecting development and government.

In another example, the Department of Housing and Urban Development has given a Section 701 grant to the New Jersey Division of State and Regional Planning to provide several planners to work specifically with the New Jersey State Health Department on fitting the New Jersey state health plan into the framework of the comprehensive statewide development plan.

This is the pattern we hope would develop in every state—sufficient federal grants under Section 314 of the Public Health Service Act to the State Departments of Health to provide truly adequate health planning—combined with funds under Section 701 of the Housing Act to the state planning agency to coordinate the state health plan with other functional plans being prepared by state agencies (many of them required by federal agencies).

Professional comprehensive planners have long worked with health professionals in aiding communities to protect, design and engineer the total community for healthful human development. This coordination has taken four general forms: joint planning of community programs, interdisciplinary research, ex-

change of knowledge of professional conferences, and interdisciplinary training. The many examples of effective interrelationships are, however, too often overshadowed by a complete lack of communication about programs of mutual interest. This is often attributed to the fact that there is today severe fragmentation of responsibility for community health planning among a wide variety of organizations, or else a complete lack of planning activity for health at both the state and local levels.

It is against this background and with recognition of the need to strive continually to improve the health of the community that the American Institute of Planners strongly endorses the goal in HR 13197 of improving state, regional, metropolitan area and local health planning agencies. We further specifically endorse the concept of intergovernmental coordination, coordination among functional program interests, and the authority contained in the bill which would make it possible to train personnel and support studies and demonstrations relative to the art and science of planning. The passage of HR 13197 would, in our opinion, represent a major step toward giving American communities the responsibility and support necessary to plan for their future social development.

We would recommend that the "single state agency" in the amended Sec. 314 (a) (2) (A) might in some cases be a sub-section of a general state planning agency responsible for physical, economic and social planning if the Governor or the legislature or the state and local officials would so desire. Similarly, the regional, metropolitan or other local area health planning agency might well be a sub-section of a general planning agency. For instance, the Metropolitan Washington Council of Governors, which is a voluntary organization of municipal and county governments in the Washington area, has a comprehensive health planning division which would be doing the planning under this legislation. However, it is related in the same organization to transportation, open space and economic development planning.

Furthermore, we would recommend that the comprehensive regional, metropolitan or local area health planning organization delineate their planning areas to correspond with planning jurisdictions for other community functions such as transportation or land use planning. The vehicle for this, of course, is the state planning agency and the metropolitan planning agency.

We would also recommend that the training and research resources of the city and state planning profession should be eligible to participate in training, research and demonstration projects which will improve the art and science of health planning. The U.S. Public Health Service is already encouraging this participation. A few examples of the programs for interdisciplinary training in schools of city planning are those established at the University of Pennsylvania, University of North Carolina, Harvard, University of Cincinnati, and Cornell University. The Public Health Services has for a number of years been sponsoring short-term training courses in environmental health for city planning. We would like to see this expanded.

We would also recommend that those responsible for administering these programs in the U.S. Public Health Service work with officials of other federal agencies responsible for administering grants to state and local planning agencies in order to foster the entire coordination of planning activities on the state and local levels, to avoid duplication and/or competition of planning efforts. Many aspects of environmental health planning and personal health care planning can be undertaken through traditional city planning programs, including general social service planning within the community renewal program or specific urban renewal project planning and Section 701 urban planning. This opportunity for coordination will, of course, be enhanced under the Cities Demonstration program now pending before this Congress.

In this respect, the Advisory Commission on Intergovernmental Relations has proposed that "federal planning aids or urban development, including Section 701 Urban planning assistance and comprehensive transportation planning, should specifically authorize and encourage economic and social planning for the community as a basic justification for physical planning." This is necessary to broaden traditional physical and regional planning to make it more viable and to relate it more directly to the needs of people through planning for services as well as for facilities.

We understand that the U.S. Public Health Service is sponsoring two major studies to determine the content and technique of coordination between city planning agencies and health organizations. We look forward to publication of these studies and to their impact upon making our planning activities more viable and more useful to local areas.

## STATEMENT OF NICHOLAS POHLIT, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF SANITARIANS

The Partnership in Health Bill is one of the more forward-looking pieces of legislation in the opinion of those of us in executive positions in health professional organizations. Its implementation should rival the beneficial effects of the now-famous Hill-Burton Act for, as that Act provided our Nation with a strengthened health facility posture, so this Bill would provide the Nation with a health-planning scheme that puts the expenditure of health resources on an objective output-oriented base rather than a base of pure emotion. Under the direction of such men as the Surgeon General, Dr. Stewart, and Assistant Surgeon General Carruth J. Wagner, it would indeed move us to the point of the most productive use of our health resources directed toward the goal of assuring health services for every American regardless of his financial ability or social status.

The National Association of Sanitarians is vitally interested in this Bill, not only for its general contribution to the health system of the Nation but because the sanitarian, by dint of his training and experience, becomes a logical choice for a key health planner at every echelon of government and nongovernment programs. This second largest group of allied health professionals and the only group trained at the undergraduate level for public health work, some 14,000 strong, has for many years been an instrument of the health team who has insisted upon recognition of the final effects of health effort as a pre-cursor to request for support resources.

The National Association of Sanitarians strongly urges that this Bill be passed during this Session of Congress to move us more rapidly to that point in time when all health moneys will be directed toward specific health objectives regardless of the field of endeavor.

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[Telegram]

NEW YORK, N.Y., *October 10, 1966.*

Congressman HARLEY STAGGERS,  
*Chairman, House Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.:*

Please enter in the record of your hearing on H.R. 18231 the strong support of the Association of Schools of Public Health for the objective of the proposed legislation on behalf of the Association. I strongly urge the support of your Committee for the section continuing the \$5,000,000 authorization for grants to Schools of Public Health. These grants are vital to the continued effort of the schools to meet the ever increasing demand for training public health personnel—a demand greatly increased by the passage of Medicare.

RAY E. TRUSSELL, M.D.,  
*President, Association of Schools of Public Health.*

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[Telegram]

WEST PALM BEACH, FLA., *October 10, 1966.*

Hon. PAUL G. ROGERS,  
*House of Representatives,*  
*Rayburn House Office Building, Washington, D.C.:*

I urge your assistance in passage of S. 3008 including mental retardation funds, in preference to H.R. 18231 and 18232. This is on basis of demonstrated experience in your own community here in Palm Beach County, that sheltered workshop and evaluation and training services for retarded pay huge dividends to society far in excess of their cost.

At the Rehabilitation Center at John Prince Park in Lake Worth, on land donated by county and in buildings and equipment supplied entirely by community gifts, without any public money at all, the Palm Beach County Association for Retarded Children in our first 4 years from 1959 through 1962 put back into permanent employment in competitive industry over 30 people—average 10 per year—who were unemployable until we developed their latent abilities.

From 1962 through 1965 we got a total of \$37,000 Federal and State assistance for additional staffing and equipment, and we increased our output of useful people to 100—average 30 per year.

At current minimum wage of \$1.25 per hour our total 130 permanently placed trainees are thus earning minimum \$325,000 per year, actually more, since some earn as high as \$2.39. This compares with total less than \$90,000 current annual deficit now made up from public funds and private donations. Our average employment in sheltered workshop of people who would otherwise be entirely unemployable public charges has also increased from average 25 to average 95 for this same two successive periods.

Demand for our services is constantly increasing, and presently available funds, public and private, are grossly insufficient. We are turning people away who need us now, for insufficiency of diagnostic services, halfway-house facilities, and other resources that S. 3008 proposes.

PALM BEACH COUNTY ASSOCIATION FOR RETARDED CHILDREN, INC.  
IRVIN L. LANGBEIN, *President*.

MONTANA STATE UNIVERSITY,  
AGRICULTURAL EXPERIMENT STATION,  
*Bozeman, Mont., April 29, 1966.*

DR. WILLIAM H. STEWART,  
*Surgeon General, U.S. Public Health Service, Department of Health, Education,  
and Welfare, Washington, D.C.*

DEAR DR. STEWART: At the request of Dr. John S. Anderson, State Health Officer of Montana, I have prepared the enclosed statement (attachment A) in regard to the cost of space. I will introduce myself only by saying I have studied and written extensively on the social and economic cost of space, most particularly in the Great Plains.

The formula prepared by Dr. Anderson and sent to you on April 6, 1966 is a good one, particularly for allocation of money within the states. It certainly indicates the problem very well. It is my conviction, however, that since there is such a low population density in the Western States as a whole, with the exception of California and Hawaii, a more equitable formula will need to include the sparsity of the whole of the states. The federal law should also provide similarly for allocation within all the states to meet the problem more specifically described by Dr. Anderson, i.e. specifically more money to the areas with lesser population, particularly those under 50,000 population.

I most sincerely support H.R. 13197 and S. 3008 in principle, but without some real weight given for the space factor, it will only intensify the problem for the more sparsely populated states. While the average population density of the United States was 50.5 persons per square mile in 1960, this figure will rise in the future, and will need to be changed or will change the number and identity of the states involved in the sparsity category. The Great Plains and Rocky Mountain states will probably never be removed from the sparsity category since gains will occur only in small amounts and only in the already existing larger towns and cities. The problem for these sparsely populated states will become more acute in the future in comparison with the rest of the United States, and the problems within the states will become more intense.

Respectfully,

CARL F. KRAENZEL,  
*Professor of Rural Sociology.*

#### ATTACHMENT A

THE SOCIAL COST OF SPACE AS A CRITERION IN THE DISTRIBUTION OF FEDERAL GRANTS,<sup>1</sup> BY CARL F. KRAENZEL, PROFESSOR OF RURAL SOCIOLOGY, AND FRANCES H. MACDONALD, RESEARCH ASSISTANT, MONTANA STATE UNIVERSITY, BOZEMAN, MONT.

Federal grants and aid programs have now been generally accepted as a way of equalizing certain basic services to people the nation over. They are so extensive that distortions in the formula are likely to produce burdensome inequities that were intended to be corrected. Specifically, grants based on population and per capita gross income, such as the Public Health grants, discriminate

<sup>1</sup> Prepared for presentation to the Surgeon General of the U.S. Public Health Service, and Dr. John Anderson, Executive Officer, Montana State Board of Health, and for Senators and Congressmen for the Upper Great Plains States relative to S. 3008 and H.R. 13197; and for a graduate student and faculty seminar in Agricultural Economics and Rural Sociology, April 28, 1966.

against the sparsely settled states, chiefly in the West. This paper is intended to report on the social cost of space in the less populated states for which adjustments must be made if the principle of equity is to be fully approximated. The social cost of space is so extensive and pervading that it must be included as the third criterion in the formula for distribution of aid.

#### THE ECONOMIC COST OF SPACE

It is not difficult to demonstrate that there is an economic cost of space, borne and paid directly by the individual citizen. The average Montanan travels perhaps ten times farther than the average Iowan and perhaps fifty times farther than the average New Yorker for goods and services, as indicated in the following table.

This is based on the assumption that the residents of each area make about an equal number of trips for each type of service and for similar type of services. Hence, the Montanan pays more in out-of-pocket expense daily and yearly just for travel.

State	Area (square miles)	Population (1960)	Density	Square miles per thousand persons
Montana.....	147,138	674,757	4.6	218
Iowa.....	56,290	2,757,537	49.0	20
New York.....	49,576	16,782,304	338.5	3

But even this figure favors the Iowan and the New Yorker. When faced with great distances and weather hazards, the risk of getting there and back is greater than when distances are shorter. It is, therefore, necessary to have private stand-by transportation—two or more motor vehicles rather than one, for example; with all the attendant investment, financing and insurance cost for the several vehicles. Sometimes this expresses itself as investment and upkeep costs for two homes, or offices, or schools rather than one. For example, for many farmers and ranchers this may mean one rural home and one town home near school, doctor and recreation services. At other times this may express itself as additional costs attendant on sending children to boarding places when in school.

It is clear, then, that distance represents a greater outlay of expenditures per unit of service. But this is only one side of the coin—the expenditure side for individuals in terms of private and public outlay. People in remote places also tend to have less income—distance results in less income. The price of wheat or cattle tends to be that established in the central market places—Minneapolis, St. Paul, Buffalo, Chicago, Omaha and St. Louis, for example. Therefore, the farmers near these markets get more income per unit of product than the Montanans for their bushel of wheat or pound of beef.<sup>2</sup> The difference is the amount of the freight not only as a rate per mile (often lower when near the market) but also as a total bill. At the same time the farmers near Minneapolis pay less for their tractors, their fuel, their cars and trucks, their feed, and most of the other cost-of-living items that enter their operation and living cost budget. The oil field and mine workers, the forest workers and other laborers, and the businessmen and professional workers are similarly disadvantaged compared with their fellow earners in the densely populated areas.

Therefore, the economics of the nation discriminates against the residents who live in distant and remote places<sup>3</sup> on two counts at least: (1) they pay more to get the service; and (2) they have less net income to buy the services. They have only one temporary defense, economic and management wise: that is to enlarge their volume of business operations. By doing this they intensify the

<sup>2</sup> See Corley, Joseph R., *Changing Patterns of Grain Transportation in Montana*, Master's Degree Thesis, Montana State University, Bozeman, Montana, June, 1964, p. 16. Also see Trock, Warren L., *Cattle Feeding in the Northern Great Plains*, Ph.D. Thesis, Montana State University Library, Bozeman, Montana, March, 1963, p. 111 ff. In some instances for wheat and cattle, per mile rates are higher for longer than for shorter distances.

<sup>3</sup> For an analysis of the economic aspect of the cost of space see Kelso, Maurice M., "Costs of Space in the West", in *Land and Water Use*, edited by Wayne Thorne, AAAS publication No. 73, Washington, D.C., 1963.

very difficulty they suffer from—they create more distance between themselves as neighbors, employers and employees, buyers and sellers, clients and professional men.

#### THE SOCIAL COST OF SPACE

The above dilemma has resulted in one other way of coping with problems in the sparsely populated area—a solution not generally advertised and difficult to prove. People in the sparsely populated areas have received fewer services, have accepted poorer quality of services, or have had services only intermittently, or have had a combination of these deficits.<sup>4</sup>

It is difficult to measure quantity and quality differentials for services between areas and the statements above stand largely unsupported, except by inferences. The writers know of little research that has measured these differentials.<sup>5</sup> But a reference to information for Montana will be offered. The most recent report of the Facilities and Planning Division of the Montana State Board of Health has just been released. In recognition of the introduction of the medicare program this coming July, a stiffer set of standards of inspection for hospitals and nursing homes has been applied, compared to the standards employed as recently as two years ago. As a result of applying these stiffer and more uniform standards, the number of suitable or acceptable beds in hospitals has been decreased from 84.6 percent of the total in 1963 to 35.8 percent of the total in 1965. For nursing homes the number of suitable beds decreased from 85.6 percent of the total in 1963 to 77.9 percent of the total in 1965. This lower decrease for nursing homes is explained by an increase in new facilities almost entirely. It should be noted that the Montana bed-population ratios for both the hospitals and the nursing homes are relatively low by national standards, especially when considering acceptable beds. One might expect a higher bed ratio in a sparsely populated area because of higher occupancy ratios that attends distance and sparsity, a fact that is a measure of the social cost of space. The following table gives specific information.

<sup>4</sup>For a more detailed statement of this social cost aspect see Kraenzel, Carl F., "A Direct Measure of the Social Cost of Space", *Proceedings of the Montana Academy of Science*, 14: 82-89, 1964; also "Pillars of Service for the Emerging Community of the Plains", *Journal of Health and Human Behavior*, Summer, Fall, 1964, Vol. 5, pp. 67-74.

<sup>5</sup>The U.S. Public Health Service itself has recognized the absence of full-time public health services in sparsely populated regions. To get at this problem the Service itself undertook a study to get at this problem. The results were reported in *The Health Study of Kit Carson County, Colorado*, U.S. Department of Health, Education, and Welfare, Public Health Service, Division of Community Health Services, Publication No. 844, 1962.

TABLE 1.—Hospital and nursing home beds classified by total, 1963 and 1965; acceptable and nonacceptable beds, and differences between 1963 and 1965; and population-bed ratios for Montana

[I—acceptable beds; II—nonacceptable beds; III—total beds]

	Beds						Difference in beds						Percent of—			
	1963			1965			Number			Percent			Acceptable		Nonacceptable	
	I	II	III	I	II	III	I	II	III	I	II	III	1963	1965	1963	1965
Hospital beds	2,830	517	3,347	1,165	2,088	3,253	-1,065	1,571	-94	-41.2	403.9	-9.7	84.6	35.8	15.4	64.2
Total population	4.03	0.74	4.77	1.58	2.83	739,000	739,000	4.4								
Nursing home beds	1,661	280	1,941	2,045	380	2,625	384	380	684	123.1	207.1	135.2	85.6	77.9	14.4	22.1
Population 65 and over	2.62	0.44	3.06	3.05	0.87	67,018	67,018	3.92								

<sup>1</sup> Number of beds per 1,000 total population in the case of the hospitals and and per 1,000 aged (65 and over) in the case of nursing homes.

There is no doubt that almost all, if not all, of this differential between 1963 and 1965 is to be explained by the tolerance of poor quality facilities as much as only two years ago—the poorer quality accepted as the result of the social cost of space. The differential is one important measure of the social cost of space.<sup>6</sup>

By doing without or by accepting lower quality services, including the postponing of services, many people have lowered their potential for retraining and job rehabilitation, their experience level, their health level, and their general adaptation level when faced with change. Prevention has been neglected; and cures or treatment are difficult to effect. These aspects necessarily are the true social costs that follow from the fact of space—deferred services, costs paid by the taxpayer rather than by the individual, costs resulting in diminution of productivity and economic and social effectiveness, costs measured in human pain and suffering.

Often, for all these reasons, there has been out-migration of population, a factor contributing to an intensification of the problem of the social cost of space. Even aged adults who had planned to make the area their home for their last days resort to migration.

#### SOME PARTIAL WAYS OF COPING WITH THE SOCIAL COST OF SPACE

In addition to out-migration and the lowering of the level of services or their number and type, there are some adjustments of a necessarily temporary nature that have come into being to cope with the social cost of space. These, however, have limits and may even penalize the principle of equal service eventually.

One example has to do with highways. The nation is building an extensive interstate highway system with 90 percent federal financing. The thirteen western States, including Hawaii and Alaska, are known as public domain States. Sparsely populated, it is an accidental fact that their portions of federal aid are increased beyond the 90 percent specification by an amount that represents the public domain involvement. For Montana the current cost ratio is reported to be 91.27 percent for the federal share and 8.79 percent for the State. For Alaska the ratios are reported as 94.91 percent and 5.09 percent; and for Nevada, 95.0 percent and 5.0 percent.<sup>7</sup> The formula for the ABC road system allows a greater federal matching, measured by the proximity and access to public domain.

Here then is an example of an accidental adjustment for sparsity by virtue of public domain. This, however, applies to construction only. For maintenance of the greater road mileage in the sparsely populated area, there is no such recognition of space costs.

The Bureau of Public Roads is, however, an "Angel of Good Tidings" in this respect compared with the ICC and the FAC. A look at the air trip costs shows how the small airlines in the Yonland areas<sup>8</sup> must charge first class fares to survive, while the lines closer to cities which also have inter-city traffic, with high volume, have "economy" runs. ICC has set a long history for a subsidy to the cities in this respect, based on such questionable historical rationalization as developed by Von Thünen and Alfred Weber.<sup>9</sup>

Progress in curtailing the burden of the social cost of space can come about in sparsely populated states by limiting settlement and consequently, community and social services, to certain areas only. In the arid western states this is easier to accomplish. Population, including rural, is confined to irrigated oases only. Man cannot survive in the non-irrigated areas. Rural and urban

<sup>6</sup> See *Montana State Plans for Hospital and Medical Facilities Construction for 1964* (1963 data) and 1966 (1965 data) published by the Division of Hospital Facilities, Montana State Board of Health, Helena, Montana.

<sup>7</sup> Reported to the writers by way of telephone from the State Highway Office, Helena, Montana. The ABC system has reference to primary and secondary roads.

<sup>8</sup> By Yonland the writer has reference to the small towns and sparsely populated areas out away from the settled areas of the Plains. The Sutiland areas are the more heavily settled, stringlike retail and wholesale areas in the Plains. These sometimes are the irrigated areas too and have ready access to communication facilities.

<sup>9</sup> These theories hold that for reason of geography, history, accident or other, populations begin to concentrate in what become cities. Land values, rents and prices go up and assist the development and offer advantages. From these centers transportation expands outward, and becomes more costly. Therefore, land values go down as distance increases, costs go up, net income goes down. These facts explain the location and growth of industry in limited areas. These are rationalizations perhaps as much as explanations at first, and later may be rationalizations chiefly.

people live relatively close together. The social cost of space is limited, in part, fortunately by the fact of aridity. However, the oases may be small and may need to be knitted together into a service area of adequate size.

But in the sparsely populated semi-arid Great Plains and other semi-arid islands of the nation, rural farm and ranch and village populations are scattered all over the land, in the fashion similar to that of humid America. Services have been similarly dispersed all over the land, with the consequences described by the social cost of space. There is gradually emerging a heavier concentration of this population in what is called Sutland areas. But because of lack of zoning, it will take a long time for the Sutland to acquire the degree of concentration typical of the oases in the arid regions. Nevertheless, this adjustment is being recognized as a necessary adaptation and is becoming more prevalent. As the level of living rises, the pressure for this kind of adaptation will become greater.

There is a third kind of adaptation that is emerging. This is the possibility of coordination and integration of services among several cases and between Sutland and Yonland areas. By stressing flexibility and mobility of services and programs, rather than self-sufficiency, an entire area can be organized into a special service district and can have more effective services than is now the case. But this requires a higher and more sophisticated degree of cooperation than now prevails in the region. Costs would undoubtedly be higher than now, in many instances; but services would be more adequate. The task is to develop the special loyalties that must go with supporting this kind of program rather than destroying the community by shopping around. There are isolated examples of this kind of development. This represents a kind of consolidation not often practiced—one that encourages local survival of many services but back-stopping by specialists from larger places. It would mean the hand-in-glove cooperation of the generalist and the specialist.<sup>10</sup>

#### THE NEED FOR INCLUDING THE SOCIAL COST OF SPACE IN THE ALLOCATION FORMULA FOR FEDERAL AID

From the evidence above it would appear that (1) in addition to gross population, (2) adjusted for per capita income relative to the national average, a third criterion in the formula should be (3) an allowance for the social cost of space. It is suggested that H.R. 13197 and S. 3008 include this criterion in their formula for financing the public health services and programs envisioned.

The only aspect subject to debate is the specific amounts to be allowed in the formula for the social cost of space. In the absence of specific research data at this time, it is proposed that this be a 100 percent increase, without matching requirement for the most sparse states of the nation. Perhaps only years of experience will ferret out the specific details for the formula amounts. Adjustments will undoubtedly be required as time progresses, as improvements are made and as national policy goals require.

Therefore it is recommended that all of lines 18 through 22 of part B of page 12 in H.R. 13197 be deleted and the following be substituted: "per capita income of the United States; except that an additional 100 per centum of the total thus computed shall be added to all states whose population density is less than five; an additional 80 per centum of the total thus computed shall be added to all states whose population density ranges from five to ten; an additional 60 per centum of the total thus computed shall be added to all states whose population density ranges from 10 to 37; and an additional 40 per centum of the total thus computed shall be added to all states whose population density ranges from 37 to 50.5 (the latter being the national average in 1960); and except that a like 100 per centum shall be added to the share for the Commonwealth of Puerto Rico, Guam, American Samoa, and the Virgin Islands; and except that none of this addition of 100 through 40 per centum shall require matching by the respective states, and only the original amounts governed by the per capita and income criteria shall require matching; and except that every state shall itself distribute these grant funds within its own state according to a formula that allows for the social cost of space, using its own density as the central criteria for a differential in a manner similar to the federal funds here allocated."

<sup>10</sup> The senior writer has emphasized this in "Pillars of Service for the Emerging Community of the Plains", *ibid.*

By way of explanation it should be stated that, using 1960 density data, this allowance for the social cost of space would do the following, namely increase the allowance:

- (1) by 100 percent for Alaska, Nevada, Wyoming and Montana;
- (2) by 80 percent for New Mexico, Idaho, South Dakota and North Dakota;
- (3) by 60 percent for Utah, Arizona, Colorado, Nebraska, Oregon, Kansas, Oklahoma, Texas, Arkansas, and Maine;
- (4) by 40 percent for Washington, Minnesota, Vermont, Mississippi, and Iowa;
- (5) by 100 percent for Puerto Rico, Guam, American Samoa and the Virgin Islands.

This same kind of social cost of space criterion should be instituted for federal grant programs in other areas such as elementary education, experiment station support in agriculture, adult education efforts, public welfare and social security programs generally, and for labor and small business programs.

There is usually an attempt to counter the argument of the social cost of space with one pointing up the social cost of density, and thus argue in favor of the status quo. The authors admit that there is a cost of density, but the latter argument can and should not be used to regate or destroy the former. It is only necessary to point out that people in a densely populated place represent a great volume, and a small payment by each person produces a considerable income. "Standing on the corner" in a city and watching the traffic enter a covered parking area, an airport, or almost any business demonstrates this fact. In the sparsely populated areas there is not the volume of business. Almost any charge is too high except for the bare essentials. Standing along a highway in Wyoming or Montana and attempting to hitch a ride is a measure of this fact.

It should be noted that the suggested formula imposes no penalty on density that is progressively greater than the national average by decreasing the federal aid below the original allocation for population and per capita income. It is concluded that there is nothing in the American tradition that should penalize sparsity. It would appear to be in the national interest to include the social cost of space as the third dimension in a formula for federal aid.

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NATIONAL CATHOLIC WELFARE CONFERENCE,  
Washington, D.C., October 11, 1966.

HON. HARLEY O. STAGGERS,  
*Chairman, Committee on Interstate and Foreign Commerce,  
House of Representatives,  
Washington, D.C.*

DEAR MR. CHAIRMAN: As official spokesman for the general body of Bishops of the Roman Catholic Church, speaking through the National Catholic Welfare Conference, I wish to make several observations concerning legislation currently pending before your Committee.

It is my understanding that your distinguished Committee is now considering HR 18231 and S. 3008, which provide for the extension and improvement of comprehensive health planning and public health services. The bill referred to your Committee by the Senate (S. 3008) has disturbing legislative history, indicating that the proposed legislation may also be intended to authorize Federal funds to promote language authorizing such programs.

On page 11 of the Senate Report on S. 3008, the following language appears: "The proposed authority would permit project grants for program support, program development and demonstration purposes for these kinds of targets, and for other areas such as dental health, urban health, narcotics and drug addiction, rural health services, family planning, and alcoholism."

Additionally, a colloquy on the Senate floor between Senator Tydings of Maryland and Senator Hill of Alabama clearly demonstrates that this measure is intended to be used as a means of financing family planning. (Congressional Record, October 3, 1966, page 23789)

Neither bill contains language authorizing the use of Federal funds for family planning. Our concern is that it may be amended or otherwise interpreted in the Report of the Committee in such a way as to approve Federal funding of birth limitation.

While there are grave moral considerations prompting our protest, there also are policy and legal arguments against government involvement in birth control programs beyond mere research. These are relevant to the provisions of HR 18321.

On an earlier occasion, William B. Ball, Esquire, General Counsel to the Pennsylvania Catholic Conference, appeared before a Subcommittee of the Senate to urge rejection of other proposed legislation of similar purport to the immediate provision of concern to us. Mr. Ball's statement had the approbation of the National Catholic Welfare Conference. In it the constitutional permissibility of the use of tax revenues for birth control programs was challenged because of the inevitability of interference with cherished personal liberties and unavoidable coercion of conscience in administration. The whole statement is directly related to our present concern. So that your Committee may have before it for consideration in its current deliberations the position of the National Catholic Welfare Conference on this issue, I am attaching a copy of that statement (attachment A) although it was drafted as comment on another bill.

The issue assumes additional gravity when it is considered in light of the provisions of S. 3008 authorizing the establishment of a "National Health Policy" to be determined by the Surgeon General. The Catholic Bishops of the United States have previously taken a firm position against the inclusion of government-sponsored birth control programs as an integral part of our national health policy. This position requires additional emphasis when broad authority is delegated to the Surgeon General to determine health goals including family limitation.

The implications of this question are too complex and far-reaching to handle in the indirect manner of the Senate approach or in a one-day hearing before a congressional committee. Extended hearings on a specifically defined and narrowly limited legislative program should be an essential condition to any legislation involving the use of Federal funds for family planning.

Accordingly, I respectfully request that your Committee reject the implication that the bills before it may be utilized as a means of making birth control an integral part of health planning programs which, according to the language of the legislative proposals is designed primarily to promote better utilization of our health-caring agencies.

Respectfully submitted.

Most Rev. PAUL S. TANNER, D.D.,  
*General Secretary.*

(Attachment A)

ISSUED BY THE PRESS DEPARTMENT, NATIONAL CATHOLIC WELFARE CONFERENCE,  
WASHINGTON, D.C., AUGUST 24, 1965

[Following is a statement on public policy and birth control presented August 24 by William B. Ball, general counsel of the Pennsylvania Catholic Welfare Committee, before the Subcommittee on Foreign Aid Expenditures of the Senate Government Operations Committee. Ball spoke on behalf of the PCWC and the National Catholic Welfare Conference.]

#### GOVERNMENT AND BIRTH CONTROL

I am William B. Ball, general counsel to the Pennsylvania Catholic Committee, an agency jointly created by the eight Roman Catholic dioceses of Pennsylvania. Let me express to you the committee's appreciation at being permitted to present, through its attorney, testimony respecting Senate Bill 1676 and the important public issues which it brings into scope. I am authorized to say that this statement has been reviewed by the National Catholic Welfare Conference and is submitted with its express approval.

It is said that Senator Gruening, who introduced this bill, has been particularly interested in seeing that these public hearings advance the community dialogue respecting the subject matter of S. 1676. We heartily agree with this laudable aim, and precisely for that reason we are hopeful that many points of view will be brought to bear upon the proposals made by this bill and the most varied and searching inquiry be offered respecting the principles upon which the proposals are based.

My own commentary, upon behalf of the Pennsylvania Catholic Committee, will be primarily from the viewpoint of constitutional law. And before coming to grips with some of the specifics of Senate Bill 1676 (as well as with testimony

already presented here interpreting it), I should like preliminarily to sketch the constitutional scene upon which this bill arrives.

Two features have marked the development of American law in our time: one, a development by the legislature in the broadening of social welfare; the other, a development by the courts in the narrowing of the powers of government over individuals. While most of our people applaud each of these developments, some have always insisted that the one must necessarily be at the expense of the other—that is, that more social welfare must entail the shrinking of personal liberty, or that the widening recognition of civil rights and individual liberties must necessarily be destructive of the welfare of the body politic.

Yet, looking back upon three decades of acceleration in both of these developments, we must judge these critics of the American scene wrong. Social welfare and individual liberty are flourishing in the United States side by side. Big government and the individual seem to be getting along quite well together. Both are undoubtedly going to expand—government in its care for people, individuals in the realization of civil freedom. And nothing is threatened by this fact.

Therefore, in presently raising questions about the things called "family planning" or "population control" or the various "programs" of which S. 1676 speaks, the Pennsylvania Catholic Committee and the National Catholic Welfare Conference in no wise question an expanding role for government in the care of people, the need vigorously to use public resources to promote health, to relieve poverty, to stimulate learning and to help emerging nations to a better economy and more stable order.

Yet these things are not ends in themselves, to be achieved at any cost. As the NCWC and the PCWC are emphatic in pressing for the achieving of these things, they are equally emphatic in declaring that if they are sought without the finest sensitivity to personal liberty, they will have been achieved in vain, or not at all. At every moment must be kept in mind the inseparableness of social progress with individual freedom. As Professor Walter Gellhorn has stated:

"Individuals comprise the state. The state has no existence as an abstract entity, capable of demanding homage in its own right. It exists only as an amalgam of human beings, who are its blood, bones and sinew. The subordination of the individual and the exaltation of the state have always impressed Americans as obnoxious . . . Today, however, too many administrators seek, and too often are given, powers that unduly obscure traditional protections against expendent invasions of individual rights."<sup>1</sup>

And therefore, as we contemplate the march to new horizons of mass betterment, we redouble our concern for the integrity and individuality of persons, for the inviolability of their privacy, the freedom of their judgment, the liberty of their conscience, the availability to them of untrammelled moral choice.

The Supreme Court of the United States has long been engaged in setting up guideposts for the protecting of personal liberty, and especially in the past 30 years which have witnessed greatly expanded roles for American government at all levels as well as critical internal pressures, threatening the individual, which have been generated by a world in conflict. These guideposts are particularly relevant to the matters we are discussing here today. They have pertained, in general, to

- freedom from governmental inquisition;
- the related right of privacy;
- concern for the weaker members of society;
- governmental coercion of mind and conscience.

Governmental inquisition. We willingly accept a great deal of information-taking by government today. The income tax return, pension forms, and Social Security applications are common examples of processes which we recognize that government must employ if it is to act responsibly and efficiently. At the same time, it may be hazarded that a trend to set limits about governmental inquiry into the lives of individuals is being sparked by recent Supreme Court decisions.

Illuminating various provisions of the Bill of Rights, the court has more narrowly defined what may be reasonable search and seizure,<sup>2</sup> more literally defined the self-incrimination clause of the fifth amendment,<sup>3</sup> more tightly constricted the freedom of governmental bodies "to expose for the sake of exposure."<sup>4</sup>

<sup>1</sup> Gellhorn, *Individual Freedom and Governmental Restraints*, 46.

<sup>2</sup> *Wong Sung v. United States*, 371 U.S. 471 (1962).

<sup>3</sup> *Townsend v. Sain*, 372 U.S. 293 (1963).

<sup>4</sup> Per Warren, C. J., in *Watkins v. United States*, 354 U.S. 178 (1957).

(and, impliedly, to inquire for the sake of inquiry). On the frontier of freedom from unreasonable governmental inquiry lie those areas of governmental abuse recently described as helping render our society "naked"<sup>5</sup>—not the least of these being the de facto non-confidentiality of files in which personal case histories of, for example, individuals on public assistance, are recorded.

The right of privacy. Closely related to a freedom from governmental inquisition is the right of privacy so well elaborated by the Supreme Court in its recent decision in the Connecticut birth control case. Here the court described the area of the marriage relationship as "lying within the zone of privacy created by several constitutional guarantees."<sup>6</sup> The particularly noteworthy opinion of Justice Goldberg, now Ambassador to the United Nations, decried the slightest experimentation in the area of the personal rights of citizens.<sup>7</sup>

Concern for the weaker members of society. A third area of marked concern by the Supreme Court (and indeed in our decisional and statutory law traditionally) has been that pertaining to the weaker members of our society—children, mothers, the aged, for example. Most recently, this concern has been more emphatically extended to the criminally accused,<sup>8</sup> the alien,<sup>9</sup> the Negro,<sup>10</sup> and the poor.<sup>11</sup>

Especially with respect to the latter two groups has our concern more and more become one that recognizes their human dignity, and less and less one that regards them paternalistically—as wards to be fed in the name of peace and order. At the same time this concern recognizes the ease with which it is possible for the rights of the distressed members of society to be violated. Both the poor and the Negroes in our country—like the poor and the darker people in most parts of the world for the past two centuries—have been de facto "rightless," that is to say, lacking in any power whatever to assert rights or realize liberties. And this, in our discussion, relates very directly to questions of governmental coercion.

Governmental coercion of mind and conscience. Of recent years our courts have tended ever more closely to examine relationships between government and individuals where questions of governmental compulsion might become material. Particularly has this been so where the relationship involves matters pertaining to conscience, or to religion, or to belief or outlook on life, to political creed, to familial relationships, to all that we have long deemed "the personal".

In its recent decisions on prayer and Bible reading in the public schools, the Supreme Court wrote into our constitutional law an extremely important body of doctrine upon the nature of governmental coercion. In those cases these elements were present: (a) sponsorship by government of the practice in question; (b) these practices involving a matter in the area of the personal; (c) a weak member of society (the child) cast in a relationship with government (through the school); (d) a general attitude in the community favoring the practices; (e) an exemption procedure available to the child upon the basis of conscientious objection. The Supreme Court, you will recall, found coercion to be inherent in the child-state relationship, even though the state's role was almost wholly passive, even though the project was broadly considered good for children and needful for society, and even though the child could be exempt by claiming his privilege of non-participation.

To these four elements—pertaining to governmental inquiry, privacy, the weak members of society and coercion—must be added some other principles of constitutional protection with which the courts have historically restricted governmental action. For example, that if government may act at all in matters affecting liberty of mind and conscience, it must do so only within the confines of the most plainly stated standards. We do not, in the American system, provide government with blank checks where personal liberties are involved.

Again, there is the principle, well established in our law, that where government is to act in matters closely involved with personal liberty, the rational basis for its action must be firmly—not loosely—established. As Justice Goldberg stated this summer in *Griswold v. Connecticut*:

"In a long series of cases this court has held that where fundamental personal liberties are involved, they may not be abridged . . . simply on a showing that

<sup>5</sup> Packard, *The Naked Society*.

<sup>6</sup> *Griswold v. Connecticut*, — U.S. —, 14 L. ed. 2d 510, 515 (1965).

<sup>7</sup> *Id.* at 522.

<sup>8</sup> *Massiah v. United States*, 377 U.S. 201 (1964).

<sup>9</sup> *Brownell v. Tom We Shung*, 352 U.S. 180 (1956).

<sup>10</sup> *Brown v. Board of Education*, 349 U.S. 294 (1955).

<sup>11</sup> *Gideon v. Wainwright*, 372 U.S. 335 (19—).

a regulatory statute has some rational relationship to the effectuation of a proper state purpose. 'Where there is a significant encroachment upon personal liberty, the State may prevail only upon showing a subordinating interest which is compelling. . . . The law must be shown necessary, and not merely rationally related, to the accomplishment of a permissible state policy.'"<sup>12</sup>

Having thus stated some principles which have been developed in our constitutional law, let me turn particularly to S. 1676. In part, this bill calls for study and research respecting problems of population growth. Where such study and research can be conducted without intrusion by representatives of our nation upon the sensibilities and customs of other national communities, it is desirable that they be pursued.

Indeed, we have heard it said that that is all that S. 1676 is about and nothing more. We cannot, however, ignore the fact that organized supporters of this bill, as well as several witnesses before this subcommittee, have described the bill as going well beyond study and research. In fact, some comment upon the bill would lead one to believe that study and research are its lesser features. We think that latter view of the bill correct and direct our comment to this reading of it.

Section 1(b)(1), for example, calls for such restructuring of governmental organs as to enable the United States "more effectively to deal with" rapid population growth throughout the world. The subsection following this would declare in the policy of the Congress that the United States should "assist" other nations, and groups and individuals in their efforts "to cope with problems arising out of rapid population growth." Section 2(a)(10) enjoins upon the Secretary of State the duty to make available to recognized scientific and medical authorities in foreign countries, upon request of the government thereof, "assistance pertaining to medical and other aspects of population growth problems." The next ensuing subsection contemplates programs of the United States relating not only to population growth but to population "control." Section 3(a) makes it the duty of the Secretary of Health, Education, and Welfare to review "health and medical programs" of the department insofar as they relate to problems of population growth.

The repetition of the term "population" throughout the text, the reference in the bill to population "control" coupled with an absence of any indication of means other than population control as a solution to problems of population growth, and, finally, the proposed findings in Section 1(a)(3) that it is presumably the increase of population alone which causes hundreds of millions of parents to be unable to provide for their families, leads us to the necessary conclusion that S. 1676 is, plainly and simply, a bill for the establishing of a domestic and international birth control program and for the creating of permanent federal governmental organs for the carrying out of the same.

If we have been at some labor to prove this, it is no fault of the bill nor due any artifice of its sponsors in drafting it, but only because there have been a few denials that it is any such bill. On the contrary: it is a completely frank and aboveboard proposal and its aim not at all a matter of doubt.

The term "birth control," as witnesses before the subcommittee have noted, of course, refers primarily to contraception. It also appears to have necessary reference to the somewhat more spacious term, "family planning," or program which take into account broader aspects of the lives of individuals who are recipients of birth control services.

At the time when the Congress contemplates embarking the nation upon so unprecedented a program, the National Catholic Welfare Conference and the Pennsylvania Catholic Committee feel it their duty to state their conviction that the public power and public funds should not be used for the providing of birth control services.

As noted, they do not oppose, but rather welcome, the furthering of research upon population growth. Moreover, they speak today with sensitive appreciation of the anxieties and motivations which have stimulated the introduction of Senate Bill 1676. They believe, however, that the main features of the bill pose serious dangers to civil liberty, while offering no genuine prospect of relieving the problems of poverty, crowding and disease which they purport to solve.

The distinguishing feature of S. 1676 is, of course, the use of the public power as the sponsor of birth control services. We feel that the implications of public

<sup>12</sup> *Grissold v. Connecticut*, — U.S. —, 14 L. ed. 2d 510, 523 (1965).

intervention in this area have been scarcely considered and now require the most careful weighing. The actions of privately supported agencies in the promoting of education in birth control, the setting up by them of clinics, and their furnishing of contraceptive materials are entirely protected under the law of the land. This appears clearly in the recent decision of the Supreme Court in the Connecticut case. Thus the sponsors of such programs have total freedom to get their ideas "accepted in the competition of the market,"<sup>13</sup> with the assurance that, in a free society, their ideas if sound, will in time win acceptance. But it is a totally different thing to attempt to shortcut the route to such acceptance by the use of subsidies, derived from the taxes contributed by all.

We have particular concern over this, because we believe that if the power and prestige of government is placed behind programs aimed at providing birth control services to the poor, coercion necessarily results and violations of human privacy become inevitable.

It appears sufficiently from the statement of findings and declaration of policy of S. 1676 that the programs in question are intended to be effected primarily among the poor. In the United States, certainly, the main target group in birth control programs has been the poor, as public assistance programs at the State level and the anti-poverty program at the federal level demonstrate.

The statement of findings lays particular stress upon the underdeveloped countries and those whose population growth is extreme. The programs contemplated by S. 1676 for these foreign countries can have reference solely to an implementation among their poverty-stricken majorities—or else it could not possibly be ventured that these programs would achieve the universal benefits claimed for them.

We have spoken of the poor as a class of "weaker members of society", but we have not had reference merely to their lack of income or low economic standard of living. We refer, in addition, to factors revealed in the Cornell University department of psychiatry study in 1963 of New York City: joblessness, ignorance, disrupted family life, sickness. Michael Harrington, in his perceptive study, *The Other America*, says of the poor:

"The poor are subject to more mental illness than anyone else in the society, and their disturbances tend to be more serious than those of any other class."<sup>14</sup>

The encounter between government and the poor person, therefore, is an encounter in which the potential for coercion by government is at maximum. What heightens the importance of the encounter where birth control or family planning are introduced, however, is the potential for inquiry by government into the personal affairs of the individual, data-taking respecting these, dictation concerning conduct, especially regarding sexual life or marital relationship (a thing described by the Supreme Court as "intimate to the degree of being sacred").

It is very easy indeed to say that procedures can be created, governing such encounters, whereby "no coercion or pressure is exerted against individual moral choice,"<sup>15</sup> but such prescription does little or anything to relieve the encounter of its built-in coercive atmosphere. If it is apparent to the "client" that government has a role in the program, he is at once rendered more susceptible to government's suggestions.

Here, as where child confronts state in the school prayer situation, the availability of an exemption means very little indeed. The procedure may not be comprehended; taking advantage of it may be feared. Especially is the latter true where one governmental program which one may refuse is intertwined with another—such as subsistence benefits—which one can scarcely refuse.

It hardly need be stated that for the Catholic a very special problem is raised in such encounter. He has been taught, as a moral precept, that "sexual power is generative by nature and must be so respected whenever it is employed."<sup>16</sup> He has been given to understand, in other words, that any form of contraception is forbidden to him by the teachings of his religion.

To this citizen a most serious problem, then, may be posed by the very fact of his having to answer a question about his religious beliefs (even though the

<sup>13</sup> Holmes, J., in *Abrams v. United States*, 250 U.S. 616, 630 (1919).

<sup>14</sup> 132.

<sup>15</sup> Hanley, *Problems of Public Policy Arising Out of Tax-Supported Family Planning*, address given before Family Law Section of American Bar Association, Aug. 9, 1965, p. 9.

<sup>16</sup> 1965 National Catholic Almanac, 118. And see Pope Paul VI, address of June 23, 1964: "But meanwhile we say frankly that so far we do not have sufficient reason to regard the norms given by Pope Pius XII (rejecting the contraceptive use of drugs, pills or medicines) in this matter as surpassed and therefore not binding; they must therefore be considered valid . . ."

question may be asked solely to protect him in his religious beliefs). For some, undoubtedly, the sense of the caseworker's question will seem to be thus: "Government (or your state, or city, or society itself, or this government-certified agency) has a birth control program. Do you wish to except to it?" The same protective procedure, on the other hand, may impose upon the freedom of conscience of a person not a Catholic or who is a non-believer.

It is recognized, of course, that birth control programs may be of many different sorts. They may cover a broad spectrum of efforts, ranging from a mass issuance of pills or devices with only the briefest instruction to the case approach of "family planning," where individual interviews, counsel, record-keeping and follow-up are all involved.

We are told by proponents of publicly funded contraception that only the latter sort of program promises effectiveness and indeed that failures which have been ascribed to birth control programs have been due to attempts to conduct them with techniques assimilated from mass immunization programs (without, therefore, any sort of casework). But it is precisely the casework type of program—the genuine "family planning" program—which, as government or government-funded activity, opens widest the scope for thought control and conduct control and, in general, human engineering.

Inevitably, in casework, the ambit of inquiry is large. What is the client's familial situation? History of pregnancies? Frequency of sexual intercourse—within or outside of marriage? Experience in use of contraceptives? Faithfulness in following advice previously given? Menstrual history? Sex-or-family-related factors (e.g., drinking habits, treatment of partner or children, health, income, etc.)? Data relating to mental health? And where does the whole process end?

In this connection something needs to be said about interviewers since theirs is the exquisitely sensitive task (or so it should be deemed) of helping plan in the "family planning" (in fact, guiding it). Whether it is constitutionally possible or not, where governmental agencies are concerned, to set any sort of moral qualifications to be met by public servants charged with exploring the most intimate areas of the lives of the poor and the ignorant who will constitute the majority of the intended class of recipients of birth control services, moral qualifications of the highest sort are plainly requisite.

Going beyond this, educational and professional qualifications would seem necessary. Yet the 1960 Survey of Salaries and Working Conditions of Social Welfare Manpower reveals that in 1960, 30 percent of all public assistance caseworkers were not college graduates, while 10 percent had only high school training or less. While the Congress appears to contemplate a program of international family planning, little seems to be said about who the planners are really to be. And yet their role will be the very marrow of the program.

Recalling the statements of the Supreme Court respecting the constitutional necessity of establishing, where civil liberties are involved, a "necessary, and not merely rational" relationship between a statute and the accomplishment of state policy, one must further ask not what do the proponents of state-supported birth control *predict* will flow from their policies but what can they *prove* will flow therefrom? What is the experience, and where is the record of it, which demonstrates a tight cause-effect linkage between the proposed adventure and the peace, health, relief of poverty and betterment of economies which, it is said, will result? The astounding fact is that there is no such record and no such experience but at best a large scale effort in deductive logic.

It is easy indeed to be mesmerized by concepts of social planning, just as it is natural to want the least and shortest steps to solve the worst and most complex of our problems. But we must remember that the planning of families is a thing radically different from the planning of highways, and the government control of birth may come close to being government control of life. We think that this is no place for government.

While the Pennsylvania Catholic Committee and the National Catholic Welfare Conference feel that the question of civil liberty raised in this statement should be considerations of paramount interest to this subcommittee, we cannot but point to two questions of policy which appeared to not have been discussed in the present hearings.

The first relates to the fact already noted that population control means many things—and among these are sterilization and abortion. There exists substantial evidence of a correlation between contraception and these two practices. Dr. Alfred C. Kinsey, in 1955, stated at a conference sponsored by Planned Parenthood Federation of America, Inc.:

"At the risk of being repetitious, I would remind the group that we have found the highest frequency of induced abortion in the group which, in general, most frequently uses contraceptives."<sup>17</sup>

As sterilization and abortion so increase in a society respect for life decreases. Sterilization and abortion are not excluded, we may note, from a definition of population control in this bill.

The second policy question has been raised by others but, we feel, with insufficient emphasis. It pertains to the note of racial eugenicism which is inescapable in the proposal of S. 1676. It is known (and it is indeed whispered) that Negroes dominate in numbers our public assistance rolls. No one asserts that it is the intention of the proponents of S. 1676 to limit the production of American Negro offspring, and no one can doubt that de facto this will result if large scale programs of government-supported birth control realize their intended goals.

Certainly, the members of this subcommittee should take pause before asking the Congress to commit itself further to programs having this potential. In this hour of the painful emergence of our Negro brothers into the American society, surely this consideration should be weighed in the balance with the assumed but unproved benefits of S. 1676's birth control proposal.

A similar consideration should be weighed when the Congress contemplates bringing birth control, as yet one more blessing of white civilization, to the countries of the black and brown and yellow peoples. They will, we suppose, be free to reject this American advice, but we do not think that the psychology of the "white man's burden" ought to be furthered today, particularly in so vital a matter.

To conclude—and with deep thanks for your gracious attention—may I state that the Pennsylvania Catholic Committee and the National Catholic Welfare Conference believe, with respect to birth control, that government should neither penalize nor promote it, but pursue a policy of strict neutrality.

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THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,  
Washington, D.C., October 10, 1966.

HON. HARLEY O. STAGGERS,  
Chairman, House Committee on Interstate and Foreign Commerce,  
Washington, D.C.

DEAR MR. CHAIRMAN: I wish to express to you the appreciation of the American Public Health Association for the action that you are taking on Tuesday, October 11, in considering amendments to the Public Health Service Act as they relate to formula and project grants to States for public health services, for grants to assist in planning for more efficient health programs, and for continuation of the grants to schools of public health. Just as you are not unmindful of our deep interest and concern relative to this legislation, we too are not unmindful of the tremendous pressures which have been upon you and your Committee during this year—the work that has been required of the Committee in long considerations of extremely important programs. We believe the action that you and the Committee are taking is due to the realization that this is an extremely important issue and that at least some temporary means must be found in order that public health programs of the nation can continue to provide needed services. Please be assured that the over 17,000 public health workers who are members of the APHA and the over 40 thousand additional members of State public health associations will be apprised of this action which you are taking that is so essential to continuation of public health programs.

We are informed that the Committee will be considering on Tuesday, October 11, only the proposed substitute to the original legislation which you had introduced some time ago, H.R. 13197. Because of this change, I shall address my remarks only to the substitute, H.R. 18231, as I understand it. Most certainly the initial proposal, that which would provide for planning grants to States and to localities for regional and areawide planning, and which was contained in your original bill, is a concept with which we are in complete accord. There are, as you know, planning funds from Federal, State and local sources which are utilized to bring about a much more orderly process in some health programs. Unquestionably, the best known of these is the Hill-Burton planning grants which have proven to be a most effective way of better organizing these facilities. Not

<sup>17</sup> Calderone, *Abortion in the United States*, 157.

to discount at all earnest and conscientious desires to have hospital facilities just as close as possible to each person, it is, nonetheless, a fact of life that, unless there are a minimum number of beds and common facilities, the hospital does not operate efficiently from the standpoint of finances or from the standpoint of quality of care which is provided to the patients. The proposal in your bill would enable the States and communities within the States, with the advice of all of the various health interests within the locality or within the State, to decide for themselves their most serious health needs, establish priorities to meet these needs, and prepare to progress in an orderly fashion. Our Association strongly supports this concept and urges the approval thereof by your Committee and by the Congress.

As stated previously, our Association is disappointed that it has not been possible for your Committee to give full consideration to the premise and the promise of H.R. 13197. We are most appreciative of your assurance, however, that full hearings will be conducted on this early in the 90th Congress, and we look forward to making what contribution we can at that time. We are somewhat perplexed by the proposal in your bill which would provide formula and project grants totalling \$125 million each for both 1968 and 1969. It is easily understood why immediate action is needed in respect to 1968, but with hearings to be held early in 1967 we do not see why it would be advantageous to authorize these grants through 1969, especially at the minimum level which is included in the bill. It is the conviction of our membership that the Federal Government has not been assuming its rightful share of responsibility for the public health programs of the nation. Even a cursory comparison between these programs and the level of Federal support for construction of waste treatment facilities in the water pollution program, the Federal grants for highways, for agriculture, for education and for numerous other completely justified and much needed programs indicates to us that the Federal Government has not really assumed a true health partnership role. It might better be described as that of a minor stockholder. We hope, therefore, that action or a commitment for 1969 could be withheld until your Committee has had time to consider fully all of the problems that are attendant to this situation. As a consequence, we are impelled to recommend that approval be given for continuation of the formula grants and the project grants through 1968, preferably at a somewhat increased level, but that there not be provision made for 1969 until you have had an opportunity to study the situation more closely.

We are certainly pleased that you have included in your bill a continuation of the Federal grants to schools of public health. This has been an important factor in the support of these schools which, though few in number, must attempt to satisfy the needs for public health programs throughout the entire nation and, in fact, much of the world. As you may know, there is an increased interest relative to initiating additional schools of public health, and this is a factor which I believe your Committee will wish to look at very closely when you have your hearings early in 1967. In the interim, however, we certainly hope that you will include in the action taken by your Committee authorization for the continuation of these grants to the schools of public health through 1968 and 1969.

Again, may I express to you the very real gratitude of the members of the American Public Health Association whose vocation in these public health programs brings them into day-to-day contact with the people who are benefited thereby and who have an intimate knowledge of the fact that new, exciting, vibrant programs are needed in which you and your Committee will have an integral part. I would like to request that this communication be made a part of your hearings on October 11.

Yours truly,

BERWYN F. MATTISON, M.D.,  
*Executive Director.*

AMERICAN DENTAL ASSOCIATION,  
*Washington, D.C., October 11, 1966.*

HON. HARLEY O. STAGGERS,  
*Chairman, Committee on Interstate and Foreign Commerce,  
U.S. House of Representatives,  
Washington, D.C.*

DEAR MR. STAGGERS: The American Dental Association wishes to submit the following brief comments on S. 3008, H.R. 18231 and similar bills which are

under consideration by your Committee and respectfully requests that this letter be included in the record.

As indicated in testimony presented earlier this year to the Senate Committee on Labor and Public Welfare, the American Dental Association is in accord with many of the objectives of S. 3008 and H.R. 18231. The Association recognizes in particular the desirability of encouraging states and communities to make comprehensive plans in order to meet in the most efficient manner the health problems in their own areas. It also is recognized that states and communities should have reasonable flexibility in implementing such plans.

The Association has a major concern, however, with these provisions of S. 3008 and H.R. 18231 which would make a fundamental revision of the existing health grant structure by abolishing all disease categories except mental. After many years of disheartening experience with general health grants, the Association is convinced that support for dental public health activities should be specifically authorized.

Unlike many other afflictions which vary in incidence and seriousness from one state or community to another, dental disease is prevalent to the same extent everywhere. But while dental disease is universal, history demonstrates that it does not receive the emphasis it deserves in public health programs. It simply is not able to compete for support and funds with the more dramatic diseases such as cancer and heart disease.

Congress recognized this problem three years ago when it began allocating specifically modest amounts (\$1 million in fiscal 1967) for grants to states for dental public health activities. This was done under the authority of section 314(c) of the Public Health Service Act which would be repealed by enactment of S. 3008 and H.R. 18231. While \$1 million is only a token amount when compared with the dental disease problem in this country, it probably is more than would have been allocated without the specific direction of Congress.

This conclusion received substantiation in 1967 by the Honorable Wilbur J. Cohen who testified on behalf of the Department of Health, Education and Welfare before the Senate Committee on Labor and Public Welfare in support of legislation creating a separate grant-in-aid program for dental public health activities. Among other things, Mr. Cohen pointed out:

"In 1961, for example, the Public Health Service made general health grants of \$17 million to state public health departments. Yet these departments allocated to dental activities only \$125,000—just 0.7 percent of the total. . . . of the more than half a billion dollars spent in 1961 on all state health programs, only \$6.6 million—about 1 percent—went to dental health. This pattern of allocation of public funds is in sharp contrast with that of private funds, where \$15 out of every \$100 spent for health care goes for the purchase of dental services.

"So great a disparity cannot be ignored, for the current allocation allows less than 4 cents per person per year for all state and community activities in dental health. And 4 cents per person a year simply is not enough. It does not permit programs which even begin to meet the existing national need."

It was following this hearing that Congress established a line item in the budget for state dental public health activities. It is submitted respectfully that the continuation of specific authority for Congress to allocate funds for dental health would not be inconsistent with the purpose of S. 3008 and H.R. 18231. Dental health, like mental health, traditionally has been separately identified in state health departments. Professional dental personnel are separately licensed and carry on separate programs without conflict or overlap with other state and local health programs. Thus, specific allocation of funds for dental health would not disturb existing relationships and would not prevent the coordination and flexibility envisioned in S. 3008 and H.R. 18231. The Association recommends an allocation of 5 per cent of the sum authorized in S. 3008 and H.R. 18231 for "Grants for Comprehensive Public Health Services."

The American Dental Association is pleased with the language in S. 3008 and H.R. 18231 stating that nothing may be done to interfere "with existing patterns of private professional practice of medicine and dentistry and related healing arts." It is assumed that the intent of this language is to make clear that the activities authorized are to be carried out within the framework of what have been traditionally considered to be public health services. It is suggested that this intent be emphasized in the Committee's report on the bill.

With this understanding the Association believes that the provisions of S. 3008 and H.R. 18231, if adequately funded, hold considerable promise for improving the methods by which public health service programs are established and implemented in states and communities.

The American Dental Association appreciates this opportunity to present its views.

Sincerely yours,

JOHN B. WILSON, D.D.S.,  
*Chairman, Council on Legislation.*

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AMERICAN NURSES' ASSOCIATION, INC.  
*New York, N.Y., October 7, 1966.*

HON. HARLEY STAGGERS,  
*Chairman, Committee on Interstate and Foreign Commerce,  
U.S. House of Representatives,  
Washington, D.C.*

DEAR MR. STAGGERS: The American Nurses' Association wishes to record its support of your bill 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 service, to provide for a more effective use of available Federal funds for such planning and services, and for other reasons.

Our interest and support stems from the members' deep concern for the provision of adequate health services for the American people. The system of public health services has developed piecemeal over the years to meet current problems without an assessment of the changing needs of society for these services. Programs have been built around and on top of each other, creating an unwieldy, inefficient operation. Local programs have developed only to the extent that local pressures will allow. Bold action is indicated if we are to meet the needs of the changing times.

As interest in each disease category was stimulated, programs were established to prevent, and control the particular disease. Each program has grown into a totality and as the programs develop in depth, they have a tendency to become increasingly ingrown. Meaningful coordination of the multiple programs is essential for planning for the total health needs of a community.

Categorical funding to reach a specific health goal enabled states to give attention to new or long neglected health problems. In the past, it proved a useful mechanism for encouraging action in a given area which might never have been undertaken had such funding not been available. However, at this time a different approach is indicated in order to develop a comprehensive health program of prevention, care and rehabilitation.

Certain practices associated with categorical funding have resulted in fragmentation and disruption of service. These include the requirement of assigning staff on a specialized basis, a complicated system of accounting for funds and the focusing of resources on a special need to the neglect of more pressing problems.

H.R. 13197 will provide a focus for an integrated generalized program. Health service needs for any given area may vary widely. Such factors as age and education level of the population, the economy, and the topography influence the kinds of program which must be tailored to suit each community. Flexibility in the use of federal grants will provide a stimulus for imaginative planning and reduce the emphasis on disease-oriented programs.

H.R. 13197 provides for the development and improvement of home health services. The passage of the Health Insurance Benefits Amendments to the Social Security Act with the provision for paid home health services as a benefit, makes it imperative that community health services be developed, extended and improved.

We believe that there is urgent need to enact H.R. 13197 so that, as the title of the bill states, planning for comprehensive health services can become a reality.

Respectfully,

JUDITH G. WHITAKER, R.N.,  
*Executive Director.*

NATIONAL ASSOCIATION OF COUNTIES,  
Washington, D.C., October 11, 1966.

HON. HARLEY O. STAGGERS,  
Chairman, Committee on Interstate and Foreign Commerce,  
House of Representatives,  
Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the National Association of Counties, I should like to express our support of H.R. 13197, a bill to improve comprehensive health planning and public health services. The growing complex of problems confronting local governments has in many instances been compounded by the rigidity of the federal programs designed to assist them. In our view H.R. 13197 will assist in correcting this situation in the important area of health.

We would strongly suggest that the bill be amended to:

(a) strengthen the emphasis of the role of official local health agencies; and

(b) of areawide planning being carried out by agencies responsible to and appointed by the participating local governments, vis-a-vis, nongovernmental private agency or organization.

In order to obtain the maximum benefit, health programs should be coordinated with one another as well as many other programs being carried out by our local governments. This can best be done by having the areawide planning carried out under the auspices of the local government. This would in no way preclude the inclusion of representation from sources other than governmental on the planning body.

Specifically, we suggest that the proposed new Section 314(a) (2) (B) of Title III be amended to read as follows:

"(B) provide for the establishment of a State health planning council, which shall include representatives of State and local [official] agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, to advise such State agency in carrying out its functions under the plan;"

We further suggest that the proposed Section 314(a) (b). "Project Grants for Areawide Health Planning" be amended to include the following provision:

"In the absence of substantial reasons to the contrary, Project Grants under this Section will be made to public agencies which are composed of officials appointed by and responsible to the participating local governments comprising the area being planned for."

It is our view these two amendments will not complicate the administration of this program, but rather will greatly facilitate its being successfully implemented. I should like to thank you in advance for your consideration of our comments.

Very truly yours,

BERNARD F. HILLENBRAND,  
Executive Director.

HOUSE OF REPRESENTATIVES,  
Washington, D.C., June 15, 1966.

HON. HARLEY O. STAGGERS,  
Chairman, House Committee on Interstate and Foreign Commerce,  
Washington, D.C.

DEAR MR. CHAIRMAN: I am writing to give my support for H.R. 13197, the Comprehensive Health Planning and Public Health Services Amendments of 1966.

At the same time, I would like to enclose a copy of a letter I received recently from Alfred M. Pelham, the chairman of the Southeastern Michigan Task Force on Community Health Services. Mr. Pelham has given a brief but very persuasive discussion of how important H.R. 13197 is for my State, and I hope it can be included in the permanent record of the committee's hearings on this important proposal.

Thank you very much for your consideration and interest.

Sincerely,

BILLIE S. FARNUM, M.C.

SOUTHEASTERN MICHIGAN TASK FORCE  
ON COMMUNITY HEALTH SERVICES,  
*Ann Arbor, Mich., June 3, 1966.*

HON. BILLIE S. FARNUM,  
*House Office Building,  
Washington, D.C.*

DEAR SIR: At the June 1, 1966, meeting of the Southeastern Michigan Task Force on Community Health Services, the membership resolved to support House Bill 13197 and Senate Bill 3008, "Comprehensive Health Planning and Public Health Amendments of 1966."

The Southeastern Michigan Task Force has been studying the community health problems and needs in Southeastern Michigan and the ways in which these problems are met. It is obvious, that in the community health area, there is a great deal of confusion as to who is doing what or even who should be doing what. Our data reveals, for example, that in Michigan eleven different state agencies are involved in the provision of health services. A recent survey by our staff has revealed that one of the most urgent needs in the community health area is for coordination and cooperation of the efforts and activities of the various health agencies and groups. All experts agree that in the public health area there is a large gap between what is known and what is applied. Senate Bill 3008 and House Bill 13197 will allow for meaningful planning and the orderly development of comprehensive community health services to all citizens in the United States.

As Chairman of the Southeastern Michigan Task Force on Community Health Services and on behalf of the membership and staff, I urge that you support this needed legislation.

Sincerely yours,

ALFRED M. PELHAM, *Chairman.*

STATE OF MINNESOTA,  
EXECUTIVE OFFICE,  
*St. Paul, Minn., April 7, 1966.*

HON. HARLEY STAGGERS,  
*House of Representatives,  
Washington, D.C.*

DEAR CONGRESSMAN STAGGERS: I want to extend my congratulations to you for the excellent proposal you have made in H.R. 13197, the Comprehensive Health Planning and Public Health Services Amendments of 1966.

Here in Minnesota we have moved forward with the appointment of a Governor's Commission on Health and Rehabilitation which will carry the broad assignment of planning health and rehabilitation services for the immediate future and long-range. The responsibilities of the Commission, which is composed of prominent medical and lay leaders from every corner of the state, will include the following:

- a. An evaluation of the present State vocational rehabilitation program and the preparation of a comprehensive statewide plan to make rehabilitation services available to every person who could benefit thereby.
- b. An analysis of the overall quality of the health of the citizens of the State of Minnesota, including an assessment of the health and illness statistics available in various state and federal bureaus.
- c. A review of the existing health manpower, including an analysis of the distribution of health manpower, the number of persons in the various medical and pari-medical professions, and the resources for educating additional health manpower.
- d. The organization of publicly financed and operated health care programs, including an analysis of the State-Federal relationship and a review of the quality of publicly supported health care.
- e. A review of the existing and proposed health facilities under the various federal and state construction programs.
- f. An analysis of the economics of health care—the extent and quality of private and public health care insurance coverage, an examination of the variation by regions in the cost and supply of health care, and the possibility of developing optimum utilization of health care services.

It is a broad undertaking but the needs of the times require it. The vocational rehabilitation planning funds will finance that aspect of the program. Your proposal would be of great value in providing assistance with the costs incurred in the broader health planning assignment. I hope that H.R. 13197 will become law and would be happy to be of assistance in any way possible. I am sending a copy of this letter to the Minnesota delegation so that they may be fully aware of the implications of H.R. 13197 for the improvement and more effective organization of health services in Minnesota.

With kindest personal regards,

Yours very truly,

KARL ROLVAAG, *Governor.*

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THE STATE OF WISCONSIN,  
STATE BOARD OF HEALTH,  
Madison, Wis., April 15, 1966.

Re H.R. 13197.

HON. HARLEY O. STAGGERS,  
*House of Representatives,*  
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: The Wisconsin State Board of Health is in favor in principle with the objectives of bill H.R. 13197 and its companion bill S. 3008. With one amendment it is believed that these bills would have great possibilities of strengthening comprehensive health planning and the leadership of official State health agencies.

There is one defect, however, which should be corrected to insure that just the opposite does not happen. As the bills are now written any State agency can be designated as the sole agency for administration of the State's health planning functions. This could result in the State's official health agency losing its leadership role and jurisdiction in policy determination in the field of public health and thus weakening rather than strengthening the State health agency.

It is recommended that, on page 3 of H.R. 13197, (2) (A) be amended to read as follows:

"(A) designate *the official State public health agency* as the sole agency for administering or supervising the administration of the State's health planning functions under the plan;"

This one change is urged by the individual members of Wisconsin's official State Board of Health and by me personally as Wisconsin State Health Officer.

Sincerely yours,

E. H. JORRIS, M.D.,  
*State Health Officer.*

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STATE OF NEW JERSEY,  
DEPARTMENT OF HEALTH,  
Trenton, N. J., March 28, 1966.

HON. HARLEY O. STAGGERS,  
*House of Representatives,*  
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: Attached is a copy of a letter (attachment A) sent to all New Jersey Members of the House of Representatives respectfully requesting their support of H.R. 13197.

Your constructive interest in public health is commendable. The provisions of the bill introduced by you will allow for most necessary and important advances in the planning and administrative processes needed to meet modern day public health demands.

Sincerely,

ROSCOE P. KANDLE, M.D.,  
*State Commissioner of Health.*

(Attachment A)

STATE OF NEW JERSEY,  
DEPARTMENT OF HEALTH,  
Trenton, N.J., March 21, 1966.

Hon. \_\_\_\_\_,  
Congress of the United States,  
House of Representatives,  
Washington, D.C.

DEAR CONGRESSMAN —: Your attention is respectfully invited to H.R. 13197 introduced by the Honorable Mr. Staggers on March 2, 1966 and referred to the Committee on Interstate and Foreign Commerce.

This bill amends the present Public Health Service Act and provides for:

1. Comprehensive state-wide health planning to include the coordination and integration of area-wide planning.

2. The strengthening and extending of community health services in a manner which would bring about close intergovernmental collaboration and would allow for a real partnership of public and private, individual and organizational, official and voluntary efforts necessary to meet the complexities of modern day public health. Much of this ability is not now possible under the existing detailed categorical grant approach.

3. Since the needs and resources of communities and states vary widely, maximum flexibility in administration is necessary in order properly to provide for public health services of a varied and different scope. Such flexibility is important to insure that local programs are designed to meet local problems. Such flexibility is not now available.

4. The continuance of project or development grants to meet specific health problems of limited geographic scope, or of specialized regional or national significance necessary to stimulate and launch new health programs, and to undertake studies, demonstrations and training programs.

5. The interchange of personnel with States and political subdivisions of a State so that maximum use of specialized knowledge could be made available in areas where needed without loss of benefits to such interchanged persons.

The measures incorporated in this bill are most important and most necessary if we are effectively to meet the broad demands of public health in this State and if we are effectively to serve the citizens of New Jersey. Public health can no longer be considered a singular, simple, parochial problem.

This bill, if passed without substantive change, would provide the means for an effective partnership and would remove current categorical restrictions to effective planning and operation.

I respectfully request your favorable consideration and support of this bill.

Sincerely,

ROScoe P. Kandle, M.D.,  
State Commissioner of Health.

STATE OF MONTANA,  
STATE BOARD OF HEALTH,  
Helena, Mont., June 9, 1966.

Congressman JAMES BATTIN,  
House Office Building, Washington, D.C.

DEAR CONGRESSMAN BATTIN: At the annual meeting of the Western Affiliates, American Public Health Association, May 23-27, 1966, the following resolution was passed:

"Organized local Public Health Services are notably lacking in rural, sparsely populated geographic areas of the United States.

Federal formula grants to states are adjusted by total population and per capita income. To meet the needs of the sparsely populated areas, it will be necessary to take into consideration the higher per capita cost of reaching people in these areas and make adjustments of formula grants.

The Confederation of Western Affiliates, APHA, recommends that Congress develop a formula which will give states with sparse populations a greater amount of subsidy for public health programs than would be the case if only total population and per capita income were used.

The Confederation of Western Affiliates, APHA, also recommends that APHA assign an appropriate committee the task of devising a suitable formula for distributing federal public health formula grants to states."

This organization represents the State Public Health Association of the western states. You might find this an additional endorsement for adjusting the grant formula under S. 3008 and H.R. 13197.

Sincerely yours,

JOHN S. ANDERSON, M.D.,  
*Executive Officer.*

STATE BOARD OF HEALTH,  
*Columbia, S.C., October 7, 1966.*

HON. WILLIAM JENNINGS BRYAN DORN,  
*House Office Building,  
Washington, D.C.*

DEAR CONGRESSMAN DORN: We have been informed that the House Interstate and Foreign Commerce Committee has voted to have a one-day hearing on H.R. 13197 and S. 3008 (the Comprehensive Health Planning and Public Health Services Amendments of 1966). We regret that the heavy load of work preceding adjournment for the year does not allow additional time for consideration of this complicated issue.

We have also been advised that the committee is seriously considering authorizing only \$62.5 million per year for health service formula grants during the fiscal years 1968 and 1969 although the Senate has approved an authorization of \$170.5 million for 1968 and \$230.7 million for 1969.

We feel that the authorizations approved by the Senate would truly allow for the development of comprehensive public health services in the States while the lesser figures quoted above are about the same as the sum of the present categorical health grants and would not allow development of services beyond the present inadequate level considering the rising costs of all commodities and services.

If the House cannot accept without additional time for study the authorizations passed by the Senate on October 3, we strongly recommend that the planning grants only be authorized at this time and that additional hearings be scheduled for January 1967 when there will be more time available to establish the justification of and need for adequate formula grants.

Sincerely yours,

MALCOLM U. DANTZLER, M.D.,  
*Assistant State Health Officer.*

UTAH STATE DEPARTMENT OF HEALTH,  
*Salt Lake City, Utah, October 7, 1966.*

HON. HARLEY O. STAGGERS,  
*Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN STAGGERS: With respect to H.R. 13197 and S. 3008 as it passed the Senate and will be before your committee for consideration on October 11, I would appreciate your reporting to your committee that the principles and objectives involved are of such importance in solving numerous problems inherent in existing legislation which these bills will replace or supplement that their favorable consideration at this time is of the highest importance.

While S. 3008 and H.R. 13197 were companion bills when introduced, the bill as finally passed by the Senate does not detract in any way from the significance of this legislation and poses no objection to the legislation as it would affect us in Utah.

The provision for improving health planning has long been needed. This is emphasized by topsy turvy development of a great variety of categorical grants in the health field. This provision, along with the significant change from categorical grants to basic comprehensive health grants will permit more effective use of the funds in the states.

The need for better health planning in Utah has been recently recognized by a report of the Commission on the Organization of the Executive Branch of the

Government (Little Hoover Commission Report) which specifically recommends that the State Department of Health establish a division for planning and research.

It is not only most important but most timely that the newer concept of Federal health grants to the States as set forth in these two bills be enacted at this time so that the program can be effective as early as possible.

May I also add appreciation to your scheduling a hearing on these bills during this very busy time for your committee.

Sincerely yours,

G. D. CARLYLE THOMPSON, M.D.,  
*Director of Public Health.*

CHAUTAUQUA COUNTY DEPARTMENT OF HEALTH,  
*Mayville, N.Y., September 29, 1966.*

HON. HARLEY O. STAGGERS,  
*Chairman of the House Committee on Interstate and Foreign Commerce,  
House of Representatives,  
Washington, D.C.*

DEAR REPRESENTATIVE STAGGERS: I understand that there is currently a bill pending before Congress, entitled "Comprehensive Health Planning and Public Health Services Amendments of 1966" (S. 3008).

Hearings on this bill have not been held in the House of Representatives to my knowledge. The end result of the bill—amend the Public Health Service Act—would be—

to promote and assist in the extension and improvement of comprehensive health planning and public health services; and  
to provide for a more effective use of available Federal Funds for such planning and services and for other purposes.

The Department of Health supports this proposed legislation and requests that you hold hearings on it.

Respectfully yours,

LYLE D. FRANZEN, M.D.,  
*Health Commissioner.*

ALLEGHENY COUNTY HEALTH DEPARTMENT,  
*Pittsburgh, Pa., September 16, 1966.*

HON. HARLEY STAGGERS,  
*House Office Building,  
Washington, D.C.*

MY DEAR MR. STAGGERS: Reference is made to Senate Bill 3008 which revises the traditional categorical formula for health program grants to States.

The lack of assurance in this bill to insure adequate coverage of urban health needs despite its stated intent "that Federal financial assistance must be directed to support the marshalling of all health resources—national, State and local—to assure comprehensive health services of high quality for every person" was and is of major concern to this department.

This concern for the lack of assurance in these bills for urban health needs has been communicated to the Congressmen from Pennsylvania. The Honorable Elmer J. Holland has advised this department that a companion bill, H.R. 13197 is before the Interstate and Foreign Commerce Committee and as yet there has been no scheduling of hearings. He further advised this department that the attached communications have been forwarded for your attention. It was suggested by Congressman Holland that these communications might be made part of committee hearing record. (See attachment A.)

Senate Bill 3008 and companion bill H.R. 13197 will have major impact on the provision of comprehensive health services to urban residents. It is essential, therefore, for the bill to specify the mechanism by which there would be local official involvement guaranteeing appropriate attention to urban health services.

Sincerely yours,

E. JANE FLEMING, M.D.,  
*Chief, Bureau of Planning, Evaluation and Research.*

(Attachment A)

ALLEGHENY COUNTY HEALTH DEPARTMENT,  
*Pittsburgh, Pa., September 7, 1966.*HON. ELMER J. HOLLAND,  
*House Office Building,  
Washington, D.C.*

MY DEAR MR. HOLLAND: Reference is made to Senate Bill 3008 which revises the traditional categorical formula for comprehensive health program grants to states.

The lack of assurance in this bill to insure adequate coverage of urban health needs despite its stated intent "that Federal Financial assistance must be directed to support the marshalling of all health resources—national, state and local—to assure comprehensive health services of high quality for every person" was and is of major concern to this department.

On July 18, 1966 this concern was communicated by Dr. Herbert R. Domke, then Director of the Allegheny County Health Department, in the attached letter to the Conference of Mayors and the Conference of City Health Officers (exhibit A) and subsequently endorsed by the latter organization in its September '66 City Health Officer News, Vol. 6, No. 9. Further, this department's newly established Bureau of Planning, Evaluation & Research was charged with the responsibility of continuing efforts to strengthen and improve S. 3008.

The importance of this bill and its profound implication to health programming on local, state and national levels demands amendment to strengthen local governmental health administration, local governmental health services and to assure that local health officers are included prominently in the planning for local health programming.

It is urged, therefore, that there be further opportunity for review and participation by local and state public health officials and Congressional committees prior to final Congressional action.

Sincerely yours,

E. JANE FLEMING, M.D.,  
*Chief, Bureau of Planning, Evaluation & Research.*

(Exhibit A)

ALLEGHENY COUNTY HEALTH DEPARTMENT,  
*Pittsburgh, Pa., July 18, 1966.*JOHN J. GUNTHER,  
*Executive Director,  
Conference of Mayors.*  
EDWIN D. LYMAN, M.D.,  
*President,  
Conference of City Health Officers.*

GENTLEMEN: The following analysis of Senate Bill 3008, Public Health Planning and Grants, is written in response to your request. I recommend that the Conference of Mayors and the Conference of City Health Officers take action to call to the attention of Congress the need for amendment if the Bill is to achieve the improvement in urban public health intended by its sponsors.

President Johnson, members of Congress and the general public as well have expressed concern that the results of the massive medical research effort are not adequately reaching the individual in his community. The administration has sponsored Senate Bill 3008 to help meet this concern and it is to do so by reorganizing the grant mechanism to channel Federal funds to state and local public health agencies.

The even greater importance of the Medicare Act has diverted attention from S. 3008. Nonetheless, the reorganization of the grant system should be the stimulus to revitalize state and local official agency programs. S. 3008, therefore, is a Bill which must be of major concern to state and local health agencies throughout the United States, and to the Conference of Mayors.

The President's 1966 Health Message gives the background for S. 3008. The President clearly recognizes and calls for action to strengthen urban health services. This is especially to be welcomed for the official health agencies at the Federal level have not given sufficient attention to the health needs of our now

preponderantly urbanized population. Certainly, therefore, the Conference of Mayors and the Conference of City Health Officers should enthusiastically support the administration's efforts to give more attention to the health problems of American cities. In any and all of the following comments and criticisms, therefore, it should be understood that the Administration's goals and basic philosophy are supported.

The specific background for S. 3008 is given in the President's message of March 1, 1966 as follows:

"The focus of our efforts is the individual and his family, living in their own community. To meet their health needs, requires the cooperation of many agencies, institutions, and experts—of State and local government, of doctors, nurses and paramedical personnel.

"These are the frontline fighters in our battle against disease, disability and death. As in military battle, a winning strategy demands wise and well planned use of manpower. It demands coordinated use of all the resources available.

"I recommend to Congress a program of grants to enable States and communities to plan the better use of manpower, facilities and financial resources for comprehensive health services . . .

"Our purpose must be to help redirect and reform fragmented programs which encourage inefficiency and confusion and fail to meet the total health needs of our citizens.

"I recommend a program to initiate new State formula grants for comprehensive public health services. This program would begin in fiscal 1968."

Undersecretary Cohen went on to say in the testimony on S. 3008:

"The important point is that State and local health agencies must shoulder the major responsibility for assuring the availability of high quality public health services. The proposed legislation will provide the State and local health departments with Federal financial support with which to meet their responsibilities and provide the leadership and coordination that is so urgently needed.

"S 3008 has two principal objectives: First to increase the capacity for continuing, comprehensive planning for health—statewide, regionally, and locally—in partnership with the Federal Government. . . . It will permit expansion of regional and metropolitan health planning . . .

"Second, to redirect the focus of health-grant programs to revitalize local and State health effort and to focus program activities more clearly on bringing services to people . . ."

There are many important features of S. 3008. These quotations were selected to show the administration's apparent intent to strengthen urban health services. Turning to the Bill itself, however, the statement of purpose begins to modify the stated goals and important sections referring to urban health departments become ambiguous. The Bill states (Page 3, Line 10):

" . . . the Congress finds that comprehensive planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible."

The phrase that support for people in communities should be "broadened and made more flexible" is not the language of the President's message. The Bill does not use the President's language of "redirect and reform fragmented programs." The "flexibility" among many of the existing programs has been a principle factor to lead to the existing fragmentation.

Turning to the State Planning Council which is the key group to carry out the provisions of the Bill, Page 4, Line 12, provides "for the establishment of a State health planning Council, which shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, to advise such State agency in carrying out its functions under the plan."

Although the Department of HEW's recent legislation for Mental Retardation Prevention administered by the Children's Bureau provides explicitly for involvement of the official health agency, the section quoted here is typical of PHS legislation in refusing recognition to the state and local official health agency. The section would be much strengthened by the inclusion of the word "official" on Line 14 to read "state and local *official* agencies."

At the Association of State and Territorial Health Officers meeting with the Surgeon General in November 1965, there was vigorous discussion on this point with many State health officers taking the position that explicit assignment to official agencies should be specified in the legislation. Representatives of the Conference of City Health Officers who were present spoke to make a relationship to the official state or local government health unit required. The S. 3008, however, does not take account of these discussions.

The Bill provides, (Page 14, Line 16 et seq.) that, "at least 70 per centum . . . of a state's allotment shall be available to communities of the State."

This is fine, but there is no comment with regard to allocation in proportion to population or any other urban or metropolitan factor. This provision could easily reinforce an existing pattern on the part of State Health Departments to provide direct expensive service to rural areas leaving the urbanized municipal areas to continue support for local health programs from their own resources.

Page 8, Line 14 et seq. provides:

" . . . the Surgeon General is authorized . . . to make . . . project grants to any other public or nonprofit private agency or organization to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services;"

If I understand this section correctly, it would be possible for a nonofficial, nongovernmental agency to take responsibility for "comprehensive regional, metropolitan area or other local area plans."

In general, as illustrated by the provisions of the Bill so far quoted, the entire Bill will tend to continue fragmentation at the local level. The Bill provides (Page 10, Line 12, et seq.) that funds will make a significant contribution toward strengthening public health services in the various political subdivisions ". . . in accordance with criteria which the Surgeon General determines . . ." Neither here nor elsewhere, however, is there any assurance that urban health services will receive appropriate attention, and the PHS has not given adequate recognition to urban health problems. It would be desirable for the Bill to specify mechanism by which there would be local official involvement to review the plans or to assist the Surgeon General in determining the criteria.

Surely there is adequate legislative precedent both in and out of HEW to provide for more effective metropolitan health councils. I am not sufficiently informed about various Congressional actions for metropolitan integration to cite many examples. In the field of transportation and highways, however, there is better precedent than this Bill uses. S. 3008 provides an unusually good opportunity to advance metropolitan planning, but realizing this opportunity will not be assisted by Congress if the Bill keeps the present vague language. This section would greatly be improved if rewritten to require coordination of and with the metropolitan government councils of the kinds now developed by local governments, such as the Supervisors Inter-County Committee of the Detroit area, the Southwestern Pennsylvania Regional Planning Council of Pittsburgh and the East-West Gateway Coordinating Council of St. Louis.

In these examples, the principal elected officials are always represented and in a majority; other members of the Council, if any, are appointed by local government authorities. In any case, it is nonsense to expect that any kind of effective comprehensive metropolitan program in health can be developed without support of the involved municipalities and their official health agencies.

It, perhaps, should be noted also that there are funds now available to medical schools in the Regional programs for Heart, Stroke and Cancer (which also exclude local health or elected officials) that provide opportunity for medical schools to extend services on a regional basis. A general provision of this kind in S. 3008, therefore, could duplicate programs developed under other legislation.

I hope this Bill will be able to receive the staff's close attention. This Bill and this letter are specific to health planning. The implications are, however, not restricted to the health field. The same kinds of criticism would be no less justified about legislation similarly phrased for urban programs other than health. A recent example comes from a St. Louis Post Dispatch editorial entitled, "Who Cares for Cities?", which concluded with the following paragraph:

"Urban aid does not depend absolutely on a rationalization of either the administrative or the congressional set-up, but it certainly would be more effective

if it were under more integrated direction. If Washington were not working at cross-purposes, it could be more effective in helping urban authorities to mesh more closely."

In summary, S. 3008 provides a mechanism for grant distribution which will have a profound effect on state and local public health operation. The criticism of the Bill provided here is that certain aspects of its wording and clauses do not achieve the purpose intended for it has an administration Bill. Furthermore, it is clear that the Bill was developed without the active participation of any local public health officials and despite adverse criticism from many state health officers.

In view of the importance of the Bill it would seem highly desirable for Congress to provide for more adequate review. It would seem very desirable for the Conference of Mayors and the National Association of County Officers and other interested groups be given the opportunity to carefully consider this and be given the opportunity to provide the Congressional committees advice to strengthen and improve the Bill.

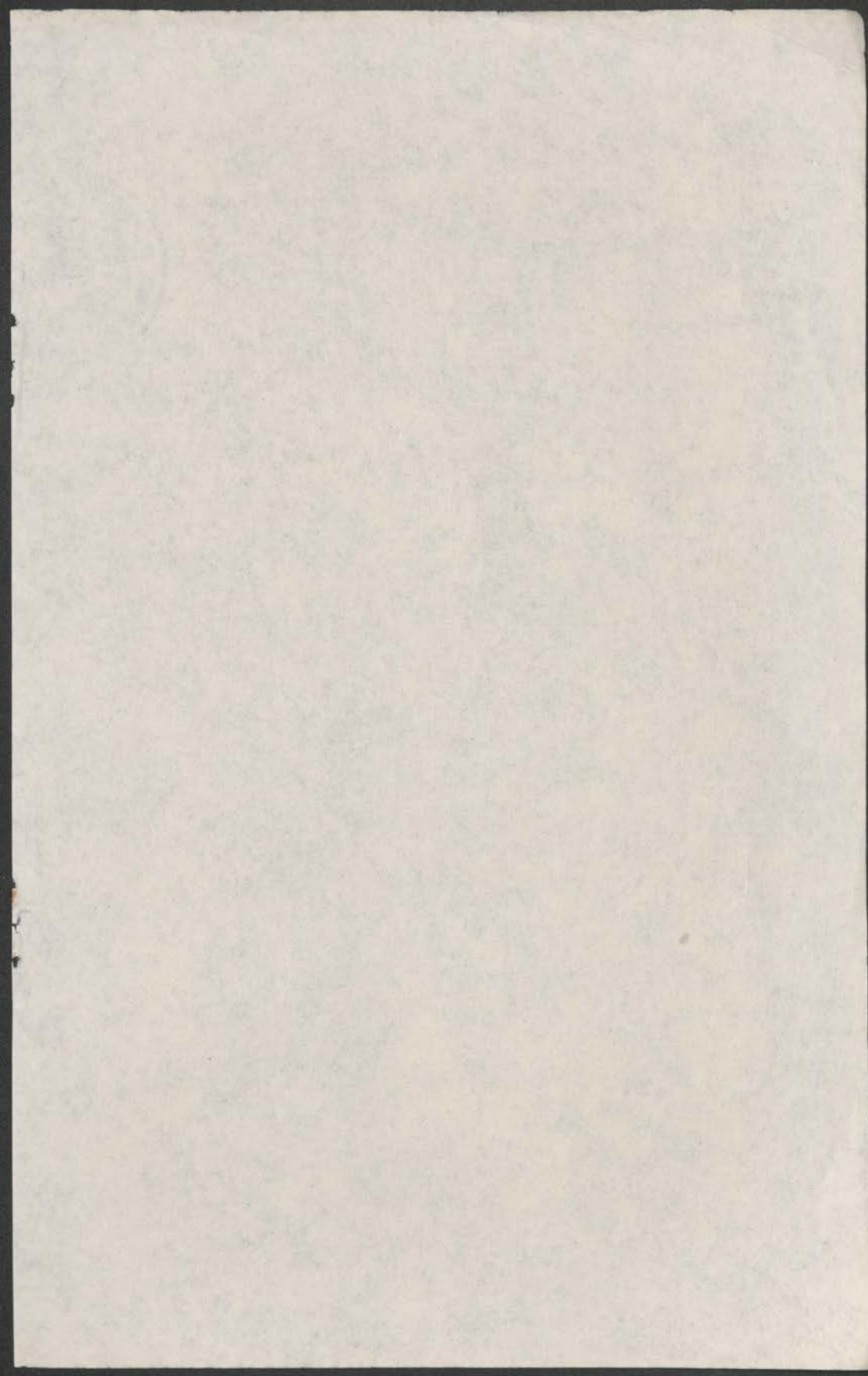
Sincerely yours,

HERBERT R. DOMKE, M.D.,  
*Director.*

(Whereupon, at 12 noon, the committee adjourned.)

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