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PARTNERSHIP FOR HEALTH AMENDMENTS OF 1967

GOVERNMENT
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HEARINGS

BEFORE THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

FIRST SESSION

ON

H.R. 6418

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND AND EXPAND THE AUTHORIZATIONS FOR GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND SERVICES, TO BROADEN AND IMPROVE THE AUTHORIZATION FOR RESEARCH AND DEMONSTRATIONS RELATING TO THE DELIVERY OF HEALTH SERVICES, TO IMPROVE THE PERFORMANCE OF CLINICAL LABORATORIES, AND TO AUTHORIZE COOPERATIVE ACTIVITIES BETWEEN THE PUBLIC HEALTH SERVICE HOSPITALS AND COMMUNITY FACILITIES, AND FOR OTHER PURPOSES

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PARTNERSHIP FOR HEALTH AMENDMENTS OF 1967

TUESDAY, MAY 2, 1967

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

The committee met at 10 a.m., pursuant to notice, in 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. 6418 which I introduced at the request of the administration, known as the Partnership for Health Amendments of 1967.

Last year in the closing days of the 89th Congress, our committee reported out a 1-year bill providing for comprehensive health planning, and eliminating the categorical grants for public health services within the States, providing instead authority for formula grants and project grants for public health programs generally.

The current legislation would extend through fiscal 1972 the authorizations for comprehensive health planning and public health services grants; would broaden and consolidate authorizations for research, experiments and demonstrations relating to the development and financing of health services and facilities; authorize cooperation with States and localities in emergency health planning; provide for licensing clinical laboratories, make permanent the existing temporary authorization for research contracts; and delete the authority currently in the law for the Commission of Education to accredit schools of nursing.

This is a very important, a very complicated bill. We expect that the hearings will last at least 2 weeks, in view of the large number of witnesses who have asked to be heard.

I might say at this time that the committee faces a rather difficult problem. I stated on the floor yesterday that if we received recommendations from the President dealing with the threatened railroad strike we would promptly start hearings on that legislation. That legislation will take some time for the committee to consider, and I regret to have to say that it may be necessary to suspend these hearings when we get the President's recommendation.

It was some years ago that Teddy Roosevelt stirred the Nation with his call for a vigorous and healthy life. We have come a long way since that time, and the medical world has been stimulated to prodigious efforts to increase the control of science over the physical man. That is the purpose of this proposed legislation today, to tie together the achievements of medical science and put behind them whatever resources of the Government may be available to reach the goal of universal health.

A healthy nation will be able to take advantage of our enormous opportunities. Although we have many problems, perplexing problems facing us and the Congress and even the Nation such as the Vietnam war, the threatened railroad strike, and many other things, we, as a committee, are determined to carry on in the field of health and do what we can to improve the lot of the medical man and medical science in getting the achievement of science to the public of the nation.

(The bill, H.R. 6418, and departmental reports thereon, follow:)

[H.R. 6418, 90th Cong., 1st sess.]

A BILL To amend the Public Health Service Act to extend and expand the authorizations for grants for comprehensive health planning and services, to broaden and improve the authorization for research and demonstrations relating to the delivery of health services, to improve the performance of clinical laboratories, and to authorize cooperative activities between the Public Health Service hospitals and community facilities, 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 "Partnership for Health Amendments of 1967".

GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

SEC. 2. (a) (1) Subsection (a) (1) of section 314 of the Public Health Service Act (42 U.S.C. 246, as amended by section 3 of the Comprehensive Health Planning and Public Health Services Amendments of 1966, Public Law 89-749) is amended (1) by striking out "1968" the first time it appears and inserting in lieu thereof "1972" and (2) by striking out "and $5,000,000 for the fiscal year ending June 30, 1968" and inserting in lieu thereof "$7,000,000 for the fiscal year ending June 30, 1968, and such sums as may be necessary for the next four fiscal years."

(2) Subsection (a) (2) of such section is amended by redesignating subparagraphs (I) and (J) as subparagraphs (J) and (K), respectively, and by inserting after subparagraph (H) the following new paragraph:

"(I) effective July 1, 1968, (i) provide for assisting each health care facility in the State to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan developed in accordance with criteria which the Secretary determines will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner, and (ii) provide that the State agency furnishing such assistance will periodically review the program (developed pursuant to clause (i)) of each health care facility in the State and recommend appropriate modifications thereof;".

(3) The last sentence of subsection (a) (4) of such section is amended by inserting before the period at the end thereof ", 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".

(b) Subsection (b) of such section is amended by striking out "1968" the first time it appears and inserting in lieu thereof "1972" and by striking out "and $7,500,000 for the fiscal year ending June 30, 1968", and inserting in lieu thereof "$7,500,000 for the fiscal year ending June 30, 1968, and such sums as may be necessary for the next four fiscal years".

(c) Subsection (c) of such section is amended by striking out "1968" the first time it appears and inserting in lieu thereof "1972" and by striking out "and $2,500,000 for the fiscal year ending June 30, 1968" and inserting in lieu thereof "$2,500,000 for the fiscal year ending June 30, 1968, and such sums as may be necessary for the next four fiscal years".

(d) (1) Subsection (d) (1) of such section is amended by striking out "$62,500,000 for the fiscal year ending June 30, 1968," and inserting in lieu thereof "$70,000,000 for the fiscal year ending June 30, 1968, and such sums as may be necessary for the next four fiscal years,".

(2) Subsection (d) (7) of such section is amended by adding at the end thereof the following new stentence: "Effective with respect to allotments under this subsection for fiscal years ending after June 30, 1968, at least 70 per centum of such amount reserved for mental health services 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 the State plan of services in communities of the State."

(e) Subsection (e) of such section is amended by striking out "$62,500,000 for the fiscal year ending June 30, 1968," and inserting in lieu thereof "$70,000,000 for the fiscal year ending June 30, 1968, and such sums as may be necessary for the next four fiscal years".

(f) Effective July 1, 1967, subsection (c) of section 309 of such Act (42 U.S.C. 242g(c)), as amended by section 4 of the Comprehensive Health Planning and Public Health Services Admendments of 1966 (Public Law 89-749), is amended by striking out "each" after "$5,000,000" and by inserting after "the fiscal year ending June 30, 1968," the following: "and such sums as may be necessary for the next four fiscal years,".

RESEARCH AND DEMONSTRATIONS RELATING TO HEALTH FACILITIES AND SERVICES

SEC. 3. (a) Section 304 (42 U.S.C. 242b) of the Public Health Service Act is amended to read as follows:

"RESEARCH AND DEMONSTRATIONS RELATING TO HEALTH FACILITIES AND SERVICES

"SEC. 304. (a) The Secretary is authorized—

"(1) to make grants to States, political subdivisions, universities, hospitals, and other public or nonprofit private agencies, institutions, or organizations for projects for the conduct of research, experiments, or demonstrations (and related training), and

"(2) to make contracts with public or private agencies, institutions, or organizations for the conduct of research, experiments, or demonstrations (and related training), relating to the development, utilization, quality, organization, and financing of services, facilities, and resources of hospitals or other medical facilities (including, for purposes of this section, facilities for the mentally retarded, as defined in the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963), agencies, institutions, or organizations or to development of new methods or improvement of existing methods of organization, delivery, or financing of health services, including, among others—

"(A) projects for the construction of units of hospitals or other medical facilities which involve experimental architectural designs or functional layout or use of new materials or new methods of construction, the efficiency of which can be tested and evaluated, or which involve the demonstration of such efficiency, particularly projects which also involve research, experiments, or demonstrations relating to delivery of health services, and

"(B) projects for development and testing of new equipment and systems, including automated equipment, and other new technology systems or concepts for the delivery of health services.

"(b) Except where the Secretary determines that unusual circumstances make a larger percentage necessary in order to effectuate the purposes of this section, a grant or contract under this section with respect to any project for construction of a facility or for acquisition of equipment may not provide for payment of more than 50 per centum of so much of the cost of the facility or equipment as the Secretary determines is reasonably attributable to research, experimental, or demonstration purposes. The provisions of clause (5) of the third sentence of section 605(a) and such other conditions as the Secretary may determine shall apply with respect to grants or contracts under this section for projects for construction of a facility or for acquisition of equipment.

"(c) Payments of any grants or under any contracts under this section may be made in advance or by way of reimbursement, and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this section.

"(d) There are authorized to be appropriated for payment of grants or under contracts under this section $20,000,000 for the fiscal year ending June 30, 1968, and such sums as may be necessary for succeeding fiscal years; except that, for any fiscal year ending after June 30, 1968, such portions of such sums as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this section."

(b) Effective with respect to appropriations for fiscal years ending after June 30, 1967—

(1) section 624 of such Act is repealed; and

(2) the first sentence of section 314(e) of such Act is amended by inserting "or" at the end of clause (1), by striking out clause (3), by striking out ", or" at the end of clause (2), by inserting "(including related training)" after "providing services" in clause (1), and by amending clause (2) to read: "(2) developing and supporting for an initial period new programs of health services (including related training)"; and

(3) the second sentence of such section 314(e) is amended by striking out "or (2)".

Any sums appropriated for the fiscal year ending June 30, 1968, for carrying out such sections 624 and 314(e)(3) which remain unobligated on the date of enactment of this Act shall be available for carrying out section 304 of the Public Health Service Act, and the total of such sums (and any portion of the appropriations for such year for such purpose obligated prior to such date of enactment in carrying out such sections) shall be deducted from the authorization for such year contained in such section 304.

COOPERATION WITH STATES IN EMERGENCIES

SEC. 4. Section 311 of the Public Health Service Act (42 U.S.C. 243) is amended by inserting at the end thereof the following new subsection:

"(c) The Secretary may enter into agreements providing for cooperative planning between Public Health Service medical facilities and community health facilities to cope with health problems resulting from disasters, and for participation by Public Health Service medical facilities in carrying out such planning. He may also, at the request of the appropriate State or local authority, extend temporary (not in excess of forty-five days) assistance to States or localities in meeting health emergencies of such a nature as to warrant Federal assistance. The Secretary may require such reimbursement of the United States for aid (other than planning) under the preceding sentences of this subsection as he may determine to be reasonable under the circumstances. Any reimbursement so paid shall be credited to the applicable appropriation of the Public Health Service for the year in which such reimbursement is received."

CLINICAL LABORATORIES IMPROVEMENT

SEC. 5. (a) Part F of title III of the Public Health Service Act (42 U.S.C. 262–3) is amended by changing the title to read: "LICENSING—BIOLOGICAL PRODUCTS AND CLINICAL LABORATORIES", and by adding after section 352 (42 U.S.C. 263) the following new section:

"LICENSING OF LABORATORIES

"SEC. 353. (a) As used in this section—

"(1) the term 'laboratory' or 'clinical laboratory' means a facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body, for the purpose of obtaining information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, man;

"(2) the term 'interstate commerce' means trade, traffic, commerce, transportation, transmission, or communication between any State, territory, or possession of the United States, the Commonwealth of Puerto Rico, or the District of Columbia and any place outside thereof; or within the District of Columbia, the Commonwealth of Puerto Rico, or any territory or possession of the United States.

"(b) No person may solicit or accept in interstate commerce, directly or indirectly, any specimen for laboratory examination, nor introduce or deliver for introduction into interstate commerce, directly or indirectly, any specimen with respect to which a laboratory has performed, or alleges to have performed, one or more laboratory procedures, or introduce, or deliver for introduction into interstate commerce, directly or indirectly, the results of or any report on any such procedures, unless there is in effect a license for such laboratory issued by the Secretary under this section applicable to such procedures.

"(c) A license issued by the Secretary under this section may be applicable to all laboratory procedures or only to specified laboratory procedures or categories of laboratory procedures.

"(d)(1) A license shall not be issued in the case of any clinical laboratory unless (A) the application therefor contains or is accompanied by such information and assurances as the Secretary finds necessary, and (B) the applicant agrees and the Secretary determines that such laboratory will be operated in accordance with standards found necessary by the Secretary to carry out the purposes of this section.

"(2) A license issued under this section shall be valid for a period of three years, or such shorter period as the Secretary may establish for any clinical laboratory or any class or classes thereof; and may be renewed in such manner as the Secretary may prescribe.

"(3) The Secretary may, if he deems it appropriate, require payment of fees for the issuance and renewal of licenses, but the amount of such fees shall not exceed such sum (which in no event may be more than the sum determined by him to be necessary on the average to provide, maintain, and equip an adequate service for the purpose) as the Secretary may by regulation prescribe from time to time.

"(e) A laboratory license may be revoked, suspended, or limited if the Secretary finds, after reasonable notice and opportunity for hearing to the owner or operator of the laboratory, that such owner or operator or any employee of the laboratory—

"(1) has been guilty of misrepresentation in obtaining the license;

"(2) has engaged or attempted to engage or represented himself as entitled to perform any laboratory procedure or category of procedures not authorized in the license;

"(3) has failed to comply with the standards with respect to laboratories and laboratory personnel prescribed by the Secretary pursuant to this section;

"(4) has failed to comply with reasonable requests of the Secretary for any information or materials, or work on materials, he deems necessary to determine the laboratory's continued eligibility for its license hereunder or continued compliance with the Secretary's standards hereunder;

"(5) has refused a request of the Secretary or any Federal officer or employee duly designated by him for permission to inspect the laboratory and its operations and pertinent records at any reasonable time; or

"(6) has violated or aided and abetted in the violation of any provisions of this section or of any rule or regulation promulgated thereunder.

"(f) The license of any laboratory under this section may be temporarily suspended without a hearing for a period of not to exceed 60 days if the Secretary determines that the public safety or welfare would otherwise be in imminent danger.

"(g)(1) Any party aggrieved by any final action taken under this section may at any time within sixty days after the date of such action file a petition with the United States court of appeals for the circuit wherein such person resides or has his principal place of business, for judicial review of such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary or other officer designated by him for that purpose. The Secretary thereupon shall file in the court the record on which the action of the Secretary is based, as provided in section 2112 of title 28, United States Code.

"(2) If the petitioner applies to the court for leave to adduce additional evidence, and shows to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the Secretary, the court may order such additional evidence (and evidence in rebuttal thereof) to be taken before the Secretary, and to be adduced upon the hearing in such manner and upon such terms and conditions as the court may deem proper. The Secretary may modify his findings as to the facts, or make new findings, by reason of the additional evidence so taken, and he shall file such modified or new findings, and his recommendations, if any, for the modification or setting aside of his original action, with the return of such additional evidence.

"(3) Upon the filing of the petition referred to in paragraph (1) of this subsection, the court shall have jurisdiction to affirm the atcion, or to set it aside in whole or in part, temporarily or permanently. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive.

"(4) The judgment of the court affirming or setting aside, in whole or in part, any such action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

"(h) Any person who violates any provision of this section or any rule or regulation promulgated thereunder shall be guilty of a misdemeanor and shall on conviction thereof be subject to imprisonment for not more than one year, or a fine of not more than $1,000, or both such imprisonment and fine.

"(i) The provisions of this section shall not apply to any clinical laboratory operated by a licensed physician, osteopath, or podiatrist who performs laboratory tests or procedures, personally or through his employees, solely as an adjunct to the treatment of his own patients.

"(j) In carrying out this functions under this section, the Secretary is authorized, pursuant to agreement, to utilize the services or facilities of any Federal or State or local public agency or nonprofit private agency or organization, and may pay therefor in advance or by way of reimbursement, and in such installments, as he may determine.

"(k) Nothing in this section shall be construed as affecting the power of any State to enact and enforce laws relating to the matters covered by this section to the extent that such laws are not inconsistent with the provisions of this section or with the rules and regulations issued under this section."

(b) The amendment made by subsection (a) shall become effective on the first day of the thirteenth month after the month in which it is enacted, except that the Secretary of Health, Education, and Welfare may postpone such effective date for such additional period as he finds necessary, but not beyond the the first day of the 19th month after such month in which the amendment is enacted.

(c) This section may be cited as the "Clinical Laboratories Improvement Act of 1967".

VOLUNTEER SERVICES

SEC. 6. Title II of the Public Health Service Act is amended by adding after section 222 (42 U.S.C. 217a) the following new section:

"VOLUNTEER SERVICES

"SEC. 223. Subject to regulations, volunteer and uncompensated services may be accepted by the Secretary, or by any other officer or employee of the Department of Health, Education, and Welfare designated by him, for use in the operation of any health care facility or in the provision of health care."

COOPERATION AS TO MEDICAL CARE FACILITIES AND RESOURCES

SEC. 7. Part C of title III of the Public Health Service Act is amended by adding after section 327 (42 U.S.C. 254) the following new section:

"SHARING OF MEDICAL CARE FACILITIES AND RESOURCES

"SEC. 328. (a) For purposes of this section—

"(1) the term 'specialized health resources' means health care resources (whether equipment, space, or personnel) which, because of cost, limited availability, or unusual nature, are either unique in the health care community or are subject to maximum utilization only through mutual use;

"(2) the term 'hospital', unless otherwise specified, includes (in addition to other hospitals) any Federal hospital.

"(b) For the purpose of maintaining or improving the quality of care in Public Health Service facilities and to provide a professional environment therein which will help to attract and retain highly qualified and talented health personnel, to encourage mutually beneficial relationships between Public Health Service facilities and hospitals and other health facilities in the health care community, and to promote the full utilization of hospitals and other health facilities and resources, the Secretary may—

"(1) enter into agreements or arrangements with schools of medicine, and with other health schools, agencies, or institutions, for such interchange or cooperative use of facilities and services on a reciprocal or reimbursable basis, as will be of benefit to the training or research programs of the participating agencies; and

"(2) enter into agreements or arrangements with hospitals and other health care facilities for the mutual use or the exchange of use of specialized health resources, and providing for reciprocal reimbursement.

Any reimbursement pursuant to any such agreement or arrangement shall be based on charges covering the reasonable cost of such utilization, including normal depreciation and amortization costs of equipment. Any proceeds to the Government under this subsection shall be credited to the applicable appropriation of the Public Health Service for the year in which such proceeds are received."

PROGRAM EVALUATION

SEC. 8. (a) Paragraph (1) of section 314(d) of the Public Health Service Act is amended by inserting before the period at the end thereof the following: ", except that, for any fiscal year ending after June 30, 1968, such portion of such sums as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the programs authorized by this subsection and the amount available for allotments hereunder shall be reduced accordingly".

(b) Section 314(e) of such Act is amended by inserting at the end thereof the following new sentence: "For any fiscal year ending after June 30, 1968, such portion of the appropriations for grants under this subsection as the Secretary may determine, but not exceeding one per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this subsection."

(c) Section 309(c) of such Act is amended by inserting "(1)" after "except that" and by inserting before the period at the end thereof the following: ", and (2) for any fiscal year ending after June 30, 1968, such portions of the funds made available under this subsection as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this subsection".

RESEARCH CONTRACT AUTHORITY

SEC. 9. Paragraph (h) of section 301 of the Public Health Service Act (42 U.S.C. 241) is amended by striking out "during the fiscal year ending June 30, 1966, and each of the two succeeding fiscal years".

MEDICAL CARE FOR FEDERAL EMPLOYEES AT REMOTE STATIONS OF THE SERVICE

SEC. 10. (a) Section 324 of the Public Health Service Act (42 U.S.C. 251) is amended by inserting "(a)" immediately after "SEC. 324." and by redesignating clauses (a) through (d) of such section, and references thereto, as clauses (1) through (4).

(b) Section 324 of such Act is further amended by adding at the end thereof the following new subsection:

"(b) At remote medical facilities of the Public Health Service where other medical care and treatment are not available, the Secretary is authorized to provide medical, surgical, and dental treatment and hospitalization for Federal employees (as defined in section 8901(1) of title 5 of the United States Code) and their dependents. Such employees and their dependents who are not entitled to this care and treatment under any other provision of law shall be charged for it at rates established by the Secretary to reflect the reasonable cost of providing the care and treatment. Any payments pursuant to the preceding sentence shall be credited to the applicable appropriation to the Public Health Service for the year in which such payments are received."

(c) Subsection (a) of section 322 of such Act is amended by striking out paragraph (7) and by renumbering paragraph (8) as paragraph (7).

MINOR OR TECHNICAL AMENDMENTS

SEC. 11. (a) Section 806(c)(1) of the Public Health Service Act (42 U.S.C. 296e(c)(1)) is amended by inserting after "from a loan fund established pursuant to section 822" the following: "or from sums paid by the Secretary from the revolving fund created by section 827(d)".

(b) The second sentence of section 312 of such Act (42 U.S.C. 244) is amended by inserting "and officials of other State or local public or private agencies, institutions, or organizations" after " such health authorities".

(c) Section 725(a) of such Act (42 U.S.C. 293e(a)) is amended by striking out "sixteen" and inserting in lieu thereof "seventeen" and by striking out "twelve" and inserting in lieu thereof "thirteen".

(d) Section 314(f) of such Act is amended by—

(1) inserting "for" before "the expenses of travel" in paragraph (5);

(2) striking out "Service" and inserting in lieu thereof "Department" in paragraphs (6) and (8).

(e) The amendment made by subsection (a) shall be effective as of November 3, 1966.

ACCREDITATION OF NURSES EDUCATION PROGRAM

SEC. 12. Section 843(f) of the Public Health Service Act (42 U.S.C. 298b(f)) is amended by striking out "or a program accredited for the program of this Act by the Commissioner of Education,".

MEANING OF SECRETARY

SEC. 13. As used in the amendments made by this Act, the term "Secretary" means the Secretary of Health, Education, and Welfare.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., May 5, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for the views of the Bureau of the Budget on H.R. 6418, a bill cited as the "Partnership for Health Amendments of 1967."

The bill authorizes the extension and expansion of the landmark Partnership for Health legislation enacted by the 89th Congress. As the President said in his Health Message, this legislation "is designed to strengthen State and local programs and to encourage broad-gauge planning in health. It gives the States new flexibility to use Federal funds by freeing them from tightly compartmentalized grant programs." It establishes for a number of health programs a single set of requirements, a single authorization, and a single appropriation. H.R. 6418 increases the dollar authorizations for 1968, and extends the program for four additional years with the provisions that such sums as may be necessary would be authorized for appropriation after 1968.

The bill also authorizes the Secretary of Health, Education, and Welfare to embark upon a broadened and coordinated program of research, experiments, and demonstrations relating to the development, coordination, and delivery of improved health services. This provision is in accord with the President's directive that the Secretary of Health, Education, and Welfare establish a National Center for Health Services Research and Development. Its aim is the application of the research techniques, which have brought us new knowledge in health and medicine, to the effort of bringing low cost, quality health care to our citizens.

A third major provision of the proposed legislation relates to the licensing of clinical laboratories. Such licenses should be issued upon the applicant's agreeing to operate the laboratory in conformance with standards established by the Secretary. The aim of this provision is to improve the performance of clinical laboratories engaged in interstate commerce.

Additionally, the bill authorizes the Secretary to enter into agreements with health schools, hospitals, and other health care training facilities to provide for the interchange or cooperative use of personnel, facilities, services, and information, on a reciprocal or reimbursable basis. This provision is designed to increase cooperative activities between the Public Health Service's hospitals and community health facilities and will result in better utilization of scarce professional personnel and expensive facilities.

The Bureau of the Budget favors action on H.R. 6418, which is in accord with the President's program.

Sincerely yours,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., April 27, 1967.

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

DEAR MR. CHAIRMAN: This letter is in response to your request of March 13, 1967, for a report on H.R. 6418, a bill to amend the Public Health Service Act to extend and expand the authorizations for grants for comprehensive health planning and services, to broaden and improve the authorization for research and demonstrations relating to the delivery of health services, to improve the performance of clinical laboratories, and to authorize cooperative activities between the Public Health Service hospitals and community facilities, and for other purposes.

This bill, to be cited as the "Partnership for Health Amendments of 1967," would—

1. Extend through fiscal year 1972, with some modifications, the authorizations for comprehensive health planning and public health services grants and for grants to schools of public health which were enacted last year in P.L. 89–749.

2. Broaden, improve, and consolidate the authorizations now contained in sections 314(e)(3) and 624 of the Public Health Service Act for grant and contract support of research, experiments, and demonstrations relating to the development, utilization, quality, organization, and financing of health services and facilities.

3. Authorize the Secretary to cooperate with States and localities in emergency health planning and in providing temporary assistance on a reimbursable basis to meet health emergencies which warrant Federal assistance.

4. Provide for the improvement of clinical laboratory services through the establishment of a Federal licensing program for such laboratories which engage in interstate commerce.

5. Authorize the Secretary to accept volunteer and uncompensated service in the operation of any health care facility or in the provision of health care.

6. Authorize cooperative agreements or arrangements on a reciprocal or reimbursable basis between hospitals and facilities of the Public Health Service and community hospitals and other health care and educational facilities.

7. Provide that not exceeding one percent of the funds appropriated for grants under Sections 314(d), 314(e), 304 and 309(c) of the Public Health Service Act shall be available to the Secretary for evaluation of the respective programs authorized by such subsections.

8. Extend without time limitation the current authorization in Section 301(h) of the Public Health Service Act with respect to research contracts.

9. Delete the current eligibility of employees and noncommissioned officers in the field service of the Public Health Service for medical, surgical, dental, and hospital care at Public Health Service facilities when injured or taken sick in line of duty, and provide that the Secretary is authorized to provide such care on a reimbursable basis for Federal employees and their dependents at remote medical facilities of the Public Health Service where other medical care and treatment are not available.

10. Delete the provision in Section 843(f) of the Public Health Service Act which currently authorizes the Commissioner of Education to accredit schools of nursing for purposes of participation in programs under the Nurse Training Act.

H.R. 6418 embodies the provisions of a draft bill transmitted by this Department to the Congress to implement a number of recommendations by the President relating to public health.

We strongly recommend early enactment of the bill.

We are advised by the Bureau of the Budget that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely,

WILBUR J. COHEN,
Under Secretary.

DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, D.C., May 24, 1967.

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

DEAR MR. CHAIRMAN: This is in reply to your request for our comments on H.R. 6418, the "Partnership for Health Amendments of 1967."

We support the proposed bill which would strengthen and extend State and local health programs, and thus carry out the President's recommendations for strengthening our Partnership for Health.

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

Sincerely,

W. WILLARD WIRTZ,
Secretary of Labor.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., April 27, 1967.

B-157924.

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

DEAR MR. CHAIRMAN: Your letter of March 13, 1967, requests our comments on H.R. 6418, which, if enacted, would be cited as the "Partnership for Health Amendments of 1967."

The purpose of the bill is stated in its title as being to amend the Public Health Service Act to extend and expand the authorizations for grants for comprehensive health planning and services, to broaden and improve the authorization for research and demonstrations relating to the delivery of health service, to improve the performance of clinical laboratories, and to authorize cooperative activities between the Public Health Service hospitals and community facilities, and for other purposes. We offer the following comments for consideration by your committee.

Section 3 of H.R. 6418 would provide for the replacement of the existing section 304 of the Public Health Service Act (42 U.S.C. 242b) with new provisions authorizing the Secretary, Department of Health, Education, and Welfare (hereinafter referred to as the Secretary) to make project grants to States and other public or nonprofit organizations, and to enter into contracts with public or private organizations, for the conduct of research, experiments, or demonstrations relating to the development, utilization, and coordination of new or existing services provided by medical facilities and new or existing methods of organization, delivery, or financing of health services. The amount of any grant or contract for construction or acquisition of equipment may not, except in unusual circumstances, exceed 50 percent of the cost of the project as determined by the Secretary.

We believe that the committee may wish to include in the bill language, similar to that now provided in legislation applicable to other construction grant programs now authorized by the Public Health Service Act, to provide for the return to the Federal Government of all or a portion of the Federal grant assistance for the construction or the purchase of facilities or equipment in the event such facilities or equipment cease to be used for the purposes for which constructed or purchased. For example, section 624, title VI, Public Health Service Act (which would be repealed by section 3(b) of H.R. 6418) concerning studies and demonstrations relating to coordinated use of hospital facilities including the construction of units of hospitals or other medical facilities which involve experimental architectural designs or functional layout, provides for the recovery of a portion of the Federal participation if, within 20 years after the completion of construction, the applicant or other owner of the facility shall cease to be a public or other nonprofit institution or organization, or the facility shall cease to be used for the purposes for which it was constructed.

Section 4 of H.R. 6418 would authorize the Secretary, at the request of the appropriate State or local authority, to extend temporary (not in excess of 45

days) assistance to States or localities in meeting health emergencies of such nature as to warrant Federal assistance. Also, this section provides that that the Secretary may require such reimbursement of the United States for aid as the Secretary may determine to be reasonable under the circumstances. Rather than to leave this determination to the Secretary's discretion, we believe that the committee may wish to amend the bill to make it mandatory that the Secretary make a formal determination as to the amount, if any, of the reimbursement which would be reasonable under the circumstances.

Section 5 of H.R. 6418 would amend the Public Health Service Act to include a new section 353 relating to the licensing of clinical laboratories by the Secretary. The proposed new section 353(d)(3) would provide that the Secretary may, if he deems it appropriate, require payment of fees for the issuance and renewal of licenses, but the amount of such fees shall not exceed such sum (which in no event may be more than the sum determined by him to be necessary on the average to provide, maintain, and equip an adequate service for the purpose) as the Secretary may by regulation prescribe from time to time.

The licensing of the clinical laboratories, in our opinion, appears to be a type of service which would be within the intent of legislation enacted in 1951 (5 U.S.C. 140) which states that it is the sense of the Congress that an agency shall charge a fair and equitable fee for "* * * any work, service publication, report, document, benefit, privilege, authority, use, franchise, license, permit, certificate, registration, or similar thing of value or utility performed, furnished, provided, granted, prepared, or issued by any Federal agency * * *." The committee may wish to amend the bill to require that fees for the furnishing of licenses be established pursuant to criteria set forth in 5 U.S.C. 140, rather than leaving the matter to the Secretary's discretion.

H.R. 6418 would provide for a number of amendments to section 314 of the Public Health Service Act including extension and expansion of formula grants to States for comprehensive health planning and public health services. As part of our review of formula grants to States for health services, we issued a report to the Congress on our review of financial administration of selected grants for health services made to the State of Indiana, dated September 23, 1966, B–156635. In this report, we pointed out that the use of research expenditures for matching formula control grants by the State, in our opinion, is not in accord with the purpose of control programs which, as stated by the House Committee on Interstate and Foreign Commerce in House Report 2144, dated June 2, 1948, is to bridge the gap between basic research discoveries and their application to the benefit of disease victims. Therefore, in our opinion, there is ample support for the view that the basic research expenditures in question are not valid for matching purposes. Because the Public Health Service expressed the view that in the absence of specific prohibitions to the contrary, such expenditures were legally acceptable and valid for State matching purposes, we proposed in our report that the Congress may wish to consider amending the Public Health Service Act to specifically preclude the use of basic research expenditures as allowable State matching funds for formula control programs. Accordingly, the committee may wish to amend the bill in this regard.

Sections 314(a)(2)(G) and 314(d)(2)(H) of the Public Health Service Act, as amended by section 3 of the Comprehensive Health Planning and Public Health Services Amendments of 1966, Public Law 89–749, concerning grants for comprehensive health planning and public health services, 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)(2)(I) and 314(d)(2)(I) 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 1966 amendments or in the current bill 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 1966 amendments or in the current 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 grants 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 grant programs contained in the 1966 amendments and the current bill. 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 299i of title 42, United States Code.

Sincerely yours,

FRANK H. WEITZEL,
Assistant Comptroller General of the United States.

U.S. CIVIL SERVICE COMMISSION,
Washington, D.C., June 2, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Rayburn House Office Building.

DEAR MR. CHAIRMAN: This is in further reference to your request for the Commission's views on H.R. 6418, a bill to amend the Public Health Service Act to extend and expand the authorizations for grants for comprehensive health planning and services, to broaden and improve the authorization for research and demonstrations relating to the delivery of health services, to improve the performance of clinical laboratories, and to authorize cooperative activities between the Public Health Service hospitals and community facilities, and for other purposes.

The Commission favors the enactment of H.R. 6418. Its comments are limited to sections 6, 7, and 10 of the bill.

Section 6 would add a new section 223 to title II of the Public Health Service Act authorizing the acceptance of volunteer and uncompensated services for use in the operation of any health care facility. Presumably the intent of this is to permit the acceptance of services of "gray ladies", and "candy stripers".

The utilization of such volunteers is a common practice in most private hospitals, and there is no objection to the authorization of similar services for Public Health Service facilities, as long as it is understood that these personnel will not be used to occupy positions normally designated for Federal personnel.

Section 7 would amend part C of title II of the Public Health Service Act by adding a new section 328 concerning the sharing of medical facilities and resources. Subsection 328(b)(1) provides authority for the Secretary to enter into agreements or arrangements with schools of medicine and other agencies and institutions for the "interchange or cooperative use of facilities and services on a reciprocal or reimbursable basis."

This provision might conceivably be interpreted as authorizing the interchange of personnel between the Public Health Service and non-Federal health facilities. However, the Commission understands that this provision is not intended to be used for personnel interchange and with that understanding, the Commission has no objection to it.

Section 10 of the bill would (1) repeal section 322(a)(7) of the Public Health Service Act which authorizes free medical services for civilian field employees of the Public Health Service, and (2) authorize the Secretary to provide medical

services, on a reimbursable basis, for Federal employees and their dependents at remote stations where other medical care is not available.

Under present law, civilian field service employees of the Public Health Service are entitled to special medical benefits which are not available to other civilian employees of the United States. Whatever the basis may have been for this preferential treatment of a small number of Federal employees, changing times and the availability of the Government-wide Health Benefits Program have made its continuance inappropriate. This bill would assure that civilian field service employees of the Public Service would receive only those medical services which are available to other Federal employees similarly situated. At the same time, this bill would help to assure adequate medical care for Federal employees in isolated areas, such as Public Health Service field employees in the Indian Health program.

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 and enactment of H.R. 6418 would be in accord with the President's program.

By direction of the Commission:

Sincerely yours,

JOHN W. MACY, JR., *Chairman.*

ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS,
Washington, D.C., May 4, 1967.

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

DEAR MR. CHAIRMAN: I am writing to comment on H.R. 6418, the "Partnership for Health Amendments of 1967." The bill would make a number of amendments to the Public Health Services Act, including extending and expanding authorizations for grants for comprehensive health planning and services. Our comments will be directed to this aspect of the bill only. The Commission has urged greater flexibility in Federal health grants and expressed support for last year's bills which established the Partnership for Health program.

In a 1961 report, *Modification of Federal Grants-in-Aid for Public Health Services*, the Advisory Commission recommended that States be authorized to transfer up to one-third of Federal public health funds in any one grant category to other categories. The Commission took this position in the belief that States should be given more discretion in applying the grant funds in areas of greatest need and that the narrow categories of the then existing public health grant system imposed undue rigidity. The Commission was gratified, therefore, when the Administration proposed and the Congress enacted the Comprehensive Health Planning and Public Health Services Amendments of 1966 which provided for administering Federal health grants through State comprehensive health plans and the use of block grants for formerly categorical grant programs.

The reaction to the new program has been most gratifying. It has been widely supported as providing a simplification of procedures and a greater adaptability to State and local needs. The President pointed out in his "Quality of American Government" message earlier this year that last year's Partnership for Health Act points the way * * *" to a consideration of fundamental restructuring of grant-in-aid programs. The Commission endorses the objectives of Sections 2(a) and 2(d) of this bill, which would extend for four years the comprehensive health planning and block grant features of the 1966 act.

We urge that consideration be given by the committee to an additional proposal as means of strengthening the Federal-State-local partnership in public health administration; namely, modification of the "single State agency" requirement for various public health grant categories so that, subject to approval of an alternative arrangement by the Secretary of Health, Education, and Welfare, States would have flexibility to develop the administrative structure suited to their overall needs. This could be accomplished by the following amendment:

"Notwithstanding any other Federal law which provides that a single State agency or multimember board or commission must be established or designated to administer or supervise the administration of any public health program, the Secretary of Health, Education, and Welfare may, upon request of the Governor or other appropriate executive or legislative authority of the State responsible for determining or revising the organizational structure of State

government, waive the single State agency or multimember board or commission provision upon adequate showing that such provision prevents the establishment of the most effective and efficient organizational arrangements within the State government and approve other State administrative structure or arrangements: *Provided*, That the Secretary determines that the objectives of the Federal statute authorizing the public health program will not be endangered by the use of such other State structure or arrangements."

The language suggested is similar to that contained in the proposed Intergovernmental Cooperation Act (H.R. 5522) which is strongly supported by this Commission.

These views are those of the Advisory Commission and its staff and do not necessarily reflect those of the Administration.

I hope they will assist the Committee in its deliberations on this significant legislation.

Sincerely yours,

FARRIS BRYANT, *Chairman.*

The CHAIRMAN. Our first witness this morning is the Under Secretary of the Department of Health, Education, and Welfare, Mr. Wilbur J. Cohen, accompanied by Dr. William H. Stewart, the Surgeon General of the United States, and his associates.

Mr. Cohen, we are very happy to have you with us today, and you may proceed with your statement in any way that you see fit.

STATEMENT OF WILBUR J. COHEN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY WILLIAM H. STEWART, M.D., SURGEON GENERAL; DAVID J. SENCER, M.D., DIRECTOR, COMMUNICABLE DISEASE CENTER; AND PAUL Q. PETERSON, M.D., DEPUTY DIRECTOR, BUREAU OF HEALTH SERVICES, PUBLIC HEALTH SERVICE

Mr. COHEN. Thank you, Mr. Chairman.

Also accompanying me at the table is Dr. Paul Peterson, the Deputy Director of the Bureau of Health Services in the Public Health Service, to my right, and Dr. David Sencer, the Director of the National Communicable Disease Center, on my left.

Mr. Chairman and members of the committee, I am pleased to be here with Dr. William H. Stewart, Surgeon General of the Public Health Service to give the Department's wholehearted and enthusiastic support to the Partnership for Health Amendments of 1967, H.R. 6418, introduced by the distinguished chairman of the committee, Mr. Staggers.

I might ask, Mr. Chairman, to put into the record at the conclusion of my testimony a tabular analysis of the provisions of the bill. As you pointed out, there are several different subsections of the bill, and I think this summary of it would help the committee when it gets to reviewing the legislation. (See p. 22.)

The CHAIRMAN. As a part of your testimony it will be carried in the record.

Mr. MOSS. Mr. Chairman, I wonder if we may have copies.

Mr. COHEN. I have a couple and can give you one here. Does any other member of the committee wish one?

In 1935 Congress passed the Social Security Act, and in 1936 the Congress first provided appropriations for a general health program to support any part of a State's public health program. Since that time the Federal Government has continued to be one of the major

financial partners in the Nation's health enterprise because congressional concern and public attention has been aroused by a variety of urgent, specific health problems. Federal support was provided in the form of ear-marked grants.

The result, over the past decades, has been a salutary growth in health resources and some dramatic breakthroughs in health protection.

Thirty years of Federal-State cooperation in health programs has brought us to the point where the States can and should be given a larger role and a much greater measure of flexibility in planning and carrying out health programs. Two important changes in this direction were provided by the Comprehensive Health Planning and Public Health Services Amendments of 1966: first, a real opportunity and a mechanism for the States and localities to identify their own most urgent health needs; and, second, a change in Federal funding to help them meet those needs.

I would like to also put in the record, Mr. Chairman, at the end of my testimony exactly the dates on which Congress authorized the different categorical programs that are replaced in this legislation, because I think it gives you an idea of the long history of the way in which Congress acted to get at the present stage of where some of these various categorical programs could be brought together.

The CHAIRMAN. As a part of your testimony, it will be included in the record.

Mr. COHEN. Last year we appeared before this committee in the closing days of the 89th Congress, as you indicated, to request that the Congress enact those amendments into law. We asked for your quick action at that time because we felt that it was of great importance that the principle embodied in the bill, which has now become Public Law 89–749, be made part of the structure of our national health effort. Your action was timely. We are grateful for it. I think our major concern at that time, Mr. Chairman, was to give every evidence that we wanted to strengthen the role of the State health departments with the passage of medicare and with the passage of medicaid. And a great deal of other legislation passed through this committee. It was imperative that we do everything possible to try to strengthen the role of the State health department in this rather substantial area of Federal-State health legislation that has been enacted since 1965.

President Johnson specifically recognized the importance of your action in his February 28 message to the Congress on health and education when he said:

> The Partnership for Health legislation, enacted by the 89th Congress, is designed to strengthen State and local programs to encourage broad gage planning in health. It gives the States new flexibility to use Federal funds by freeing them from tightly compartmentalized grant programs. It also allows the States to attack special health problems which have regional or local impact.

This is the heart of the new law: planning for the efficient use of resources, and sufficient flexibility to use resources efficiently. We have as a nation, Mr. Chairman, committed outselves to promoting and assuring the best level of health attainable for every person in this country. The magnitude and complexity of that commitment requires that we marshal all our available health recources, public and private, in a vital partnership to achieve this important objective. The bill be-

fore the committee would continue and expand the new partnership which the Congress created last year.

In the intervening months, since you last considered the partnership for health, the Public Health Service and the Department have become more intimately acquainted with the possibilities and problems posed by this large effort. We have begun to lay the base which is necessary to move away from the restrictive effects of fragmented and outmoded patterns. We have begun the task of creating a new relationship which can enable every sector of the total health community to provide fuller service to our citizens.

The Public Health Service has been consulting with representatives of State, county, and local governments; with university officials; with representatives of professional organizations such as the American Medical Association, the American Hospital Association, the American Public Health Association, the American Institute of Planners; and with many voluntary organizations which have a longstanding interest and involvement in health affairs. Some of them, for example, are the American Heart Association, the American Cancer Society, the National Tuberculosis Association. These meetings have done much to shape our initial thinking and indicate the direction we must take in launching this nationwide program.

Early in January, Secretary Gardner wrote to each of the Governors of the various States and expressed his belief that Public Law 89–749 is one of the most significant health measures passed by the Congress.

The response from the States to the Secretary's letter has been most gratifying. The Honorable William L. Guy, Governor of the State of North Dakota and chairman of the National Governors' Conference, wrote to the Governor of each State, saying:

> This new health legislation could be a milestone in our continuing progress toward improved Federal-State relations.

Then, Governor Guy wrote this to President Johnson:

> When you signed into law Public Law 89–749, known as the "Comprehensive Health Planning and Public Health Services Amendments for 1966," you gave Federal aid an historic turn for greater Federal-State relations. The act will now permit total comprehensive planning in the field of health.

The Honorable Hulett C. Smith, Governor of the State of West Virginia, wrote to say that "West Virginia is eager to take full advantage of the comprehensive Health Planning and Public Health Service Amendments."

Governor Harold LeVander, of Minnesota, concluded his letter to the Secretary by saying:

> * * * This program will undertake to assess the present level of health programming and health resources. This assessment, I am confident, will lead to improved and more efficient programs and to fruitful working relationships between the health consumer, the governmental, the private and the voluntary health agencies in our State.

I might add, Mr. Chairman, that Secretary Gardner, the Surgeon General, and myself, and various members of our staff, met with the executive committee of the Governors' Conference of which Governor Guy is chairman, with about eight or nine other Governors, and they evidenced the most complete cooperation in making this new law a success. They are very enthusiastic about its potentialities, as are we.

Thirty-seven States, the territories, and Puerto Rico, each have already designated a comprehensive health planning agency. We believe that the remaining States will take action to designate an agency within the very near future. I might say, Mr. Chairman, that I am hopeful that more States will designate it, because with the reporting out by the full Appropriations Committee of the supplemental for 1967 I think other States will be encouraged rapidly to designate the State agencies.

We are greatly encouraged, Mr. Chairman, by the very deep interest and marked enthusiasm which the States have shown in this new program.

Section 2 of this comprehensive bill which deals with the comprehensive changes embodies no major changes in philosophy, direction, or emphasis from Public Law 89-749. It extends and expands the authorizations for grants for comprehensive health planning and services which were provided last year. The important innovations enacted last year are preserved in full in the bill before you—

The concept of comprehensive health planning to be undertaken by the States with Federal grant support;

The extension of areawide planning of facilities to encompass all health services;

The training of the personnel necessary for these planning efforts;

The new program of flexible assistance through State formula grants, without categorical restriction, for the public health services the States need the most;

The broad project grant authority for the stimulation of new kinds of services, and for dealing with special types of problems.

The bill extends the authorization for each of these aspects of the program through fiscal 1972. It would increase the authorizations for assistance to the States for planning activities, under section 314(a) of the Public Health Service Act, from the present $5 million to $7 million for fiscal year 1968. It would extend for an additional 4 years, the authorization for grants to schools of public health. It would also increase the authorizations for both formula grants under section 314(d) and project grants under section 314(e) from the present $62.5 million to $70 million for fiscal 1968. Funds to support these increased authorizations are included in the President's 1968 budget request. Formula grants to the States in fiscal 1967, under the previous Public Health Service Act authorization, were at a level of approximately $55 million annually, and assistance under the project grant authorizations was at a level of $58 million annually. A large proportion of the funds authorized under the Partnership for Health Amendments for fiscal 1968 are likely to be committed by the States to programs approved and begun in earlier years. Therefore, the $70 million authorization for fiscal 1968 will thus allow for only a modest expansion in these activities, and result in a roughly constant Federal share of of the total cost.

There is little doubt that diversity of needs and resources extends down into the localities within the States; and the partnership for health legislation recognizes this, both in the planning and funding of health services. Local planning is an essential base for the statewide planning effort. Local participation and knowledge of the area to be served can best come from the areawide planning groups. The

provision in this bill that at least 70 percent of the allotments for support of health services shall be available only for services in communities is further evidence of the desire to move planning and program closer to the people and the locality to be served.

The new project grant authority in section 314(e) is also broad and flexible. It will permit the development and initial support of health services and will make it possible to mount narrower, targeted attacks on problems of limited geographical scope or of special regional or special national significance.

The combination of these two approaches, a highly focused developmental effort and flexible support for continuing service offers, we believe, a framework within which the comprehensive planning carried out by States and localities can be meaningfully translated into the highest quality health care.

The Congress has done much in the past several years to meet the justifiable expectations of the American people that this country can and will provide the best in health care to all its citizens. Medicare and medicaid are major steps in removing financial barriers to health care, and it placed a very great responsibility on State health department in carrying out this area of work.

This committee has recommended a series of laws which are building up the basic resources necessary to produce an adequate supply of trained manpower and womanpower in the health fields. Since 1946 we have been redressing imbalances and inadequacies in the supply and distribution of health facilities. And we have begun a program which will create a network of services designed to reduce the lives lost to heart, cancer, stroke, and other major diseases. Each of these individual steps was important; each was basic. We have now reached a stage really where harder tasks must be faced. We must find ways to make the total organization of our health efforts in the Nation as efficient as possible. The partnership for health is an indispensable element in reaching that goal.

HEALTH SERVICES RESEARCH AND DEVELOPMENT

I would now like to go on, Mr. Chairman, to another section in the bill, section 3, relating to research and demonstrations relating to health facilities and services. Because, as I have just pointed out, I think the next great step in our whole health field is how to bring a greater degree of coordination and efficiency and productivity, if I may put it that way, into the whole health area. At the present time we are spending in the Nation about $43 billion a year for all health services. This has been going up at a rate of about $3 billion a year, so that in the next couple of years we are going to be reaching the total of over $50 billion a year in the whole field of health and medical care.

President Johnson, in his health and education message, pointed out that despite a $43 billion annual expenditure for health and medical care our system of providing health services is not operating as efficiently and effectively as it should. The Congress has done much to train the manpower, to build the facilities, through the Hill-Burton Act, and to pay for the services through medicare and medicaid, which

the American people demand and require. We have not, however, done nearly enough to mobilize our universities, our industries, our private practitioners, and research institutions to seek new ways of providing medical services and to hold down the cost of health care. Research and development can greatly improve the health services system. Yet today, the governmentwide total investment in health services research amounts to less than one-tenth of 1 percent of our total annual investment in health care.

A major concern of the Department of Health, Education, and Welfare is to create a research and development program which will bring health services to a level of productivity which compares favorably in efficiency and effectiveness with biomedical science, on the one hand, and with some of our most advanced industries, on the other.

We must accomplish this if for no other reason than that health and medical care prices are rising rapidly. And, Mr. Chairman, any reasonable forecast that we have been able to make is that these prices will continue to increase for some time into the future. Secretary Gardner recently transmitted to President Johnson a report on the problem, and the Department has called a conference on medical care costs, to be held in Washington, D.C., on June 27. Experts from all segments of the health industry have been invited to attend and will search for the best ways to retard the rate of increase of the cost of medical care—of course, always consistent with our objective of trying to provide and improve the highest quality of medical care in the Nation.

Section 3 of H.R. 6418 would give us the broadest, most flexible kind of authority to employ the Nation's best minds, wherever they are, to design the facilities, design the information systems, develop the training methods and the more efficient patterns of health services we must have. Much knowledge, and many new technological developments already exist and we can take advantage of them immediately.

An early step that we are planning to take is the establishment within the Public Health Service of a National Center for Health Services Research and Development. The National Center will be responsible for administering coordinated grant and contract assistance for research and development in the entire health enterprise system, as well as for establishing and maintaining a flow of carefully evaluated research and development results to health service agencies and to practitioners throughout the country.

We must clearly identify the working, dynamic elements of health services. We must understand what they contribute to health, and we must select the critical points at which well-designed experiments will result in more effective medical results, greater efficiency in terms of dollar costs and other scarce resources, and greater availability of services to all of our people.

The health industry today, Mr. Chairman, employs well over 3 million people in the United States, and you can see that this very gigantic industry so important to our national life is important and essential, and we believe that there are six major areas, in which we plan to carry out research and development to bring a greater degree of efficiency and productivity to this whole industry. First, in the field of medical services the work of physicians, nurses, and other health

personnel as they engage in direct patient care in individual practice, group practices, hospitals and their clinics, nursing homes, official health agencies, and the patient's own home. The whole development of alternative methods of care, so that we don't use the most costly form of medical care but rather the least costly consistent with the medical needs of the patient is one of the most important areas for further research and development.

Second, instrumentation and automation of medical and other health services; the rapidly increasing use of electronic and other equipment to assist in diagnosis, patient monitoring and therapy, medical record handling, and overall control of medical care processes. I think all of you who have been to hospitals and medical facilities recently are aware of the tremendous increase in technical equipment and automation that is going on, and I am sure in the next decade that is going to proceed at even a faster rate than ever before.

Third, the area of facility design, organization, and operation of hospitals and other medical and health care facilities and their organization and administration. Certainly there is a great deal to be learned about how these facilities can be built more efficiently, how they can be operated more efficiently, and how the unit costs can be kept from rising as fast as they have been.

The next area is health economics: the analysis of the role of the health industry in the economy as a whole as well as cost of benefit and other studies of the efficiency and effectiveness of specific programs and systems. As I pointed out, with nearly $50 billion shortly going into the whole health system of the country, we have to be more concerned about the efficiency of every dollar that is increased in this whole field.

Social analysis: the study of social and psychological factors influencing individuals and groups in their health habits and their use of available services, and the understanding of factors which affect the operation of health institutions and programs. There is still a lot to be learned, Mr. Chairman, as to why utilization rates for hospital care and utilization rates for physicians and home nursing and home health services differ so widely in various parts of the United States. What are the different patterns of care that are given, and how are the most efficient ones to be used throughout the country?

Finally, general systems analysis, organization, and planning: the application of systems analysis to the health industry as a whole and to its components, giving attention to the processes of health planning and organization in entire communities from a research and developmental viewpoint.

These six areas that I have outlined span all of health services. Obviously they cover an enormous network of scientific, technical, and behavioral activities. To work on one, or only a few of the elements would be futile—each aspect of the problem affects the other.

This is a research program in which private industry and operating service programs have much to contribute, as do the universities, the medical, the public health schools, and other health professional schools, and the nonprofit research agencies. The Department and the Public Health Service will spare no effort to enlist the best thought, the most vigorous individuals and institutions, and the best adminis-

trative methods in this cause, Mr. Chairman, of bringing a greater degree of efficiency and productivity and more coordinated organization to the whole health industry.

CLINICAL LABORATORY IMPROVEMENT

I would now like to turn to section 5 of the bill. Section 5 of the bill is entitled the "Clinical Laboratories Improvement Act of 1967," and was recommended by the President in his message to the Congress on consumer interests. It would authorize the Secretary of Health, Education, and Welfare to regulate by licensing clinical laboratories which operate in interstate commerce.

Every day the lives of thousands of people depend upon the accuracy of the tests performed in such laboratories. I think many of you who read some of the press statements and statements before other committees were as shocked as I was when studies by the National Communicable Disease Center, and others, indicate that unsatisfactory performance is demonstrated by 10 to 40 percent of laboratories in bacteriological testing; by 30 to 50 percent in various simple clinical chemistry tests; by 12 to 18 percent in blood grouping and typing; by 20 to 30 percent in hemoglobin measurements; by 40 to 80 percent in differential characterization of blood cells; and by 20 to 30 percent in measurement of serum electrolytes. There also exists considerable variation in results from laboratory to laboratory. This information indicates that erroneous results are obtained in more than 25 percent of all tests analyzed by these studies. Clinical laboratory testing is a large and rapidly growing industry. Virtually every person who seeks medical attention uses—directly or indirectly—laboratory services.

A significant share of those services is provided by laboratories which send both reports and materials across State lines at distances remote from the physicians requesting the analyses.

The problem of regulating the interstate operation of clinical laboratories is one which the States alone are unable to cope with effectively. In most States, there is no effective regulation, even of those laboratories which operate wholly within the State. The interstate clinical laboratory industry is potentially either a major resource for the improvement of our Nation's health, or a national health hazard, depending upon its performance and reliability.

This legislation is designed to assure both physicians and their patients that the work done by a laboratory of their choice will be consistent, performed under responsible supervision, and within established clinically sound procedures.

I hope very much, Mr. Chairman, that the committee will see fit to endorse and enact section 5 of the bill dealing with the clinical laboratories improvements, which we think is extremely important. There are a number of other provisions in this bill. Dr. Stewart now is going to deal with them.

I want to thank you again, Mr. Chairman, for the opportunity to appear before you today, and I certainly urge your committee's early and favorable action on this important bill.

Thank you.

(The material referred to in Secretary Cohen's testimony follows:)

OUTLINE OF PROVISIONS OF H.R. 6418, PREPARED BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Section 1. Short title: "Partnership for Health Amendments of 1967."

Section 2 extends and revises authorities for grants for comprehensive health planning and public health services:

Section 2(a)(1) extends authority for comprehensive planning grants for 4 additional years (through FY 1972) and increases 1968 authorization from $5 million to $7 million.

Section 2(a)(2) adds to the State plan requirements a provision for State assistance to health facilities in the State in the development of a program of capital expenditures.

Section 2(a)(3) provides a 75% limit on the "Federal share" of Statewide planning costs after FY 1969.

Section 2(b) extends for 4 additional years the authority for project grants for areawide planning.

Section 2(c) extends for 4 additional years the authority for project grants for training, studies, and demonstrations relating to comprehensive health planning.

Section 2(d)(1) extends for 4 additional years the authority for formula grants for public health services and increases the authorization for FY 1968 from $62.5 million to $70 million.

Section 2(d)(2) adds a requirement that, after FY 1968, at least 70 percent of a States' allotments shall be available only for the provision of services in communities in the State.

Section 2(e) extends for 4 additional years the authority for project grants for health services and increases the authorization for FY 1968 from $62.5 million to $7 million.

Section 2(f) extends for 4 additional years the authority in sec. 309(c) of the PHS Act for grants to schools of public health.

Section 3. "Research and Demonstrations Relating to Health Facilities and Services".

Section 3(a) replaces the obsolete language of sec. 304 of the PHS Act with a consolidated and somewhat broadened authorization for grants and contracts to support research and demonstrations relating to the delivery of health services, with a FY 1968 appropriation authorization of $20 million. Also provides that not to exceed 1 per centum the amounts appropriated shall be available to the Secretary for the costs of program evaluation.

Section 3(b) repeals sec. 624 and parts of sec. 314(e) of the PHS Act, since their provisions would be incorporated in the new sec. 304, and makes other conforming and transitional amendments relating to the consolidation of authorities in the new sec. 304.

Section 4 adds a new subsection (c) to section 311 of the PHS Act to clarify and strengthen existing authorities for assistance to States and localities in coping with health emergencies and disasters.

Section 5. Clinical Laboratory Improvement

Section 5(a) adds a new section 353 to the PHS Act which would authorize the Secretary of HEW to license and regulate certain clinical laboratories operating in interstate commerce—

Section 353(a): Definitions.

Section 353(b): Requirement of licensures.

Section 353(c): Scope of licensed activities.

Section 353(d): License conditions, terms, and fees.

Section 353(e): Conditions for revoking, suspension, or limitation of licenses.

Section 353(f): Temporary suspensions of licenses.

Section 353(g): Appeals and review of license suspensions or revokations.

Section 353(h): Penalties.

Section 353(i): Exemptions from licensing regulation.

Section 353(j): Utilization of services and facilities of other agencies in the administration of the regulatory program.

Section 353(k): Disclaims re powers of States to enact and enforce regulatory laws.

Section 5(b) Effective dates.

Section 5(c) Short title of section 5, "Clinical Laboratories Improvement Act of 1967".

Section 6. Volunteer services: Adds new section 223 to PHS Act to authorize the Secretary of HEW to accept uncompensated services of volunteer workers in the operation of Departmental health care facilities.

Section 7 adds a new section 328 to the PHS Act to clarify and strengthen the authority of the Secretary of HEW to enter into agreements with health schools, hospitals, and other health care or training facilities for the interchange or cooperative use of "specialized health resources."

Section 328(a): Definitions.

Section 328(b): Scope and terms of agreements and arrangements, including reimbursement payments.

Section 8 amends three PHS grant authorizations to provide that not to exceed 1 percentum of the grant funds appropriated shall be available to the Secretary of HEW for the costs of program evaluations.

Section 8(a) amends section 314(d), the authorizations for formula grants for comprehensive public health services.

Section 8(b) amends section 314(e), the authorization for project grants for health services.

Section 8(c) amends section 309(c), the authorization for grants to schools of public health.

Section 9 amends section 301 of the PHS Act to extend, without time limitation, the present authority for research contracts (expires June 30, 1958).

Section 10 amends section 324 of the PHS Act to repeal the existing authority for medical care for civilian field employees of the Service and replace it with authority to provide care, on a reimbursable basis for Federal employees and their dependents at remote stations where other medical care is not available.

Section 11 contains four minor or technical amendments to the PHS Act.

Section 12 deletes the provision in section 843(f) of the PHS Act which now authorized the Commissioner of Education or accredit schools of nursing for purposes of participation in grant programs under the Nurse Training Act (title VIII of the PHS Act).

Section 13 defines the term "Secretary," as used in the amendments contained in the bill, to mean the Secretary of Health, Education, and Welfare.

Summary of Public Health Service formula grant programs now included in section 314(d) of PHS Act as amended by Public Law 89-749

Year of authorization:	*Program*
1947	Venereal disease.
1960	Cancer.
1961	Radiological health.
1962	Tuberculosis; chronic illness and aged; neurology and sensory diseases.
1964	Mental retardation.

Summary of Public Health Service project grant programs now included in section 314(e) of PHS Act as amended by Public Law 89-749

Year of authorization:	*Program*
1936	General health.
1939	Venereal disease.
1945	Tuberculosis.
1948	Cancer; mental health.
1950	Heart disease; water pollution control.[1]
1962	Chronic illness and aged.
1963	Radiological health.
1965	Dental health.

[1] This program was transferred to the Department of Interior in 1966.

The CHAIRMAN. Thank you, Mr. Cohen. We appreciate your view of the bill and we will now hear from Dr. Stewart.

I have some questions I would like to ask you later, but I will put this off until we have heard from Dr. Stewart.

Dr. STEWART. Mr. Chairman and members of the committee, Mr. Cohen has outlined some of the major provisions of H.R. 6418 for you and described its importance to the future development of health programs in the Nation. I will address myself to others.

Mr. Chairman, the Public Health Service has moved to implement the comprehensive health planning provisions of last year's legislation.

Final action on Public Law 89-749 came on October 23, 1966. Within 60 days the Office of Comprehensive Health Planning had been established in my office under the direction of Dr. James H. Cavanaugh.

We organized a staff nucleus drawn from the programs most affected by the new policy and philosophy established by the legislation.

Today, I can report these benchmarks in carrying out Public Law 89-749:

Regulations implementing sections 314(a)—the statewide planning agency grants—have been drafted and submitted to the designated State agencies for comments. Within the next 30 days, I expect the comments to be in our office and reviewed. The law calls for a conference of designated State agency delegates to discuss the regulations, and the conference is to be called early in June.

Policies and procedures to implement areawide planning and training, studies, and demonstration projects under section 314 (b) and (c) have been sent out to the interested public for comments and suggestions.

Regulations for awarding the formula grants under section 314(d) have been submitted to the Association of State and Territorial Health Officers and Mental Health Authorities for comment. I expect these regulations to go to the Federal Register in June.

And the regulations governing awards of project grants authorized by section 314(e) are in the final states of development and will be submitted to interested groups for comment within the near future.

We have moved rapidly to carry out congressional intent in adopting this legislation. I am pleased to report to you that if the Congress approves the supplemental appropriation requested for a conference of State agencies as required by law, we will be ready to award planning grants under section 314(a) to some of the States before June 30.

COOPERATION WITH STATES IN EMERGENCIES

I would like to turn now, Mr. Chairman, to section 4 of the bill which authorizes Public Health Service hospitals and related units to participate in the development and execution of community or areawide disaster preparedness plans.

The section also broadens and amplifies the existing authority of the Secretary of Health, Education, and Welfare to render temporary assistance to States and communities faced with health emergencies, and would authorize the provision of such services on a reimbursable basis.

The purpose of this language is to bring Public Health Service facilities—including hospitals—into local plans for meeting emergency

situations. The lack of clear authority in present law puts us in an unreasonable position. Aid in these situations may be desperately needed—in fact, it may be a matter of life and death to a community struck by disaster.

The second part of this amendment permits the Secretary of HEW to approve plans which not only integrate Public Health Service facilities into the response mechanism of a local community in time of disaster but provides a basis for repayment for services rendered.

VOLUNTEER SERVICES

I would like now to move to section 6 of the bill which allows the medical facilities of the Public Health Service to accept the generous offers of volunteer help frequently received from medical personnel in communities around our facilities. Under present law, we cannot accept volunteer services except those not directly related to patient care. Under this amendment, we would be able to use volunteer medical personnel.

Section 7 of the bill would authorize the sharing of community facilities and the services or facilities of any Federal hospitals.

Both Federal and local health services would benefit from this amendment. It would permit sharing of rare and costly medical equipment in a given locality, exchanging of specialized skilled staff, and help break down the barriers that sometimes separate Federal medical personnel from those serving the community.

PROGRAM EVALUATION

Section 8 of this bill authorizes the Secretary to use appropriated funds—up to 1 percent—for evaluation of the programs authorized by the Congress.

Evaluation, review, and self-study are demonstrably valuable in any enterprise but are essential in programs as large as ours. The allowance of 1 percent of a program budget for evaluation is a modest request in terms of the value that will be received, and continuing evaluation of some programs is a necessity to your interests and ours if effective operations are to be satisfied.

As an administrator of a program totaling $2.9 billion per year, I can tell you that it is unreasonable to expect evaluation to be undertaken by the very staff authorized to carry out the program. This section would provide the Secretary with sufficient flexibility in choosing his evaluation mechanisms to assure that both the administration and the Congress would get the best possible review of those programs of major interest to both.

RESEARCH THROUGH CONTRACTS

Section 9 of this bill simply extends the present authority of the Public Health Service to conduct research under contract. Specifically, the authority being extended provides (1) that a research contract may include the cost of acquiring or constructing facilities or equipment which the Secretary determines to be necessary for performance of the contract and (2) that the Government may indem-

nify the contractor against claims for death, injury, or property loss or damage resulting from risks which are determined to be unusually hazardous.

MEDICAL CARE FOR EMPLOYEES AT REMOTE STATIONS

Section 10(a) simply revises the present format of section 324 of the Public Health Service Act by redesignating clauses (a) through (d) as clauses (1) through (4).

Section 10(b) adds a subsection authorizing the Public Health Service to provide medical, surgical, dental treatment, and hospitalization to Federal employees and their dependents at remote stations. Such care and treatment would be provided on a reimbursable basis at rates established by the Secretary, representing the reasonable cost of such services.

Section 10(c) repeals the authority to provide medical care and treatment at Service facilities to employees and noncommissioned officers in the field service who are injured or taken ill in line of duty. This section would no longer be necessary if section 10(b) is enacted.

The availability of adequate medical care is a major factor in recruiting staff and maintaining a high level of employee morale and performance. Many Public Health Service employees are required to serve in areas where medical care for themselves and their families is available only at great distance. This amendment would enable the PHS to serve itself and yet be reimbursed. I recommend it to you as a reasonable measure in the interests of employee safety and security and efficiency of our operations.

MINOR TECHNICAL AMENDMENTS

Section 11 corrects an oversight in legislation enacted last year, by amending the definition of a "federally sponsored student" in section 806(c)(1) of the Public Health Service Act.

Originally, a federally sponsored student was defined in the original Nurse Training Act to mean any student enrolled in a diploma school of nursing who had received for that year a loan of $100 or more from a loan fund established pursuant to section 822, the capital contribution loan fund.

Last year, the Allied Health Professions Educational Assistance Act (Public Law 89–751) established a student loan revolving fund. By an oversight, specific mention of the revolving fund was not added to the definition of "federally sponsored student." The amendment before you would clarify our intention that students receiving loans from the revolving fund are federally sponsored students as are those receiving loans from the capital contribution fund.

Section 12 would amend section 843(f) of the Public Health Service Act, which defines the term "accredited" for purposes of the Nurse Training Act. Under present law, the term "accredited," when applied to any program of nurse education, means a program accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, or a program accredited for the purpose of the Nurse Training Act by the Commissioner of Education. The proposed amendment would delete the authority of the Commissioner of Education to accredit programs himself.

Mr. Chairman, that concludes my formal testimony on this legislation. Seated at the table with me are members of the Public Health Service staff. We are at your disposal for questions and discussion. We will be very happy to answer any questions we can.

The CHAIRMAN. Thank you, Dr. Stewart.

I notice that in a number of places the bill provides authorization for such sums as may be necessary for the next 4 fiscal years. Would you please supply for the record the specific cost estimate for these years in these places?

Mr. COHEN. I would be glad to do so, Mr. Chairman.

(The information requested follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—NEW OBLIGATIONAL AUTHORITY

Partnership for health amendments (S. 1131; H.R. 6418)

[In millions of dollars]

	1968	1969	1970	1971	1972	Cumulative total, NOA
Sec. 304: Research and demonstrations relating to health facilities and services	8.0 (12.0)	60	100.0	135	170	473.0
Sec. 309: Grants to schools of public health	(5.0)	6	7.0	8	9	30.0
Sec. 314:						
1. Planning grants:						
(a) 314(a)—Comprehensive state planning	2.0 (5.0)	10	15.0	20	20	67.0
(b) 314(b)—Areawide planning	(7.5)	10	15.0	15	15	55.0
(c) 314(c)—Training, studies, and demonstrations	(2.5)	5	7.5	10	10	32.5
2. Health service formula grants, 314(d)	7.5 (62.5)	113	170.0	230	275	795.5
3. Health service project grants, 314(e)	7.5 (62.5)	80	90.0	100	100	377.5
Total	25.0 (157.0)	284	404.5	518	599	1,830.5

NOTE.—Figures in parentheses represent amounts authorized under existing law.

The CHAIRMAN. Is all of the money requested budgeted?

Mr. COHEN. For 1968; yes, sir.

Could I comment a bit on that point unless you wanted to ask further questions?

The CHAIRMAN. Yes.

Mr. COHEN. I would like to comment on two points relating to this. First, with regard to the amount that we are asking for in 1968, that is an increase over the amounts that you have already authorized to be appropriated for 1968 in the legislation last year.

As you know, we submitted in the legislation last year a proposal for 1968 which had a very substantially greater amount of funds but since the consideration of the legislation came at the very last moment, the committee itself wrote in specific amounts which were substantially lower than what we had submitted. Recognizing the lateness of the hour and the need to get started, we felt that the committee's reaction was certainly proper. The Senate, as you recall, which had passed a larger amount for 1968, nevertheless receded and concurred in the House amendment.

We have now come back for 1968 with some modest increases in the 1968 authorizations which we hoped you would endorse because we believe in the light of the review since that time that we ought to help the States a bit more with regard to the planning grants, and we are asking for $2 million more there for the comprehensive planning grants than what was already authorized and we are asking for $7.5 million each in the formula grants and in the health service project grants.

So that would be $17 million more in the section 314 for 1968 than you had already authorized.

Our general feeling is that the additional amounts in the formula and project grants are necessary to assist the States in developing their projects in accordance with the way they would have developed had the categorical grants been retained.

Taking into account the normal increase in projects and the increases in prices in this area, we think the $15 million for the formula grants and project grants is really only keeping pace with the present developments that have occurred since the funds in the categorical areas in those two fields were developed.

Now, when you come to 1969 and thereafter you will see by looking at our figures that we would hope the committee would authorize rather substantial increases in funds. We feel that, as I pointed out, if we are going to help the States in dealing with these very fundamental and very pervasive health problems, that we must put more Federal moneys in to strengthen the State health departments.

Quite frankly, Mr. Chairman, many of the State health departments are extremely weak, are very weakly staffed and in many cases the local health departments in many jurisdictions are also. I think one of the reasons many of us have been perhaps more slow in developing the kind of health services we think we need is that we realize that one foundation in the localities and the States needs to be greatly strengthened if they are to really take on all of these problems of medicaid, which is going to be increasing rapidly during the next 5 years in many States and already has increased very rapidly in California and in New York, and will be extended to other States also, all of the problems of licensing and establishing standards for nursing homes and the whole question of being concerned about the modernization of facilities in this area and developing the trained manpower and womanpower, are of great concern to all of us, so that I hope you will look with favor upon our requests for 1969 and ensuing years which provide for a substantial increase in the Federal funds.

I would also like to point out to you that the States, of course, are spending far more of their own State and local funds in the whole public health field. We really think this partnership of Federal funds, State funds, and local funds is very important, and we think all three are going to have to increase their expenditures during the next decade if we are really going to deliver high quality health services to all of the American people.

The CHAIRMAN. Mr. Friedel.

Mr. FRIEDEL. I have a bad cold.

Mr. COHEN. The Surgeon General is right here if you need medical care.

Mr. FRIEDEL. The question I want to ask does not relate to this bill, but under the medicare bill you take care of the doctor bills and hospital bills, but there is no provision to help cover the cost of drugs. I think that is one of the fallacies of the medicare bill. Has your department, or have you, Doctor, ever given any thought to including drugs under the medicare bill?

Mr. COHEN. Yes, sir. We have given very extensive thought to it, and if you recall the Senate passed Senator Long's amendment in 1965 to include drugs under the medicare program, and the President this year has indicated that we will be studying this entire problem. There is no question, and I would agree with you, Mr. Friedel, that drugs and the cost of drugs are an extremely important matter to the aged person and his family.

There are many older people who do not need hospitalization, do not need nursing home care and whose drug bills may be as much as $30, $40, $50 a month under present circumstances and with their limited social security and in the absence of coverage under medicare, the only recourse they have is to go to medicaid under the State programs to get that cost reimbursed.

There is no question that the cost of many drugs is prohibitive to many individuals, and the whole question of the cost of particular drugs and the matter of the use of generic drugs as against brand names is an extremely complex one and one that needs a good deal of study which we are now undertaking.

I think there should be methods found to enable individuals to have the drugs that the doctor prescribes at a cost that they can afford.

Now, to turn to the medicare program, I would have to say this: I have studied the drug programs in most of the health insurance programs of foreign countries, and practically none of them have yet been able to discover how to control the use of prescribed drugs in a way that brings it within normal cost controls.

By that I mean that there is a natural human tendency for people when they go to a physician or go to a hospital and the doctor says to them, "I can't do anything for you today," to usually say, "Can't you give me something to take?" And the fact of the matter is that in most health insurance programs the cost of drugs has increased once they have been insured, and I would have to say to you in all honesty today we don't know the answer to the question of how to bring cost controls into prescribed drugs, and, at the same time benefiting the patient and not making it necessary to increase the Federal cost for either medicare or medicaid in a way that Congress would think is prohibitive.

So that we are in the process right now of studying this entire problem. I am very hopeful that in the course of time we might come up with something that is practical and feasible, but as of today I would have to say that I agree with your hypothesis, but honestly I don't know how to solve the practical problems of administering it under a nationwide system.

Perhaps the Surgeon General would like to say something.

Mr. CARTER. It is quite a problem, the cost of medicine, particularly for an older patient. I would recommend to the distinguished gentleman, however, that this would have been taken care of under elder-

care. All of these medical payments for prescriptions and so on would have been paid for, would they not?

Mr. COHEN. Yes, it would, Dr. Carter, but I would say that at the time I testified before the Ways and Means Committee, I had to quite honestly point out to them that I think the cost estimates for eldercare at that time would have been even far more grossly underestimated than they were for medicaid had it been enacted because the cost controls on prescription drugs have not seemed to be adequate in any country that has tried it.

I can't give you the answer for that and perhaps you can speak on it better than I can as a physician, but there just seems to be an element in the drug problem that makes it completely impossible to control. Whether it is possible to devise a system where you would only deal with very high cost drugs or certain classes of drugs that are very essential for people rather than, let's say, aspirin or bufferin or cold tablets or cough sirup, I don't know. That is one of the things we would like to look into.

Mr. CARTER. Thank you. Certainly we see that in retrospect eldercare was not such a bad bill after all because it would have taken care of a lot of the costs which are not taken care of by medicare today.

I yield back to the gentleman.

Mr. FRIEDEL. Personally, I really feel that it would be cheaper in the long run for the person to use medicine rather than to go to a hospital.

Mr. COHEN. One of the things, for instance, that we would have to look into is whether a higher amount of deductible and a higher amount of coinsurance that is paid by the patient might have the necessary balancing effect between the need for the prescribed drug and their paying part of the cost.

If we could undertake some kind of experiments and demonstrations with that, we might find the place where the sharing between the individual and the insurance system might balance those considerations off.

The CHAIRMAN. Mr. Devine?

Mr. DEVINE. Thank you, Mr. Chairman.

Mr. Cohen, in listening to your testimony here and reading over this bill, I am reminded of the President telling the housewives of this country now is the time to tighten up their belts and buy the cheaper grade of meats, and so forth. Is this an example of reduction in domestic spending?

Mr. COHEN. No, this is not.

Mr. DEVINE. It's an increase?

Mr. COHEN. It is an increase and, as I explained, I think that it is a justifiable increase.

Mr. DEVINE. The chairman asked you earlier to provide us with the figures which you agreed to do on this open-end business and "such sums as may be necessary in the next 4 fiscal years." I can anticipate that these can be astronomical. Do you have any figures off the top of your head right now that you can suggest to us on what this could cost in the next 4 years.

Mr. COHEN. Well, the estimated cost when we look at the figures that I will put in the record would show that the program for section 314 that we are talking about instead of the $157 million——

Mr. DEVINE. You are going to provide the figures to the chairman anyway, but I want to know: Is this not going to be a substantial amount of money?

Mr. COHEN. Yes, I think you have to increase this program in the nature of something more than $100 million more per year. You have to increase it in order to provide for the expansion in the population and the prices that are occurring in this health area and to take account of these very serious health problems we have, Mr. Devine.

Mr. DEVINE. Under the terms of this bill, wouldn't you encompass almost every clinical laboratory in the country the way it is worded?

Mr. COHEN. With regard to the regulation under section 5, yes. Only those of course engaged in interstate commerce which are a significant segment of the group.

Mr. DEVINE. I am talking about the jurisdictional language on page 10 of sections (a) and (b), pages 9 and 10. That seems to be all-encompassing.

Dr. SENCER. We only estimate that about 10 percent of the clinical laboratories in this country are in interstate commerce.

Mr. DEVINE. That is all you would expect to come under the provisions of this bill?

Dr. SENCER. Yes, sir.

Mr. DEVINE. You have already set guidelines for laboratories qualified for reimbursement under medicare. Do you intend a completely different set of standards for these?

Dr. SENCER. No, sir. Many of the standards would be very equivalent to medicare standards.

Mr. DEVINE. Would be equivalent to?

Dr. SENCER. Many of the standards would, yes, sir.

Mr. DEVINE. On page 10 at the bottom under section (c), it is contemplated that a laboratory performing a variety of procedures or having several departments would be licensed separately as to such procedures of the department and if a license were to be suspended or revoked for such a laboratory, would such license only affect that particular activity or the entire laboratory?

Dr. SENCER. It would only affect the activity for which the license was issued. We would anticipate that laboratories would be licensed to provide a wide gamut of different services depending on the capabilities of the laboratory and that if we found that they would not live up to the standards for one section, they would be prohibited then from practicing in that section.

Mr. DEVINE. How about the fees set forth here under the jurisdiction of the Secretary that could be charged under this section? Since the licensing of the laboratories is in the public welfare, should the Government pay the cost of the activity and the amount of the license fee be set by statute as customary?

Dr. SENCER. I think the problem of fees is something that is being considered in the Secretary's office at the present time. I think it is important to remember that the title of this provision is "Laboratories' Improvement" and not just licensure. We are concerned about developing better laboratory services rather than just the licensure side of it.

Mr. COHEN. Mr. Devine, the fee provision in paragraph (3), line 16, is a permissive one as it now reads, and we have made no decision on this matter as to whether to charge the fees or what amount to

charge them in terms of this authority, but we felt that the authority ought to be there in case the experience showed that it was warranted.

However, I want to stress very strongly that I consider this whole area of laboratory performance an important public health service rather than one which the consumer should necessarily pay for. There ought to be a situation in the United States that when you go to your physician and a laboratory examination is taken, that you and your family have absolute assurance that that laboratory performance is up to the highest medical standards that the country can perform.

Mr. DEVINE. One other question, Mr. Chairman, if I may.

I am a little concerned about this authority vested in you to suspend for a period of 60 days without notice, without anything, just kind of a czarist type of authority placed in you. That is on the top of page 13 of the bill. Would you consider that similar procedures as under the Federal Food and Drug and Cosmetic Act should be had, where prompt notice should be given, and opportunity for hearings and things like that?

Dr. SENCER. I would envision that this provision would only be used where the health of the Nation would be imperiled if we found that the laboratory was making gross errors that would endanger life.

Mr. DEVINE. We would assume that you wouldn't act arbitrarily, but you could put a laboratory out of business by mistakenly stopping them.

Dr. SENCER. I would hope our system would be such that we would not be mistaken in our actions, sir.

Mr. DEVINE. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Jarman?

Mr. JARMAN. Mr. Cohen, I am very much interested in your statement this morning. I have several questions which occur to me.

One in particular I would like to ask would be in reference to the provisions of section 2(d)(2), on page 4, which refers to funds allotted to the State mental health authorities requiring 70 percent of the funds allotted to these authorities to be available only for providing services to the communities. We, in this committee, as you know, have been holding hearings on extension of legislation dealing with community health centers and with mental retardation provisions.

I simply wanted a comment from you or Dr. Stewart on how it fits into this comprehensive program.

Dr. STEWART. Mr. Jarman, in the act as it now exists, the law provides that 15 percent of the funds will be allocated for mental health. This was done because in many, many States the mental health authority is different than the State health agency.

The present bill before you adds the provision that 70 percent of the funds after this 15 percent allotment has been made must be spent for services in local communities. So that if a State is allotted $100, 15 percent of that must go to the mental health authority, 85 percent will stay with the State health department, and then 70 percent of 85 percent would be spent in local communities and 70 percent of 15 percent would be spent in local communities, so that this is really a requirement that 70 percent of the already existing 15 percent must be used for local community services.

In the bill we had before the Congress last year which was enacted, the original bill, has the 70-percent provision included. The whole

purpose of it is to make sure that these funds result in services in the local communities. This is the whole intent of this provision of the act.

At that time we felt that because of the lateness of the time of the year and our inability to discuss the authorization ceilings in depth, if the ceilings were set with the 70-percent requirement it would have resulted in some of the State health departments having a decrease of funds that they retained centrally. For that reason this was carried over to the legislation before you now.

Mr. JARMAN. Thank you very much.

I have one other question at this time.

Dr. Stewart, I would appreciate a little more elaboration on a part of your statement on page 3. You refer to emergency situations and make reference to the purpose of the language "to bring Public Health Service facilities—including hospitals—into local plans for meeting emergency situations. The lack of clear authority in present law puts us in an unreasonable position."

Could you clarify the record on that?

Dr. STEWART. Mr. Jarman, at the present time, if an emergency case shows up at our hospital, we can obviously take care of it, but we cannot enter into planning in a community as to what you would do if a disaster, a tornado or airplane crash or something occurred because we do not have clear authority to enter into the emergency action when such an event occurs. This provision would give us the authority to enter in with the community in the planning of disaster plans which go into action when some localized disaster occurs like the flood in New Orleans, like the recent airplane crash in New Orleans, the recent tornadoes in the Midwest, anything else which is a localized emergency.

We do have authority to render assistance to States in disasters which may affect the health of individuals. This is old authority related to the possible spread of typhoid fever or something like this. It is not clear as to whether it covers such disasters as the sunken chlorine barges in the Mississippi River.

This again is an attempt to clarify our role in planning with communities to meet localized disasters and secondly to broaden the idea of what a disaster is to our modern-day problems with chemicals and other substances. Large disasters which come under the President's power of course are covered under that.

Mr. JARMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. In the instance of licensing of laboratories in interstate commerce, have you any idea how many employees you would need for this operation?

Dr. SENCER. Yes, sir. We would emphasize that since this is not just licensure but is also trying to improve the quality of services, it will take more than just people who will be actually inspecting and issuing licenses. This would be a total of about 51 people when we are in action.

Mr. NELSEN. You indicate that this will only apply to laboratories in interstate commerce and you indicate on page 12 that 25 percent of all tests analyzed by these studies indicate erroneous results. Now, is it likely that the laboratories in intrastate commerce would be in greater percentage of error than those in interstate because they are smaller?

Dr. SENCER. Well, we recognize that there are serious deficiencies in all clinical laboratories in the country and for the past several years have been working with the State health departments trying to develop programs to improve laboratory services within the State. We have recently, with the request of the State and territorial health officers, tried to develop laws for State health departments and there is an increasing amount of activity in this area.

Mr. NELSEN. I would like to direct a question to Mr. Cohen. Is it a policy approach that is developing in HEW to provide greater flexibility to the States in the way of loosening the hands of the States as to the Federal money coming into the State, harnessing to the greatest degree the State level of government?

Mr. COHEN. Yes, sir. Secretary Gardner and I have undertaken in the last 2 years a complete review of the roles of the State education departments, the State welfare departments, and the State Health departments, and some of the other State agencies that are involved as well as with local agencies particularly in the urban areas, to see how the Federal money and the Federal leadership and Federal stimulation might better be handled by utilizing the resources that we have.

One of the first things we recognize as we go through all of the programs is that there is a very, very wide variation in the competence of State agencies in all of these fields.

Mr. NELSEN. But you do move in the direction of at least giving recognition to the need of a little more flexibility within the State and also recognize as a matter of policy that it is beneficial to all programs involved to have the State hands untied a bit as to specific earmarking of grants.

I noticed your statement on page 2 that the President in his statement to the Congress said:

> The Partnership for Health legislation, enacted by 89th Congress, is designed to strengthen State and local programs to encourage broad guage planning in health. It gives the States new flexibility to use Federal funds by freeing them from tightly compartmentalized grant programs. It also allows the States to attack special health problems which have regional or local impact.

I thoroughly agree with that statement. The question I am getting to is this: If this is a matter of policy that is developing, how does it happen that HEW takes an opposite view in education?

Mr. COHEN. Well, I think what I tried to point out is that you have to look at the historical development. We started, as I tried to point out, with the small grant of $8 million in the public health field in 1936, and then by a series of accretions by congressional action a whole series of other categorical grants were added for cancer, for radiological health, for TB, for mental health, for heart disease, for dental health; and, as the State agencies began to get experience in handling these now for nearly 30 years, it became apparent that it was possible to develop these in a broader context, but in the education field we have only really gotten into the whole educational area in the last 2 years since title I of the Elementary and Secondary Education Act, although you might say, going back to 1958 with the National Defense Education Act, and I think to break up the categorical approach in education at this early stage will be disruptive of the States' operation of their programs, would be precipitous, would be inappropriate, and would sacrifice the gains we have made.

Now, it may well be that in 2 or 5 or 10 years in education, based upon the experience we have, we can do what we have done in health, but it took us 30 years in the health field to get to this point. We had to work with the State health officers. We had to work with the local health officers. I think that if we did that at the present time in the education field it would be disruptive.

Mr. NELSEN. Mr. Chairman, my time has expired. I would only say that the States have been in the field of education much longer than the Federal Government, and the greatest number of complaints that I get in the administration of the Elementary and Secondary Education Act come from the school administrators themselves because of the interference of the Federal Government. It is my understanding that some of the proposals before the Congress now would attempt to implement the same programs with some more flexibility within the States, and I wish to comment that there seems to be an inconsistency as to policies within HEW on different programs. This I find difficult to understand.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Moss.

Mr. Moss. Mr. Cohen, I notice that section 12 is described in your summary and tabular analysis as a widening of the program. Would you elaborate? That is the last page of the bill, page 21.

Mr. COHEN. Mr. Moss, as you and Mr. Rogers I think particularly are aware, we have had over the last few years in connection with the Nurse Training Act a series of problems growing out of the fact of the role of the junior colleges in the accreditation of the nurse training program.

As a result of that you wrote into the act a provision that would give direct program accreditation of the nurse programs to the Commissioner of Education. As you are well aware at the time we were very, very much opposed to that amendment because we didn't want the Commissioner of Education to directly accredit individual programs and so we promised you at the time that we would work with the junior colleges and the regional accrediting board and the nurse groups to try to find a satisfactory solution.

We have worked with them and we felt we had a resolved position on it, and I wrote you and the chairman of the committee informing you of our action, but since the time I wrote you a couple of the groups have felt that they wanted some change in that, and they are meeting on May 5, in a couple of days, to act on the proposal which I assume will be satisfactory both to the American Association of Junior Colleges, the Federation or Regional Accrediting Commissions of Higher Education, and the National Commission on Accreditation as well as the National League for Nursing.

It was on that basis that we submitted this amendment and included it in section 12 to eliminate the amendment giving the Commissioner the authority to do that accrediting.

If the May 5 meeting is completely successful and if they wholeheartedly endorse the proposals which I previously outlined to you, perhaps with some minor modifications, I will write the chairman of the committee and you informing you, and I hope on that basis it will be possible to repeal that provision in the act on the assumption that what has been worked out is satisfactory to all concerned.

Mr. Moss. I hope that you can find it. I was intrigued by the use of the term "widen accreditation options." It is my interpretation that the repeal would have the effect of narrowing them.

Mr. COHEN. I guess we used the word "widen" in the sense that the agreement to be reached by the groups would permit this kind of credit.

Mr. Moss. Prospectively we may have widened it. We will await that law pending before another committee, the Ways and Means Committee, H.R. 5710. In section 129 of that act there is also authority for planning. I wonder if you might tell us whether there is a correlation between the authority granted under this comprehensive bill and H.R. 5710 or whether there is duplication or whether duplication is an inherent possibility or probability under H.R. 5710?

Mr. COHEN. Well, in the first place, Mr. Moss, I would say that the language in the bill before you today stands on its own merits and can be enacted on its own basis.

The legislation in section 129 of H.R. 5710 also can be enacted on its own basis. If both were to be enacted, there would be no duplication. Rather there would be a strengthening of the two.

Now, following out the kind of question that Mr. Nelsen asked me, we feel very strongly that the States must begin to go into a whole new area of planning for facilities more affirmatively and constructively than they have ever done before. Only one State in the Union, at the present time, to my knowledge, is doing at least what I think is vitally necessary and that is the State of New York which has the so-called Folsom law which gives the State health authority the responsibility not merely for licensing facilities but for approving their modernization, their expansion, their modification, their inclusion of equipment.

The reason for this, if we stop and think for a moment is the fact that there are tremendous shortages in the health field, tremendous shortages of personnel, and costs are going up enormously. Hospital costs this last year depending on how you compute them went up somewhere between 12 to 15 percent, which is double the average cost of increase from 1946 to 1965 which was about 7 percent per year.

Mr. Moss. Could you tell us why?

Mr. COHEN. Well, I think that a factor, a very substantial factor in the increase in hospital costs is the increase in nurses' salaries which has been taking place in the last couple of years because, quite frankly, nurses' salaries were very low in many places. I think that it has been true that many young women in some localities could do better not by going to nursing school but by becoming a secretary, and nurses' salaries were not really competitive with other employment for young women in terms of the educational requirements.

I think, as you will recall, in California they have had nurses' strikes and pressure for increased nurses' salaries that has been a factor.

Secondly, the amount of personnel per patient in a hospital has been increasing because of the technical equipment that hospitals have.

Mr. Moss. Mr. Secretary, you have said that in a period of years a 7-percent increase occurred.

Mr. COHEN. Per year.

Mr. Moss. Per year?

Mr. COHEN. Per year, yes, sir.

Mr. Moss. And in the past year that has increased to 12 to 15 percent.

Mr. COHEN. Let's say about 14 percent.

Mr. Moss. Has there been just suddenly in the last year an increase in staffing beyond that characteristic of previous years? You are not ascribing the entire increase to nurses' salaries?

Mr. COHEN. No, sir. I am not.

Mr. Moss. Would you give us a breakdown on the components of that increase?

Mr. COHEN. I will put in the record the best information we have on what the components are. This may not be a factor but the minimum wage was also increased for hospital employees, and I don't know just what date that was effective, but I do think that also will have an effect on hospital costs.

(The information requested follows:)

STATEMENT OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ON HOSPITAL COST INCREASES IN 1966

From December 1965 to December 1966, total costs per patient day in nonfederal short-term general hospitals increased 13.7 percent. During this period, total cost per patient day rose from $49.87 to $56.69. Payroll costs per patient day, which are more than 60.0 percent of total costs, went up 15.0 percent. Nonpayroll costs per patient day increased 11.3 percent. In contrast, from 1960–65, the rate of increase in payroll and nonpayroll costs were nearly identical.

Hospital payroll per employee went up 9.0 percent in 1966. Furthermore, the number of full-time equivalent employees in hospitals rose 8.2 percent.

There is some evidence that nurses salaries increased faster than the wages and salaries of other hospital employees in 1966. The Bureau of Labor Statistics reported that many hospitals throughout the country granted substantial salary increases to nurses in the last half of 1966. In Baltimore, for example, the starting salaries of professional nurses have been raised in a number of hospitals from $4,800 to $6,500 per year.

Further, the BLS reported that in several metropolitan areas, the amount of the increase during the last half of 1966 exceeded the entire increase between July 1963 and July 1966. During this period, the salaries of general duty nurses employed in nonfederal short-term general hospitals rose 20 percent. Since the internal consistency among the wages of employees in hospitals cannot be severely distorted, salary increases of this magnitude are bound to exert upward pressure on the wages of all hospital employees.

Mr. COHEN. If I might take just one more second, Mr. Chairman, I want to finish this thought, that I think that the tremendous need for increased facilities for the modernization of hospital facilities, the increased need for nursing homes, the increased need for equipment is going to bring us more and more to the point where State health agencies have to take a greater role in determining whether facilities can or should be built, expanded or modernized in a community or otherwise the costs are going to continue to be, you might say, imposed upon us, and the extent of Federal and State financing in it will rise so rapidly that the only other alternative would be for the Federal Government to get into the field, and I would rather see the States be encouraged to take a more affirmative role in this at the earliest possible moment.

Mr. Moss. Then, going back to my original question, your view is that H.R. 5710 is complementary to this legislation and not duplicative at all?

Mr. COHEN. That is correct, Mr. Moss.

Mr. Moss. Thank you.

The CHAIRMAN. Mr. Broyhill?

Mr. BROYHILL. Thank you, Mr. Chairman.

Mr. Cohen, under section 3 of this bill, who would get some of these grants? What are some specific examples of some of the institutions who would get these grants?

Would they be medical schools or would they be individual hospitals?

Dr. STEWART. May I answer that?

Mr. BROYHILL. Yes.

Dr. STEWART. The grants would be to nonprofit organizations that do research; universities, medical schools, large hospitals, other schools within the university that are involved in the problems of organization like schools of hospital administration or possibly the schools of economics; the whole gamut of nonprofit research groups. The contracts would be used with nonprofit organizations that are in the business of conducting studies and demonstrations in these areas.

Mr. BROYHILL. Would they be going to nursing homes?

Dr. STEWART. Well, it is conceivable that a grant would go to a nursing home to demonstrate a new type of organization of service or experimenting with a new kind of service which would have some effect on, say, diet or bed sores or some other subject of concern to nursing homes such as improving the quality of care and the efficiency and organization of it.

Mr. BROYHILL. Then your smalltown hospitals would not benefit from this section?

Dr. STEWART. Well, they certainly would benefit from the information that is generated. This is an attempt to provide grants and contracts to do the research and then to put the findings into operational settings to see if it works. These findings would then be adopted by many health institutions.

Mr. BROYHILL. What about facility design, organization and operation of hospitals? Could this not be undertaken in a smaller town hospital?

Dr. STEWART. I think it is quite possible. When we experiment with smaller town hospitals, these smaller hospitals have a unique set of problems and would be eligible to carry out the type of research or demonstration of a kind of new type of facility which would meet the needs of smalltown hospital care.

Mr. BROYHILL. You are asking for $20 million for this section in the fiscal year ending June 30, 1968?

Dr. STEWART. That is correct.

Mr. BROYHILL. How much are you asking for the 4 succeeding years?

Dr. STEWART. Mr. Cohen has said we will supply that to the committee.

Mr. COHEN. Of that $20 million, $12 million is existing money and $8 million is new money to make the $20 million, so that then we would propose that it go up to $60 million in 1969 and $100 million in 1970, $135 million in 1971 and $170 million in 1972.

I would like to say in further expansion of what the Surgeon General said that one of the areas that I think is extremely important in relation to my discussion with Mr. Moss is to find a way to bring

more comprehensive medical care to the rural areas without building hospitals and clinics and cobalt bombs in every community in the United States or in every hospital in the United States.

Mr. BROYHILL. My thought is you may have three or four small towns who together might do some sharing in this.

Dr. STEWART. Quite right, Mr. Broyhill, and I think this might be a good approach to considering a pattern of care for an area where three or four towns are served instead of building four different structures with limited service.

Mr. BROYHILL. You may already have the structures there and all you do is work out a plan where one would specialize in one area and one another, and they would only be 20 or 30 miles apart and have referral back and forth.

Dr. STEWART. This would be quite possible, too.

Mr. COHEN. The other thing, Mr. Broyhill, the way I see it is to work out ways in which you have a continuity of care with your convalescent care, your extended care facilities, your skilled nursing homes and your nursing homes so that people don't get into acute $50 or $75-a-day hospital care when they could be as well taken care of for their medical needs at a lower per diem cost in a less than acute care facility.

Hospital care is already running on the average close to $50 a day and if these increased costs keep going up as the trend indicates, it is going to be $75 or $80 a day in the next decade, and we have to find some way that any person who doesn't need a day of hospital care doesn't get in that hospital for that day and gets in for the proper facility at the proper time and in the proper place.

Mr. BROYHILL. You have outlined six major areas in which you plan to carry out this research and development. Is there criteria as to how this money will be divided among these six areas?

Dr. STEWART. No, sir, Mr. Broyhill. These are just the areas in which we will be trying to stimulate research and demonstration effort, but how it is divided will really depend on the availability of people to carry out these types of research and demonstrations, and their ability to move. These are the areas which we think will receive the greatest emphasis because they are the areas which will have the greatest impact and in which the interest lies now.

Mr. BROYHILL. One other question, Mr. Chairman.

Dr. Stewart, in your testimony on page 4 you were explaining what section 9 of the bill does. What does this do in effect on your research contracts?

Dr. STEWART. Well, it extends the present authority that the Public Health Service has to conduct research under contract which expires as of this June.

Mr. BROYHILL. It expires as of 1968, is that right, or 1967?

Dr. STEWART. I believe it's 1968.

Mr. BROYHILL. As I recall, we gave you a 2-year authorization here, was it? I believe it was 2 or 3 years ago.

Dr. STEWART. Yes, about 3 years ago this contract authority was established. It now is expiring and this is an attempt to extend it.

Mr. BROYHILL. What this does is to extend it for how many years?

Mr. COHEN. It's making it permanent.

Mr. BROYHILL. It would make it permanent rather than extending it for any specific number of years, is that correct?

Dr. STEWART. That is correct.

Mr. ROGERS. Would the gentleman yield at that point?

Mr. BROYHILL. I will be glad to yield.

Mr. ROGERS. Does the present authority also include the cost of acquiring or constructing facilities or equipment which the Secretary determines necessay?

Dr. STEWART. Yes, it does.

Mr. ROGERS. There is no additional authority? It is simply an extension of present authority?

Dr. STEWART. That is correct.

Mr. BROYHILL. Since it is unlimited.

Mr. ROGERS. Without any limitation.

Thank you.

Dr. STEWART. This is authority which we feel we need all the time in order to carry out our effort and particularly as we move into the developmental area. This has been exercised on a few occasions. For example, when one is making a research contract to pilot study a new vaccine, a type of facility may have to be constructed under the contract arrangement to see if you can make the vaccine this way.

Two of those have been made and there are five presently under consideration which include costs of construction of the research facility to carry out the specific research contract purpose.

Mr. DINGELL. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman.

It is a pleasure to welcome my old friend, Mr. Cohen, to the committee, and the distinguished gentlemen with him.

Very briefly, this legislation does nothing to provide for new construction of hospitals, does it?

Dr. STEWART. That is correct.

Mr. DINGELL. There is great need for new construction in terms of Hill-Burton in all areas of the country.

Mr. COHEN. There is a tremendous need for modernization of hospitals and new construction and also for nursing homes and other facilities as well.

Mr. DINGELL. Can we look forward to new legislation in that area coming forward from the administration shortly?

Mr. COHEN. Well, the President's statement in his message indicating that Hill-Burton expires on June 30, 1969, and the importance of all of these factors has indicated that, in that he recommends in his message the appointment of a national commission to study the entire problem with a view to seeing in what way Hill-Burton ought to be modified or extended.

Mr. DINGELL. Now, you have in section 5 of the legislation before us a provision dealing with licensing of clinics and facilities of this kind. I happen to think that this is a desirable thing. As you recall, Mr. Secretary, there has been some correspondence between my office and the Department of Health, Education, and Welfare with regard to the utilization of the medicare program for this function. As you will recall, I have questioned the authority of the Department of Health, Education, and Welfare to utilize the medicare device as an instrument for the regulation of these facilities even though I recognize that certain regulation is necessary.

I would like to refer you to that section, if I may, now and ask you what standards will be utilized by the Secretary in terms of issuance of licenses?

Mr. COHEN. Dr. Sencer will respond to that.

Dr. SENCER. There are four major areas in which standards will be set. Undoubtedly you would have to set standards for the qualifications.

Mr. DINGELL. I am in thorough agreement but in view of the very short time I have, I would like you to be as particular as you can as to what are the standards in the bill which the Secretary would apply in licensing those agencies. As a matter of fact I can make the bald statement, and I think you will agree, that there are no standards that the Secretary would apply that are fixed by statute. These criteria that he would apply in this matter would be fixed entirely by him, not by the statute, am I correct?

Dr. SENCER. I think that the statutory authority would be on pages 11 and 12, Mr. Dingell.

Mr. DINGELL. But nowhere in this is there any fixing of the qualifications that an individual concerned under this legislation would be required to meet by law. We are in this sense vesting the broadest kind of authority in the Secretary to do this.

Dr. SENCER. That is correct.

Mr. DINGELL. What I would like to know is why is it not possible for the Secretary to come up to this committee with some kind of understanding of what he proposes to do and why is it not possible to include some statutory language?

You will recall in many instances the Supreme Court has held statutes to be unconstitutional where they have failed to present adequate framework for the administrators to utilize in terms of the regulatory policies that they would carry out.

Clearly, Mr. Secretary, I am troubled that there is no such set of statutory standards presented for the Secretary for his administration.

Mr. COHEN. First, let me say that I think you are quite correct that the bill does not establish any criteria in any detail. Second, I will be glad to put in the record the kind of factors and criteria that we would use in regulation, for your consideration.

(The information requested follows:)

STATEMENT OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON RECOMMENDED STANDARDS FOR CLINICAL LABORATORY LICENSURE

The following standards would be required of clinical laboratories to qualify for a license:

1. The laboratory must maintain a quality control program which would assure the accuracy of the laboratory's procedures and services. This program would include the use of reference or control sera; calibrating standards, etc.

2. The laboratory must maintain records, equipment and facilities necessary to the effective operation of a laboratory. This would include records on specimens received and a system for their identification; procedures to minimize the risk of infection and to insure the rapid reporting of results to physicians.

3. The director of the laboratory and other supervisory professional personnel must meet qualification standards to assure the adequate and efficient operation of the laboratory.

Mr. DINGELL. Wouldn't it be well, wouldn't it be really very well, Mr. Secretary, for us to have a clear statement included in the legislation?

Mr. COHEN. I think to the extent that you can develop the elements, it would be proper to define them generally in the legislation and to expand in the committee report the character of them. I would see no objection to that.

Mr. DINGELL. I would think this would be very important. For example, under medicare your agency has sought to regulate these kinds of services to require that in a certain period of time they should have a person who would have a degree, some with a bachelor's degree, some with a Ph. D., or be a doctor of medicine.

Mr. COHEN. Yes, sir.

Mr. DINGELL. There would be different standards applied under that for clinical services available within the doctor's office and those available without. The proposed regulations have sought to have an M.D. or Ph. D. be available on the premises. There was, for example, no grandfather clause available to those who, I am sure, lack that Ph. D. or M.D. yet who I am satisfied in many instances are providing valuable and useful and adequate services in this area.

Mr. Secretary, the other question I would like to know is: What have you been doing in terms of carrying forward the discussions that have been going on between my office and the Department of Health, Education, and Welfare with regard to the fairness of these clinical standards which we are establishing here?

Mr. COHEN. All I could say is those questions are now under review in the Committee on Ways and Means. We are in executive session and the committee has asked us to review those with them, and we are doing so now.

Mr. DINGELL. I think in view of the fact that you do have a clear duplication of regulatory authority within the Department of Health, Education, and Welfare in one instance before Ways and Means and in the other before this committee, it would be very well for us to have a very clear view in the record both of what is going on in Ways and Means in terms of the regulatory authority that you are seeking to exercise and the activities that the Ways and Means is taking, and also as I indicated with regard to the question of what regulation we want and whether it should be statutory and not left to the discretion of the Secretary and not just conferring upon the Secretary the divine right of kings to issue regulations without any regulatory guidelines from the Congress at all.

I hope I have not been too hard on you. It is always a pleasure to see you.

Mr. COHEN. No, sir.

The CHAIRMAN. Mr. Friedel.

Mr. FRIEDEL. Mr. Chairman, I have eight questions I would like to have answered.

The first one is in four parts.

I wish you would furnish for the record the questions and answers: How much is the Public Health Service spending in 1967 for family planning and so forth?

Mr. COHEN. We would be glad to answer those, Mr. Friedel.

Mr. FRIEDEL. Send me a copy.

(The information requested follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., June 8, 1967.

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

DEAR MR. CHAIRMAN: On May 2, when I appeared before the Committee to testify on H.R. 6418, the "Partnership for Health Amendments of 1967", Congressman Friedel raised several questions concerning the Department's family planning program, and asked that we submit answers for inclusion in the record of the hearings.

In response to his request, I am enclosing answers to the questions, a current status report of the Department's family planning programs, and a detailed breakdown of expenditures in 1967 and 1968 for family planning activities conducted by HEW.

If I can be of any further assistance, please let me know.

Sincerely yours,

WILBUR J. COHEN,
Under Secretary.

REPLIES TO QUESTIONS PROPOUNDED BY CONGRESSMAN FRIEDEL

1. *How much is the PHS spending in 1967 on family planning? How much of those funds are going for training? How much of those funds are going for research? How much of those funds are going for direct services through demonstrations projects?*

Public Health Services expenditures on family planning 1967	$8,361,000
Training	2,047,000
Services, information and counseling	199,000
Research and demonstration	6,115,000

2. *Of the increase of $7.5 million (for project grants and for formula grants respectively) proposed under H.R. 6418, what new areas do you anticipate will be included, or to what extent does the increase in funding merely reflect higher health costs?*

The State agencies and applicants for project grants will be submitting plans and applications on the basis of their estimates of health priority areas. We anticipate that the requested increase of $7.5 million for project grants and $7.5 million for formula grants will permit support of programs in areas such as family planning, alcoholism, and rural health which could not be supported under the categorical approach. Although we anticipate that there will be considerable emphasis on family planning, since Federally pre-determined categories of support have been eliminated, we cannot predict which areas of activity will receive support in *1968*. The increased authorization requested reflects the need for support of health services and is not predicated on increased costs.

3. How much of the proposed $7.5 million (for formula and project grants respectively) would you expect to be expended on family planning? What would be proportion of investment into (a) *services*, (b) *training*, (c) *research*?

Since we will not prescribe the activities which will be supported, we cannot say what the level of requests for support of family planning will be. Requests for support of family planning activity, because of the nature of the grant program, will be principally in the services area.

4. During the hearings on this measure last October, the Surgeon General in response to questioning by members of the Committee estimated that at least $15 million would be needed in fiscal 1968 for family planning and larger amounts in subsequent years. Following the hearings on H.R. 1823.1, Under Secretary of HEW, Wilbur Cohen projected expenditures for family planning in a letter to Senator Joseph Tydings dated October 20, 1966 as follows, "For the purposes of supporting programs under S. 3008 in the field of family planning, our present plans contemplate $20 million in fiscal year 1968, $25 million in fiscal year 1969 and $30 million in fiscal year 1970." What are the expectations of achieving this level of spending in this area for fiscal 1968 in view of the level of funding projected?

The estimate provided by Under Secretary Cohen to Senator Tydings on October 1, 1966, was based upon an estimated appropriation authorization for formula and project grants for 1968 in excess of $270,000,000 as provided in S. 3008. Since this anticipated authorization was ultimately reduced to $125,000,000 by both Houses, it is doubtful that the State and other applicant agencies will request support at the level projected in October 1966. In any event, under P.L. 89–749 categorical support will no longer be provided and, therefore, we cannot predict the impact of the increased authorization in any health services area, including family planning.

5. It is our understanding that in a recent survey, 30 out of 45 State Health Departments listed family planning in the first 10 items of the priority un-met needs. Did the survey indicate how much money would be needed in each State to establish State-wide family planning programs? What proportion could be expected to be available locally?

The survey which was conducted by the Association of State and Territorial Health Officers was concerned principally with Federal support of health services. It did indicate that many States intend to emphasize the importance of family planning, but since it did not require specific funding estimates for each priority area or cost figures on State and local funding support, no such figures are available.

6. In the initial starting period of new programs, it has been customary to provide sheltered or special funding to enable these programs to get underway. Will family planning programs which are new and a disadvantage in relation to established older programs, have to depend for funding on whatever is left after existing programs are supported at existing or higher level? Could they be expanded more rapidly and more widely if special funds were to be made available, for a limited, initial starting period?

The intention of the "Partnership for Health" legislation is to permit those at the State and local level close to the problem of health services to determine their priority health needs. Accordingly, if family planning projects are identified by the State planning agencies as being among the top health priorities, and if support is requested, such projects can be funded, depending upon the availability of funds in relation to the priority rating.

It is likely that categorical support of family planning would result in rapid expansion of projects. However, we believe that special categories in the "Partnership for Health" program by the Federal government would defeat the purpose of the Act, which is to allow State and local determination of health priorities.

7. What new health programs have been initiated or established by the PHS without specific sheltered or categorical funds in the initial period?

The initial formula grant program, authorized by the Social Security Act of 1935, provided general health grants to support any part of a State's public health program. Subsequently, specific health problems aroused public and Congressional concern and these problems were isolated for special attack with earmarked grants. These categorical formula grant programs included: cancer control, chronic illness and aged, dental health, heart disease control, home health services, mental health, radiological health, and tuberculosis control.

The first categorical project grant programs established in 1947, was for venereal disease. Subsequently, project grants were authorized for cancer, radiological health, tuberculosis, chronic illness and aged, neurology and sensory diseases, and mental retardation.

8. Family Planning is becoming an increasingly important part of our foreign assistance efforts. The PHS is the principal professional health resource of the U.S. Government and is being increasingly called on to offer technical assistance for AID.

What provision is now made for a central focus within the PHS for family planning activities for service programs in family planning, for training and for research?

Who has primary responsibility for developing and promoting these programs?

How many staff members are working in this area?

The Public Health Service does provide technical assistance to the Agency for International Development and the Peace Corps.

The responsibility for conducting family planning programs, developing new activities, and defending budget requests resides within the Bureaus and Divisions that make up the operating components of the Public Health Service Population Committee, composed of senior professional representatives of the com-

ponent bureaus and offices of the Public Health Service. In 1967, a full-time executive secretary was assigned to increase the Committee's effectiveness. The Committee meets regularly and is responsible for identifying the Public Health Service activities in family planning, evaluating these activities, and recommending new programs for the consideration of the Surgeon General and the bureau directors.

Approximately 50 positions have been requested for staffing for family planning service activities in Fiscal Year 1968.

Current Status of Family Planning Programs in the Department of Health, Education, and Welfare

In January, 1966, Secretary of Health, Education, and Welfare John Gardner established for the first time a formal policy in this field. At that time, the Secretary issued a policy statement relating to population dynamics, fertility, sterility, and family planning (see "Report on Family Planning" enclosed with WGPM Memo #9). Its issuance was followed by a number of significant developments.

The post of Deputy Assistant Secretary for Science and Population was established in May, 1966, to advise the Secretary on policy development, program evaluation and coordination, and to maintain liaison with other departments and agencies as well as non-government organizations.

A Departmental Committee was established and special Task Force created to plan, organize, and evaluate nine Regional Family Planning Conferences.

Regional Family Planning Conferences were conducted in Charlottesville, Virginia; Atlanta, Georgia; Dallas, Texas; Kansas City, Missouri; Denver, Colorado; Chicago, Illinois; New York City, New York; Boston, Massachusetts; and San Francisco, California between September, 1966, and January, 1967. These conferences were highly successful with broad press, television, and radio coverage and attendance averaging between 200 and 300.

Family planning policies have been established in all appropriate DHEW agencies and work is underway to expand support for programs in sex and family life education, research and research training, family planning information and services for beneficiaries of the various HEW programs, and family planning programs and services on the State and local level.

Efforts were undertaken to promote closer work with the Department of Defense and the Office of Economic Opportunity, both of which now have family planning policies in effect. The programs of these agencies differ slightly from those of the Department of Health, Education, and Welfare because of variations in legislative authority and program responsibilities.

Within the DHEW structure, each major agency has moved forward in the family planning field. The Office of Education, today, supports a number of projects in sex education and family life education in schools. With Federal assistance, States are making available to schools a wide variety of aids ranging from special library programs and materials through direct work with pupils in the classroom environment to adult basic education programs (designed to better equip parents to meet their obligations in this area).

The Welfare Administration supports the provision of family planning services to the needy through the new Medical Assistance Program which provides matching funds to State for this purpose. The Program commonly called Medicaid, is presently in effect in 26 States and 2 territories. All provide family planning services as part of comprehensive health care. In all States, Medicaid recipients may receive oral contraceptives—when prescribed by physicians in private practice or in hospitals. Connecticut (in which some 2 years ago Supreme Court action was required to nullify anti-contraception laws) has recently developed a plan to use public funds for family planning programs.

In the Children's Bureau, there are 2 major sources of funds to support family planning programs: (1) a system of matching grants to States, on a formula basis, to support maternal and child health programs, and (2) Maternal and Infant Care project grants to be used to develop services for high-risk mothers in low income areas. Funds provided under these grants may be used for both

family planning information and services. About 60 to 80 percent of the women in Maternal and Infant Care projects are using family planning services after they have had a baby delivered. This represents a high rate of utilization—one equal to that in middle and upper income groups. The Maternal and Infant Care projects will be expanded this year.

The Public Health Service now provides Indians and Alaskan natives with family planning services—this assistance also is available to others eligible for direct PHS health care. The Division of Community Health Services has asked for a $500,000 appropriation for fiscal year 1968 to develop a full time staff to provide consulation and technical assistance for the development and coordination of programs. The recently enacted Partnership for Health legislation (P.L. 89–749) will make it possible for States and local health organizations (public and private) to provide family planning to needy persons not now receiving comprehensive health care. Under this new law, project grants and non-categorical formula grants will be used for a wide variety of medical needs, including family planning.

Family planning research is underway in a number of areas within the DHEW structure with efforts targeted principally in 3 directions: (1) investigation of social and behavioral aspects. Studies at Princeton, for example, indicated for the first time the extent of oral contraceptive use in the United States; (2) testing efficacy and safety of oral and other types of contraceptives; and (3) basic studies on human reproduction. The bulk of the latter is supported by National Institutes of Health, with the Food and Drug Administration supporting special studies on oral contraceptives and the Welfare Administration supporting those on the social and behavioral aspects of family planning.

This country's experience with oral contraceptives is of interest to family planning experts abroad where high birth rates are a major concern. Between 1947 and 1965 the number of births annually in the United States have totaled more than 4 million; for 1965 and 1966, the figures have dropped to 3.7 million and 3.6 million despite an upswing in the number of marriages. In 1964 the birth rate per thousand in the United States was 21; in 1965 the rate was 19.4; provisional data indicate a continuing reduction to 18.5 for 1966. In 2 cities—Baltimore and Washington, D.C.—family planning efforts appear to have had a definite effect on birth rates among low income groups, and it is widely felt that a continued decrease can be attributed in part to contraceptive use. In line with this, it is noteworthy that, in the United States, the number of women using oral conraceptives comes to about 6 million, with nearly double that number having used these drugs at one time or another. At present, there are some 30 million women—or about one-sixth of the total population—in the reproductive age group. Of these 90 percent in the high income brackets have access to family planning information; only 10 percent of those in the low income group are informed on these matters. Experts feel that a greater drop in the number of births will be seen as family planning information becomes more available to all segments of society.

Also of interest abroad is the United States rate of acceptance of family planning services, particularly among the poor. Studies reveal that upper income groups accept certain methods more readily than the poorly educated—but that family planning information is desired by the poor. In a recent Gallup Poll, "yes" responses to the question "Do you consider the oral contraceptives to be safe and effective?" were given by 30–45 percent of the lower class respondents and 50–70 percent of the upper class. In reply to the question "Do you think low income families should have family planning services available?", 50 percent of the lower class said "yes," 70 percent of the upper class said "yes."

DHEW has met almost no resistance to its family planning activities. Some 90 percent of the newspapers reporting on work in this area have provided favorable accounts, and its 9 Regional Conferences had uniformly favorable coverage. In late 1966, a question was raised regarding possible coercion of welfare recipients with whom family planning might be discussed. This provided an opportunity for the Department to restate its unequivocal opposition to pressure in any form and its vigorous attention to insuring complete freedom of choice for all. In a few communities, reservations were expressed by religious or minority groups who opposed programs on different grounds. However, nationally this has not been of major significance.

In the United States, as elsewhere in the world, one of the greatest problems relates to training of persons equipped to bring family planning information to those who need it. Described as one of the weakest links in the DHEW pro-

gram, training activities are insufficient at present. Further, the education and training of future physicians in sex education and family planning is inadequate in medical schools and teaching hospitals—a similar situation exists for nurses, social workers, and teachers.

Increasingly, the United States is recognizing its responsibilities in the family planning field both at home and abroad. It is moving ahead to correct domestic deficits and stands ready to offer encouragement and help to foreign neighbors as they struggle with this most impressive problem.

HEW financial participation in birth control and/or family planning activities

[In thousands of dollars]

Agency	Information, counseling, and services		Training		Research and demonstration		Total	
	1967	1968	1967	1968	1967	1968	1967	1968
Public Health Service	177	687	1,762	1,900	5,579	6,819	7,518	9,406
Food and Drug Administration					82	584	82	584
Welfare Administration	8,588	11,300	275	300	401	400	9,264	12,000
Office of Education	923	1,213	262	304	68	56	1,253	1,573
Total	9,688	13,200	2,299	2,504	6,130	7,859	18,117	23,563

The CHAIRMAN. Mr. Watson.

Mr. WATSON. The gentleman from Michigan has touched upon some points in which I have an interest. That is the broad authority given you. Although generally I support the intent of the legislation, I certainly would like to see some specific standards set forth and also some application of the language on page 11 stating that no license shall be issued except (a) that the application "is accompanied by such information and assurances as the Secretary finds necessary." And further, being of such standards, I can see where information and assurances is a rather nebulous thing and does give you rather broad power.

Mr. COHEN. I think that could be clarified, Mr. Watson.

Mr. WATSON. One thing which has disturbed me aside from these matters is that we have all been concerned about the alarming increase in hospital costs. I know you are disturbed about it and the Surgeon General is disturbed. You made the statement a moment ago, as I recall, that you do not want to see any person who doesn't need hospitalization get into the hospital. Did you not make such a statement as that?

Mr. COHEN. Yes, sir.

Mr. WATSON. Actually, aren't some of the programs that we are initiating here encouraging the exact thing that you don't want to see?

Mr. COHEN. Yes. I would have to admit that it does.

Unless we go and develop in this country the alternatives, satisfactory alternatives to hospital care, people are obviously going to go into hospitals when they don't have any other alternative.

Mr. WATSON. And we are making it easier for them to get into hospitals, aren't we, through those programs?

Mr. COHEN. We are making it easier to get into the hospital. If, for instance, we don't develop home health service in the community so that people can be taken care of, let's say, in the posthospital episode through home health services, the physician and family are going

to keep the person in the hospital longer than necessary when those services are not available.

Mr. WATSON. You would agree with me that perhaps we could more profitably direct our thoughts and attention to development of medical care not including hospitalization in the institutions which are presently overcrowded where the private patient is charged exorbitant rates?

Mr. COHEN. I would put it this way. I would like to do everything that is humanly feasible to develop the kind of services in the communities that make it possible for the physician to utilize the correct type of service for that individual that is indicated without his necessarily having to put them into the hospital for diagnosis or treatment if that was not indicated.

Mr. WATSON. Fine. Now, one final question.

We could have the finest clinics, and incidentally you take a rather broad swipe here at the clinics. I think they have done a rather remarkable job. Incidentally, they have been provided through the private sector, through the local government and through State government, and as of this point the Federal Government hasn't gotten into the picture too much, and you know we can provide adequate clinics. We can increase the bed capacity in hospitals and all of these other programs, but unless we get more doctors we are still going to be on the horns of a real problem here, aren't we?

Dr. STEWART. You are quite correct, Mr. Watson. I don't understand your statement about the clinics. Certainly we have no intention of making a swipe at clinics.

Mr. WATSON. I was just speaking of the language of the Secretary when he cited these figures.

Dr. STEWART. I see. The clinical laboratories?

Mr. WATSON. Yes, sir. Right now, if I had to go in the hospital, I would be rather apprehensive as to whether or not my blood type would be accurately diagnosed, the blood count, or whether they might end up giving me alcohol instead of blood.

Dr. STEWART. I think you should be concerned, Mr. Watson.

Mr. WATSON. The fact is that heretofore, all of these services have been provided locally.

Now all of a sudden, it seems that only the Federal sector has all the experience in this field. I think such a condition is really an unfair attack to be leveled at these agencies, because they have been in this field longer than you have by your own admission. They have been in the educational and medical fields longer than we have, and all of a sudden we are critical of their effort.

I would like to see a cooperative effort move forward without a blanket condemnation because we all agree that they haven't had the money. All of a sudden we say that in Washington we have all of the answers to medical problems.

Mr. CARTER. Would the gentleman yield?

Mr. WATSON. Yes, sir. I yield.

Mr. CARTER. I have no questions except that I think that the laboratories in interstate commerce certainly should be regulated. There is no question about that, because it has been found that many of their reports are inaccurate. However, most of our laboratory services are performed in local hospitals or clinics, and by far most of them

are extremely reliable. As a practitioner, I have never seen a death from transfusion from blood mismatch. It does occur, but not as often as a lot of us would think.

Certainly we still have dedicated medical personnel throughout our country, and our laboratories by and large are quite efficient, I think. Of course, there is always room for personal error in any field of endeavor, no matter what it is, and there always will be as long as we are human. None of us is perfect but I think our laboratories are quite efficient.

Thank you.

Dr. STEWART. Dr. Carter, I would agree with you that there are many dedicated medical people in the country and many of the laboratories are quite efficient. I think the problem that has been created is not related to any lack of dedication or anything like that; but, as you know, the number of laboratory tests that are requested have increased tremendously because we have more to ask for now than we had in the past.

The load has increased tremendously on laboratories. There is a shortage of well trained technicians all over the country. There are new technologies coming along almost daily, and all of these things have added up to a need to improve the laboratory effort of the country.

The attempt of this bill, as Dr. Sencer pointed out, is not purely a licensing type of activity. We have coupled it with a program to work together on improving the laboratories, training programs, performance testing, other programs which we have had experience with for about 5 or 6 or 7 years now.

Mr. CARTER. Certainly I am in agreement with the interstate provision of this. I think that is certainly all right. But in our clinics and hospitals throughout the country we rarely use interstate programs. Most of this is done locally. Cholestorols can be performed in small clinics now. We have those even down in Appalachia, Doctor.

Mr. ROGERS (presiding). Is the gentleman finished?

Mr. CARTER. Yes.

Mr. ROGERS. Mr. Secretary, and the Surgeon General, I have just a few questions.

As I understand it, you are ready to give grants to States for State planning for comprehensive plans, beginning in June.

Dr. STEWART. Well, if something happens. We are required by the law to call a conference of the State health planning agencies before we finalize the regulations before publication. The supplemental request that has been reported out by the full Appropriations Committee contains the money to call that conference.

Mr. ROGERS. So you anticipate this will be done?

Dr. STEWART. We think so. The supplemental hearings in the Senate start tomorrow.

Mr. ROGERS. What then will be time element as to putting in to a State a comprehensive health plan?

Dr. STEWART. Well, the supplemental will provide the funds for calling a conference and issuing the regulations. The 1968 funds, then, will start the staffing of the comprehensive health planning agency. The rate of growth from there to a comprehensive health plan is going to depend on how much data has been generated within each State up

to now. There is a great deal of health information which exists in the Blue Cross files, in the State health agency, in the welfare department, in studies that have been done on health manpower by many of the States, and so on; so that it is going to vary as to how long it will take.

Mr. ROGERS. In other words, it will take some time?

Dr. STEWART. I think it will take some time.

Mr. ROGERS. How are you going to handle these programs where you have asked for $70 a year to carry out these plans? What will be done?

Dr. STEWART. Well, the State plan for the formula grant, the $70 million, 314(d) is a different kind of plan than the comprehensive State health plan. This will be a plan on how the State health department plans to expend the money which they will be matching, and they will be able to have this plan in very soon. It does not have to conform with the comprehensive State health plan immediately, so that the State will have a period of time for development of the comprehensive plan.

Mr. ROGERS. Section 2(d)(1) and (e) of the bill provides for $70 million?

Dr. STEWART. That is (d) and (e).

Mr. ROGERS. I understand. What is (e)?

Dr. STEWART. Subsection (e) is the project grant area.

Mr. ROGERS. What is (d)(1)?

Dr. STEWART. Subsection (d) is the formula grants to the States. Subsection (d) is $70 million and (e) is $70 million.

Mr. ROGERS. So that there is no present plan as far as this committee is concerned with making a block grant out of the moneys that we are appropriating?

Dr. STEWART. Well, in a sense there is a block grant for health. Under the formula grant the State will develop a plan on what programs they are going to support.

Mr. ROGERS. I understand that, but this won't be in effect for 2 or 3 years, as I understand it.

Dr. STEWART. No, sir.

Mr. ROGERS. Well, another year.

Dr. STEWART. I think you are confusing the formula grant to the State Health Department for health health services with the grant to the State for the development of comprehensive health planning. The comprehensive health planning agency is a new concept, a new entity, and it will take 2 or 3 years for it to be fully operational within the States. The formula grant under 314(d) is a continuation of the categorical formula grants we had in the past. It will also require a State plan, but this plan will describe the programs which the State has selected as the priorities to support in the formula grant.

Mr. ROGERS. Have these plans already been presented?

Dr. STEWART. They have not at the present moment, but we had a meeting with the State health officers and mental health authorities a week ago to review the final draft of regulations for 314(d) grants. We will be receiving the State plans around the first of July.

Dr. PETERSON. I wonder if I might state this, Mr. Rogers. The State plan that governs the expenditure of the formula grant money really is an extension of the present State plans that we receive from each of the State health and mental health agencies for categorical grants.

The new regulations and procedures now call for a block grant with undifferentiated matching requirements rather than this being presented as categorical programs with categorical matching of non-Federal funds. The basic requirement is that the Federal and non-Federal sharing is met and that total programing is presented to utilize the funds that are available.

Mr. ROGERS. Isn't this in effect a comprehensive health plan?

Dr. PETERSON. No, the comprehensive health plan, Mr. Rogers, includes much more than is now covered by the formula grant.

Dr. STEWART. May I elaborate, Mr. Rogers. The State health plan for the formula grant is how they plan to spend the money next year in the State health agency for health services supported under 314(d).

Mr. ROGERS. But it covers the comprehensive health plan?

Dr. STEWART. It is a portion of carrying out the comprehensive health plan.

Mr. ROGERS. What would it not include?

Dr. STEWART. Well, the comprehensive health plan which the agency will put together is really the long-range health strategy for that State.

Mr. ROGERS. What I am saying is, that you are requiring them this next year to come to you with how they are going to spend this money in a plan away from a categorical approach?

Dr. STEWART. Correct.

Mr. ROGERS. So that this is the first comprehensive planning in effect, without categorical designation?

Dr. STEWART. Yes, if you will say comprehensive plan for what the health agency or health authority expends in the State under section 314(d). You are quite right.

Mr. ROGERS. They are going to make a plan for the money we are going to give them.

Dr. STEWART. Right.

Mr. ROGERS. I think that is all we are going to make them do with the money we are going to give them under the comprehensive State plan. They are only going to tell us how they are going to spend the money.

Dr. STEWART. That is correct.

Mr. ROGERS. I was concerned with your time element of getting your plan. So in effect you are moving into a comprehensive approach beginning in July of this year; is that correct?

Dr. STEWART. That is correct.

Mr. ROGERS. Now, the other $70 million is for a project approach?

Dr. STEWART. That is correct.

Mr. ROGERS. Which will be concerned mainly with what?

Dr. STEWART. Well, it will be concerned with the health services that the State and local areas feel are essentially needed.

Mr. ROGERS. In other words, you can still categorize this.

Dr. STEWART. They will categorize it by the way they apply, in a sense. What we have here, Mr. Rogers is, whereas formerly we had a series of project grants which had to be spent for a certain disease or certain other category, now the State or the locality can say "We think this is terribly important, this is a new area" or "this is a limited program that is peculiar to our area," and can apply for a grant on that basis.

We will find out what the State's priority is. In our review, we will look at it regionally and talk about priority, and we will in a sense relate it to national need in the funding of it. The ultimate granting authority is with the Surgeon General.

Mr. ROGERS. Now let me ask you this quickly.

In section 4, pages 8 and 9, on the cooperation with States in emergencies, what authorized funds are available here? Is there any limitation on the amount of funds that can be spent on this? I see none in the bill.

Dr. STEWART. No.

Dr. PETERSON. At the present time there is no authority for this function. Funds that have been used previously in emergencies such as the Surgeon General mentioned earlier with reference to chlorine barges, the flooding in New Orleans and throughout Louisiana, has had to come from reprogramed funds that were available within the budget. The provisions of these sections envision the authority that will make it possible for these types of responses to be made so that reimbursement for expenditures from the States and localities will be possible according to the preplanning for emergency response that has been had.

Mr. ROGERS. It doesn't have to be reimbursed, depending on what the Secretary decides?

Dr. STEWART. No.

Mr. ROGERS. This pretty much is a contingency fund, is it?

Dr. STEWART. Yes.

Mr. COHEN. I think——

Mr. ROGERS. It appears to me, Mr. Secretary, that this is a different approach to the contingency fund. Am I in error?

Mr. COHEN. Yes, you are, sir. I think that what we would probably have to do is to go to the Appropriations Committee and ask for a specific authorization in this area, but probably subject to also, as Dr. Peterson said, using reprograming authority at the present time. It would be for that specific purpose.

Mr. ROGERS. But there is no authorization of specific funds?

Mr. COHEN. No specific amount.

Mr. ROGERS. It would be given on the broad authority of the public health agent.

Mr. COHEN. That is correct.

Mr. ROGERS. Have you any figure that you would suggest or submit for the record?

Dr. STEWART. No. It is difficult.

Mr. ROGERS. We give the President a fund for national emergencies. You mean the Secretary of Health couldn't give us a suggested figure? I would think in real disasters the Government is going to come in and ask the President, and I thought this was generally handled in the Office of Emergency Planning and that all of the health agencies would be called anyhow.

Dr. STEWART. When the airplane crashed into the motel in New Orleans there was an immediate need for a group of people to move to that locale and render aid.

Mr. ROGERS. I thought you could respond to an emergency situation.

Dr. STEWART. If they come to our hospital, we can. Out in the community, we cannot, and cannot enter into the preplanning phase.

Mr. ROGERS. This goes for 45 days. Surely that would get into an emergency situation under the Office of Emergency Planning. I would like to pursue that. I won't take up the committee's time. I would like to pursue that with you on some possible authorization. How are you going to check the laboratories? Is there any facility to check this?

Dr. SENCER. Yes. we have on our staff in the Communicable Disease Center people who have been working on proficiency programs with the State health departments.

Mr. ROGERS. Would you supply that for the record? Would you submit for the record section 304(b) which provides the amount of contract which cannot exceed more than 50 percent of the cost of the project? Here I think that is at the discretion of the Secretary and can go to 100 percent.

Dr. STEWART. The Secretary can under unusual circumstances.

(The information requested follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON EXCEPTION TO LIMITATION OF FEDERAL CONTRIBUTION OF 50 PERCENT TO COST OF CONSTRUCTION OF FACILITY OR EQUIPMENT

The Secretary can under unusual circumstances approve the payment of more than 50% of the cost of a project. This has also been true under Section 624(a) of the Public Health Service Act, which is replaced by Section 304 under H.R. 6418. Since the development of innovative devices and automated equipment (covered under Section 304) tends to be very costly and beyond the financial resources of individual organizations, the Secretary must have the flexibility to provide a greater share of the cost where he feels it is essential to the success of a program.

The applicable portion of Section 304(b) follows:

"(b) Except where the Secretary determines that unusual circumstances make a larger percentage necessary in order to effectuate the purposes of this section, a grant or contract under this section with respect to any project for construction of a facility or for acquisition of equipment may not provide for payment of more than 50 per centum of so much of the cost of the facility or equipment as the Secretary determines is reasonably attributable to research, experimental, or demonstration purposes. The provisions of clause (5) of the third sentence of section 605(a) and such other conditions as the Secretary may determine shall apply with respect to grants or contracts under this section for projects for construction of a facility or for acquisition of equipment."

Mr. KORNEGAY. In view of the fact that we didn't get even a third of the way through, I wonder if these gentlemen will be back tomorrow. I do have some questions.

Mr. ROGERS. Why doesn't the gentleman go ahead and ask his questions? I think the chairman is anxious, if we could, to finish.

Mr. KORNEGAY. I think under ordinary procedures Dr. Carter would be next.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I have only one question, Mr. Chairman.

Is there any of the money which will be authorized which will be used for family planning, frankly, birth control, and so on?

Dr. STEWART. Yes. The money under 314(d), the formula grants to State health departments, and the project money under 314(e) could be used for family planning.

Mr. CARTER. It is not specifically earmarked for that?

Dr. STEWART. No, sir.

Mr. CARTER. I certainly wish that it could be. I think this is a vital area that we have to enter. We have to be a little bolder than we have been about this.

Dr. STEWART. This is not a matter of not being bold, Dr. Carter. It is the intention of this bill to give the States the flexibility of deciding what kind of programs are terribly important in their area. We have had an indication from the States. We have asked them what are the priority areas that they would consider under this, and some 30 States indicated that family planning would be included among the top priorities on their list.

Mr. CARTER. I am happy to hear that. I think 50 would be better.

Mr. COHEN. But could I say that one of our justifications for the increase in the authorization both with regard to the formula grants and the project grants, beginning in 1969 and thereafter, is that there would be a very substantial increase in the role of State and local health departments in family planning activities.

We anticipate that. We would encourage it, and would give every degree of sustaining those projects both in the form of the grants and the project grants to the State and local health departments. We think it is extremely important and has very high priority.

As the Surgeon General said, in view of the fact that we now have very enthusiastic support from many of the State and local health departments, we think that you will find that this bill will go in that direction.

Mr. CARTER. I am glad to hear that. Thank you, sir.

Mr. ROGERS. Mr. Kornegay?

Mr. KORNEGAY. Thank you, Mr. Chairman.

Mr. Secretary, it is certainly nice to see you and your fine associates. I welcome you to the committee. I want to first make two or three observations. I want to commend you for moving away from the categorical grant to the broad—whatever the term is—way you have this and for calling on the States to do more in these areas. I think it is the best way to do it. I think we get more for our money, both in the community health area as well as the school area. I am hopeful that you will give some reconsideration to your position on education. I can't find a school man in my area who agrees with you on the school grants.

The other day I had a meeting in which I was told about instances where school districts and superintendents had microscopes and typewriters still in the boxes and not even used, whereas in other areas there was a need for money. Of course they couldn't get it, because they could get it only for certain things. So they took the money and stocked up. Be that as it may, in connection with the rising cost of medical care expressed here this morning by certain members of the committee, and I think by you, I want to find out if I had the figures right.

You said it was about 7 percent per year from 1946 through 1965. Then in the last year, or as the first year of medicare came into effect, it about doubled, 14 percent. Is the Department of Health, Education, and Welfare investigating? Have you any sort of program of research to try to determine why these costs have increased to such a abnormal extent?

Mr. COHEN. Yes, sir. We are doing several things. One is, we are looking into the reasons why the costs have risen. We are calling this national conference of all leaders in June to find out where they think the costs have risen and how to alleviate that cost rise, and we are

asking for the substantial provisions in this bill to start the systems analysis and research that is necessary to bring a greater degree of productivity and efficiency in the health industry.

Mr. KORNEGAY. The Federal Government has increasingly put more money into health, health education, and health facilities in this country. Of course, I can recognize that this may be very superficial, but it appears to me that the more money that the Federal Government or government itself, public money that goes into health care the greater the cost becomes to the private citizen, which is somewhat of a paradox in a sense.

I can appreciate the fact that you have this research going on in various phases, but at the same time it seems to me that somewhere, somehow we ought to dig into this problem; because I think it is one of the biggest problems facing the medical community today and facing the people of this country. The average person wants to be able to pay his own way, pay his own doctor and hospital bill, but if something isn't done within—I used to say 20 years, but after the hearing this morning I am going to hold my figures to 10 years and say if something isn't done by 10 years, all the hospitals will be owned by the Government and all the doctors will be working for the Government, and it will be just like the school systems. I am afraid we will come to that, if something isn't done.

Mr. COHEN. I certainly agree with you on the importance of our finding some practical solutions to these cost efficiency problems. I think they are going to take vast changes in the way we organize and deliver services, but I don't think we need to make any change in the fundamental way we are operating; that is, the private practice of medicine and the voluntary hospital system of this country which are essential to what we are doing.

But I do think that we are not delivering the highest quality medical care in the most efficient way that would be possible, Mr. Kornegay. And that is going to be the real problem in the next decade, how to find out what is that most efficient system that is compatible with decentralized voluntary private practice of medicine.

I don't have the answer. I don't think anybody has the answer.

Mr. KORNEGAY. I am not faulting you for not having it. I don't know the answer either, but I think you ought to give it a lot of consideration, trying to find out what can be done.

Mr. COHEN. I think you are making a better argument than I have made for section 3 in the bill. I think section 3 of the bill is the essence of what you and I are talking about.

Mr. KORNEGAY. If section 3 will do what you and I are talking about, I certainly am for section 3.

Mr. COHEN. It would certainly go a long way. I can assure you of that.

Mr. KORNEGAY. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Brown?

Mr. BROWN. Mr. Cohen, I am interested in the criteria that are established in the language on page 2. It says that the grant shall be made in accordance with, and I quote "criteria which the Secretary determines will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient manner . . ."

Are these Federal criteria to be written first by the Federal Government or are they going to remain sort of anonymous and the judgment will be made on the basis of each individual application?

Mr. COHEN. I think that we would have to work very closely with the States in developing these criteria. We don't have them written out now, but I do think that they would have to deal with the kind of problems we were talking about earlier. Not every hospital would have every piece of equipment or every type of service that would duplicate others in a given community, and try to set up some type of elements that would assure that communities would have all of the services but not necessarily every facility having all of the services.

Mr. BROWN. Let me phrase the question a little differently and then we can go ahead and pursue this, perhaps. Do I understand the language of that section to mean that the criteria will vary from State to State?

Mr. COHEN. I would not think the criteria would vary from State to State. I think the criteria would be national, but broad enough to permit variations in the State, including such matters as the difference in rural and urban concentration, the per capita income, and how they proceed toward the plan from wherever they were. But I would think the criteria would have to be broad, general, national, and set out the major elements.

Mr. BROWN. Is it possible to write up such criteria? That really is my question, because it seems to me that you get into the same problem that you would have, and that we have heard mentioned here this morning by a couple of people, on the school grants.

The complaint is that the Federal criteria are so vague that what will be accepted in one community in one State will not be acceptable in another community in another State, or even in two different communities in the same State, because two different people at the Federal level make the judgment or else the judgment is being made differently in each instance.

I understand that if you are talking about Mississippi and New York City you have different medical problems that you are trying to meet. But is it possible to write the criteria in such a way that this can be covered in advance, so that somebody in rural areas knows what to measure it against?

Dr. STEWART. I think it is, Mr. Brown. First, there is a body of information existing in the country. New York State, for example, has had the statewide planning in the regional councils in a sense doing this for several years. Many of the areawide planning hospital councils have developed criteria in this area, too. I think what we are really talking about is establishing criteria in such way as to enable us to determine the need for a certain kind of operating room in an area on the basis of population density or some other measure which reflects the rural nature of an area.

This is the kind of criteria we are talking about. We are talking about criteria which allows one to have some idea of what kind of distribution of equipment and types of services are necessary to serve people in whatever the area described with the best in medical care. It is to try to get around the problem that we have now, where the planning is done within the hospital and they may be adding expensive equipment or an expensive extension, or something else, without re-

gard to the fact that there is another hospital in the same community that just made a similar innovation this last year.

Mr. BROWN. I appreciate that.

Dr. STEWART. I think we ought to develop criteria related to population density which is general enough, I think, which gives the criteria which then the State agency can take and apply to all the variations that they have within the State.

Mr. BROWN. Is it your intention to write such criteria?

Dr. STEWART. We would try to develop these criteria for the Secretary to write and put out, and we would, in developing these, certainly consult with all the area planning groups in the country that have been carrying this out.

Mr. BROWN. Has any action been taken on doing this?

Dr. STEWART. Yes. I don't know whether it is the first or not, but one of the earliest attempts at this was the Rochester, N.Y., Hospital Council in which they were faced with the problem of several hospitals asking for fundraising to add beds to their hospitals. A survey under the auspices of the council indicated that there actually wasn't a shortage of beds in the community.

Mr. BROWN. You are talking about an individual instance in Rochester. I am talking about the question, are any Federal criteria in preparation at this moment in connection with this program.

Dr. PETERSON. Mr. Brown, staff has been at work on development of regulations for 314(a) and 314(b) along with representatives from State and local planning agencies. These procedures, regulations, and policies will be submitted to the participating agencies for their review and comment prior to the time that they would become effective.

Mr. COHEN. I am not aware, Mr. Brown, of any criteria that have yet been prepared under this new subsection.

Mr. BROWN. These would presumably be prepared after legislation has been passed by Congress.

Mr. COHEN. Yes.

Mr. BROWN. And if the criteria are not satisfactory to the Congress, what recourse has the Congress at that point?

Mr. COHEN. We would only develop these criteria in accordance with the provisions of the existing statute that they have to be developed after consultation with the State health planning agency, so that I would presume that they would, in the course of time, be more or less in agreement with them.

Is that your concept, Dr. Stewart?

Dr. STEWART. This is correct.

Mr. COHEN. You could indicate that the criteria have to be consistent with the provisions of section 3.

Mr. BROWN. I don't mean to belabor this, but I think it creates a problem certainly perhaps not as great as in education; but there is still difference in opinion in the medical profession as to whether or not the payment principle is the sound one, and this may present some very serious problems. You may get a lot of howls coming up over the country that these criteria which we are enacting in this legislation blindly are not appropriate to the medical profession throughout, or not satisfactory to the medical profession.

I think you have the same problem involved in this as you do in our approval of the criteria for interstate medical laboratories without knowing what these criteria are going to be. Somebody else raised

the question about the size of areas intended to be served, and that of course occurs to me.

Mr. COHEN. I think I see your point there. We might give some further consideration as to whether that couldn't be spelled out in a little more detail.

Mr. BROWN. I was going to ask the same question that Mr. Rogers started to ask, and if I can pursue it just one step further, where do you anticipate the funds for section 4 emergencies will come from? Did I miss your explanation of that?

Dr. STEWART. These funds in the past have come from reprogramed funds. If the amount became substantial, then we would have to seek recourse in the Appropriations Committee.

Mr. BROWN. In other words, you will borrow them from some place else within the Department?

Dr. STEWART. If it were a small disaster which was over in 3 hours, it wouldn't make much difference. But if the service we provide is one that takes a great deal of equipment and supplies, we would have to seek reimbursement.

Mr. COHEN. If a program involves a substantial sum of money, we advise the Appropriations Committee. But it might well be that we give consideration to ask the Appropriations Committee for a separate item to take care of that, because our major argument about reprograming is that it does set back the program for which the Appropriation Committee gave the money. By the time you get it all going again, you have disrupted a program. And I think my own preference would be, at least within some margin of error, to ask for a modest appropriation from the Appropriations Committee.

Mr. BROWN. Let me move to item (2) on page 10, "Definition of interstate commerce in the laboratories." If I live in Arlington, Va., and am being treated or analyzed by a laboratory in Washington, D.C., am I to presume that if I take a biological specimen at my home in the morning in Arlington and bring it to the laboratory in Washington, D.C., that that laboratory qualifies in interstate commerce?

Dr. STEWART. Yes, sir. That is correct.

Mr. BROWN. If I were in Arlington, however, and went to Richmond, Va., it would not be; is that correct?

Dr. STEWART. That is correct.

Mr. BROWN. If the laboratory is in a hospital, does that put it also in interstate commerce?

Dr. SENCER. Not necessarily, sir.

Dr. STEWART. Not just the fact of being in a hospital.

Mr. BROWN. If the hospital treats people from out of State?

Dr. SENCER. The laboratory has to receive specimens from out of State.

Mr. BROWN. If it treats people from out of State? Let's put the example in a different way. If we have an accident case in a hospital on an emergency basis and the people come from out of State, and we have to send back and perhaps get some laboratory information from the persons' home for analysis in the laboratory where they are being treated on an emergency basis, does that put the laboratory in interstate commerce?

Dr. STEWART. I think, Mr. Brown, the best explanation would be that if a specimen is transmitted across a State boundary to the laboratory, that comes under the definition.

Mr. BROWN. Let me phrase the question. I think you are in a difficult area here, and I am trying to feel my way through it. I don't want to take the time of the committe in too much detail, but let's presume that we have a university with a university hospital and a student from out of State in that university hospital and the student goes home for the holidays and is asked to send a biological specimen to the hospital for the continuation of a series of tests. That puts the hospital laboratory in interstate commerce; is that correct? So that the laboratory never really knows when it may come under the classification of interstate commerce, because it treats people who may in effect move out of State or be residing temporarily out of State who have to continue a course of biological analysis.

Dr. SENCER. I think many of these university laboratories would qualify as being in interstate commerce for other purposes. Many university laboratories accept specimens that are for analysis that will not be readily available in their laboratories in the area.

As a physician, I know that I can send a specimen to the University of California.

Mr. BROWN. What about the clinic that does not have a hospital and the doctor does some of his own analysis and gets a specimen from a youngster who has gone home for the Christmas holidays?

Dr. STEWART. A physician taking care of his own patient is not covered.

Mr. BROWN. A group of physicians?

Dr. SENCER. That's exempted in this legislation, sir.

Mr. BROWN. Where do you draw that line?

Dr. SENCER. If in a laboratory a physician is taking specimens to use for the treatment of his patient and doing the examination under his own control in his own laboratory.

Mr. BROWN. Suppose you have a cooperation of several physicians and one does the analysis but another treats the patient?

Dr. SENCER. I think that our definition in the bill would include group practice or clinic-type practice. We are not trying to say that they automatically come into interstate commerce.

Mr. BROWN. It is a thorny area.

Dr. SENCER. Yes, sir.

Mr. BROWN. And without standards so that nobody really knows whether he is covered.

Dr. SENCER. I think there is a 13-month leadtime in which standards would be developed, would be published and would be reacted to.

Mr. BROWN. After the enactment of the legislation?

Dr. SENCER. As Mr. Cohen said, we will be glad to submit for the record the tentative standards that would be used here.

(See p. 41 for standards requested.)

Mr. BROWN. One final question. I have heard figures extended over a period of 2 or 3 years. What provision is there for the State to take over any of the financing of these grant programs that the Department has in mind here for demonstrations? Is there any thought given to that?

Dr. STEWART. Under the formula grant 70 percent of the money must be spent for local services that we talked about earlier. Thirty percent can be retained by the State.

Mr. BROWN. You are missing my point altogether, I think. What provision is there for the State to take over self-financing of some of

these demonstrations and programs for comprehensive medical plan, and so forth; in other words, to relieve the Federal Government of the necessity of financing a portion of the State effort? Is there any provision for that?

Mr. COHEN. Well, no; there really isn't.

Mr. BROWN. In other words, you presume that indefinitely the Federal Government will be assisting the States through Federal resources?

Mr. COHEN. Yes; and I think that that is what I tried to say before. I think that is what is going to happen. The States and localities are spending in the neighborhood of $700 million in this area per year.

Mr. ROGERS. Will the gentleman yield? I think it is true that this money is not just automatically allocated. Must there be now with the State plan a request from the State?

Dr. STEWART. That is correct.

Mr. ROGERS. So your action in allocating certain monies to the State is a result of a State's request for the Federal Government to participate. So that really, I presume, the basic decision as to whether a State will contribute in the program or continue to rely on Federal funds comes down to a State decision when they present their plan.

Mr. COHEN. Yes; and I was assuming that. What I think Mr. Brown may have been getting at, if I understood his question correctly, is that we are going to be putting $100, $200, $300 million into this area. The States, as I said, are putting in $700 million a year. I would expect the States and localities to have to continue to increase their share as the Federal Government increased its share, so that in a few years from now I think the total expenditures in this whole area would be well over a billion dollars a year. And I think with a growing population we need to spend more too on family planning services, the need for the training of more nurses and physicians, and the organizing of local health services.

I know in my State of many places where they do not adequately exist, and I would have to say that both the Federal Government and the State and localities are going to have to increase.

Mr. ROGERS. I am surprised to see that there is nothing in this act, as in the Mental Health Facilities Act, to encourage the States and localities to take over the responsibility of their own demonstrations or comprehensive medical plans.

Mr. COHEN. Only to the extent that they are already spending so much more than the Federal Government is spending already, and we would expect them to continue to do so.

Dr. STEWART. This is what I was going to say. There is another way to say it. Federal-State-local expenditure for public health services amounts to about $4.25 per capita: $2 is State, $1.50 is local, and 75 cents Federal. From all the studies and State surveys that we have seen, we think that the level we should approach is around $6 per capita within the next few years. This is really a shared expenditure to carry out services. While the services may change as techniques and problems change, there are so many great needs that as far as we can see this shared effort will continue.

Mr. ROGERS. Do I understand that the dollars and cents in this whole thing is $182 million?

Mr. COHEN. Well, if everything in this bill were under the present law, it would be $157 million. We are asking for $25 million more in 1968. The comparable total for 1969 would be $284 million.

Mr. ROGERS. 1968 was $192 million; is that correct?

Mr. COHEN. Yes; $182 million. That is both sections 314, 305, and 309. It doesn't include anything that is involved in the regulation and licensing of the clinical laboratories, however.

Mr. ROGERS. No expense figure for that?

Mr. COHEN. No expense figures for that, no; or the 51 additional people that Dr. Sencer mentioned as the additional number of people. This will only have to do with the grants and other factors.

Mr. ROGERS. Is it your thought to come in with a supplemental request for that later?

Mr. COHEN. Either a supplemental or in the normal appropriation for the National Communicable Disease Center.

Mr. ROGERS. Let me pursue that for just a minute. You say there will be 51 additional personnel required to administer the laboratory-licensing provision?

Dr. SENCER. Yes, sir.

Mr. ROGERS. And I think it would be well to submit for the record the number and cost.

(The information requested follows:)

"PARTNERSHIP FOR HEALTH AMENDMENTS OF 1967" CLINICAL LABORATORIES IMPROVEMENT—LICENSING OF LABORATORIES—PERSONNEL AND COST ESTIMATES

Budget summary, 1st year

Personnel	$457,648
Payroll benefits	45,765
Travel	71,500
Transportation	15,000
Communications (telephone, postage, parcel post)	20,000
Rent (300 gross square feet per person times $3 per square foot)	46,900
Contracts (consultation fees, training, films and manuals, publications, etc.) reference labs for evaluation	250,000
Supplies and reagents	293,187
Equipment (1st year cost—subsequent years 10 percent)	300,000
Total	1,500,000

BUDGET NOTES

1. Budget based on an estimated 1,000 laboratories transacting business in interstate commerce.
2. An Annual cycle for reviews and certification is planned.
3. Evaluation of performance will be carried out throughout each year.
4. Resurvey of approximately 90 laboratories where correctable deficiencies are found.
5. Review of 150 laboratories per year per man is estimated. (260 gross work days less 20 days less annual leave, 7 days sick leave, and 13 holidays=220 net work days. At 4 reviews every 5 days, 176 reviews per man-year would be performed. This is rounded to 150 reviews to allow for travel, report writing, and general in-house administrative duties.
6. Travel and per diem costs estimated on basis of seven travelers making 2 trips per week for 44 weeks during the year, as follows:

14 trips times $100 per trip times 44 weeks	$61,600
3 days per diem times 7 people times $16 per diem times 44 weeks	9,900
Total	71,500

Personnel

Office of the Chief:	
Program Chief, GS–15	$17,550
Assistant Chief, GS–14	15,106
Legal assistant, GS–13	12,873
Do	12,873
Secretary, GS–6	5,867
Secretary, GS–5	5,331
Total	69,600
Administrative office:	
Executive assistant, GS–13	12,873
Secretary, GS–4	4,776
Clerk-typist, GS–3	4,269
Do	4,269
Total	26,187
Statistical office:	
Statistician, GS–11	9,221
Statistical clerk, GS–6	5,867
Clerk-typist, GS–4	4,776
Total	19,864
Field consultation:	
Consultant (reviewer) super, GS–14	15,106
Do	15,106
Consultant (reviewer) GS–13	12,873
Do	12,873
Do	12,873
Do	12,873
Do	12,873
Secretary, GS–5	5,331
Do	5,331
Do	5,331
Do	5,331
Total	115,901
Training:	
Training supervisor, GS–14	15,106
Training specialist, GS–13	12,873
Do	12,873
Secretary, GS–5	5,331
Total	46,183
Evaluation:	
Chief evaluator, GS–15	17,550
Hematologist, GS–14	15,106
Chemist, GS–14	15,106
Chemist, GS–13	12,873
Microbiologist, GS–13	12,873
Serologist, GS–13	12,873
Cytologist, GS–13	12,873
Medical technician, GS–7	6,451
Do	6,451
Do	6,451
Do	6,451
Secretary, GS–5	5,331
Do	5,331

Personnel—Continued

Evaluation—Continued	
Laboratory assistant (sup. ser.), GS–4	$4,776
Do	4,776
Do	4,776
Do	4,776
Do	4,776
Laboratory assistant (sup. ser.), GS–3	4,269
Laboratory assistant (sup. ser.), GS–2	3,925
Do	3,925
Do	3,925
Mailroom worker, GS–3	4,269
Total	179,913
Total salaries (51 people)	457,648

Mr. ROGERS. I notice that there is also a provision that the Secretary may, if he deems it appropriate, require payment of fees for the issuance and renewal of licenses. What is the Department position on that? Do you contemplate that, and what is the stipulated cost?

Mr. COHEN. We quite frankly, Mr. Rogers, have not reached any final decision in our own mind as to whether there should be fees or not. But recognizing that if we decided that there should be fees that we couldn't do it without authorization, we put this into the law. I think there are different points of view on this matter. Some people feel that when you are giving a service to an organization like this which is a profitmaking organization you ought to charge the reasonable cost of the service that you provide them. The other way of looking at it is, as I said earlier, that this is a community service to assure you as a consumer of medical care just like in the Food and Drug Administration that you have pure food, pure drugs and, in a sense, a pure laboratory.

But we would go into it and talk with the interested parties and make some kind of a survey to see whether we should charge a fee, and on what basis.

Mr. ROGERS. I think it would be well to submit to the committee some of your thinking on this, a possible range of license fees. Because I think the committee would want to go into this before we approve any approach. We would like to have some idea of what the costs would be, what burden it would place on the laboratories and additional cost for a laboratory test if the cost is very high.

Mr. COHEN. We will be glad to submit something for the record.

(The information requested follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

EXAMPLES OF FEE SCHEDULES UNDER CLINICAL LICENSING ACT

1. A flat fee proposal of $25 per lab which would recover approximately 25 thousand dollars of the total licensing cost of one million, 500 thousand.

2. A cost per test schedule that would be graduated from a high cost per test for very complicated lab procedures to a low cost per test for simpler ones. For example, a licensing charge of 25¢ per test run by laboratories specializing in very complicated analyses and 2 to 3¢ per test for labs engaged in massive quantities of simple procedures could be made. This may produce revenues as follows:

A. A lab performing a thousand highly specialized tests at 25¢ per test would have a total licensing fee of $250.

B. A lab producing 10 thousand tests at 3¢ a test would have a licensing fee of $300.

3. A differential schedule would be designed to produce revenue meeting the full costs of the licensing program. This schedule would use a formula that extends the fee on the total number of tests run regardless of difficulty or complexity of the analytic procedures. Under this method, approximately 1 thousand labs would have to produce 1 million, 500 thousand dollars in revenue, or an average of $1500 per laboratory.

Mr. ROGERS. I think it would be well for us to clarify this quickly, and I will try not to detain you much longer. You have been very generous with your time before the committee this morning.

On comprehensive planning, I think it would be well just to clarify some of the questions that we are beginning to get on how comprehensive State planning will fit in with regional planning, how do the two mesh or do they? Maybe you could clarify that as quickly as possible.

Dr. STEWART. Mr. Rogers, the planning under a regional medical program bears the same relation to comprehensive planning as the mental health and mental retardation planning and Hill-Burton planning and all the other specific program planning that is going on.

The regional medical program planning is to move from where they are to the operation of a program which results in better care of people with heart disease, cancer, and stroke in their community setting. In so doing it creates resources and it uses resources. It uses trained people and it uses hospital beds and other things.

The comprehensive health planning agency is looking at longer range targets. They are looking at all the individual health planning efforts and all the objectives that they are attempting to meet. The comprehensive agency is saying, "Will we be able to implement these plans with the number of physicians, the number of nurses and the economic growth of our State over the next 10 years? What are the choices we have if we cannot do everything we want to do within the resources we have?"

I would bet that most of the time they will come up with more plans and more programs than they have resources for since there is a shortage of almost everything at the present time. The comprehensive health planning agency will gather information on what are the States' objectives, what are the goals they are trying to reach. Many of the goals are being defined by the individual planning efforts like the mental health and the mental retardation planning programs.

Then they have to look at what are all the resources that may be devoted to health in this State over this period of time. What kind of choices do they have? If they go this way, they might be able to make it. If they go this other way, they may have to decide to put something aside or time it differently or perhaps if they really want to carry out these objectives, they have to build two more medical schools in their State.

They are trying to relate resources to programs in a broad sense so that they are complementary to each other.

The information generated by the regional medical program to carry out its objective is part of the information that the comprehensive State health planning agency will use. Similarly, the information generated by Blue Cross or generated by Hill-Burton or generated by any other study group on resources or programs is information that is used. What the agency does is lay this out in a pattern so one can

see where they are trying to go in 10 years in their State and what are their needs and resources in order to accomplish their goals.

Mr. ROGERS. Do you anticipate that the Hill-Burton program will be carried as a separate program or in a comprehensive block program?

Dr. STEWART. The Hill-Burton program will be carried separately. It is planning and developing new facilities in the State. This information would have to be related to planning of other kinds of health facilities in the State since there is a limit to the amount of capital that may be available within that State, for the construction of facilities over the next 10 years.

Mr. ROGERS. What about the medical schools? Suppose there is a medical school or maybe there may be four of them. They want to expand. Maybe they serve more than just one State.

How does the comprehensive State plan affect the future expansion, say, of a medical college?

Dr. STEWART. I would think that a State would take a look at where their doctors come from now? They would determine how many are coming from their own schools and how many from other State schools or other schools in other States, and then determine what the pattern has been? Then they look at all the developments that are being planned for the next 10 years in their State and find their needs are going to exceed the supply of physicians in that State even though those coming from other States may be doubled in their estimate.

Therefore, they find they have an immediate need for a medical school in order to reach these 10-year program goals since a 10-year leadtime is needed in building a medical school. This means then that the capital to develop a medical school has to be put into that State to do it.

Mr. ROGERS. Suppose they have an oversupply for that particular State?

Dr. STEWART. If they have an oversupply of physicians as far as meeting the program goals that they are developing in that State, those goals being developed both privately and publicly, then they don't have to worry about developing a new medical school in their State.

Mr. ROGERS. Maybe the State is in New England. Maybe they serve a three-State area.

Dr. STEWART. If one of the objectives of that State is to be the producer of physicians not only for their State but for other areas, they would count this in their plan.

Mr. ROGERS. Here is what I think people are concerned with: Will the comprehensive State plan be the determining factor; is it going to be a regional plan or what? Then I think we need some assurance on these questions.

Dr. STEWART. The comprehensive State plan relates to that State and the resources of that State and whatever the program objectives are in that State. If that State is serving other States, as for instance in a case where a city is situated on a State boundary this will come into consideration. There will have to be come interrelation between these States.

While it will lay out these priorities and choices, there is nothing in the legislation that gives the comprehensive State health planning agency the authority to say, "This has to be," or "This has to be."

Mr. COHEN. There is no question, Mr. Rogers, that this national aspect has to be taken into consideration. The University of Michigan Medical School, with which I am very intimately familiar, obviously serves not only the State of Michigan, but being the largest, nearly the largest medical school in the Nation, it has great national significance and its research program and the people who come to it have an impact all over the country.

I think that you would have to, in the State planning, take account of that type of institution that performs out-of-State service.

Mr. ROGERS. Out-of-State service?

Mr. COHEN. There is no question about that. I think that would have to be looked at as one of the considerations of the State plan. When you get to Minnesota and you deal with the Mayo Clinic, you certainly can't deal with the Mayo Clinic in terms of the type of medical services and the people who come there and all the other things in terms of Minnesota.

Mr. ROGERS. I would agree with you, but I think there has been some concern about this and this needs to be cleared up. Now, also about the community mental health facilities, here again would be a problem I would think.

Dr. STEWART. I think the best way I can illustrate it, Mr. Rogers, is that you have a whole series of programs being planned—community mental health, regional medical programs—but there is no way at the present to look across these and relate all of these plans to determine the possibilities of using existing and developing additional resources. It is a method of collecting the information and laying it down so that one can look at it. This is what the role of the comprehensive health planning agency is.

Mr. ROGERS. Do we have a comprehensive plan for the United States?

Dr. STEWART. No, we have not. We have, I think, cited some goals. The President cited four goals in the health message this year. We do have national objectives in certain areas, but not in the sense that we are talking about here.

Mr. ROGERS. Should we?

Dr. STEWART. I think eventually we will come to this point. I think it is probably better to build it up from the legal areas than it is to start now.

Mr. BROWN. Will the gentleman yield?

Mr. ROGERS. Yes.

Mr. BROWN. It seems to me that this is really what we are talking about. There has been some implied criticism, not of the community of Rochester specifically, but of other communities, for their failure to take into account what the other guy may be doing in the interest of economics, efficiency, and so forth.

Dr. STEWART. That is correct.

Mr. BROWN. If you don't take into account what is being done in the medical schools in Cincinnati and the hospitals of Cincinnati, how are you going to have a comprehensive plan for the State of Kentucky, much of which is served by the medical facilities in Cincinnati?

Dr. STEWART. You are quite right, Mr. Brown. The development of a comprehensive State health plan in Ohio would certainly have to

take into account the relationship of the health personnel in Ohio and Kentucky.

Mr. BROWN. And it can't do this without a comprehensive plan for the United States.

Dr. STEWART. I was taking this in a different connotation. There is some comprehensive planning in the United States. We have some idea of what the economic development will be in the United States and what proportion of the dollar, the health dollar, might be 10 years from now and how that might be distributed between capital and expenditures.

Mr. ROGERS. If the gentleman will permit, I think we would be concerned about manpower here, is there enough national effort in the individual States to have enough schools to provide the proper manpower.

Dr. STEWART. No, I think we have recognized there is not enough effort.

Mr. ROGERS. Should we start devoting more effort to this area? In other words, I think we kind of need an across-the-whole-spectrum as well as vertical view.

Mr. BROWN. I don't want to appear to sandbag you in cooperation with my colleague in the chair.

Mr. ROGERS. The Chair, I might say, is not trying to.

Mr. BROWN. We have had some discussion in the State of Ohio as to whether or not we should have another medical school. I think this patently is a question which involves more than just the State of Ohio because if every State is going to have another medical school, then perhaps we have too many medical schools in the United States. Again it seems to me that in determining the criteria that are mentioned on page 2 of the legislation that there is implicit some kind of an overall plan for the entire United States in order to get an adequate plan for the individual States, and if that is not the case, then the criticism which is made of the local community in defense of the State plan is invalid.

Dr. STEWART. What I am saying, Mr. Brown, is in your decision-making as to whether you should or should not have another medical school in Ohio, besides taking into consideration the manpower needs, I think you would also need to know what kind of capital is going to be needed in your State for hospital construction in the next 10 years, for community mental health centers, and for all the other health needs in relation to what you think the capital resources will be in the next 5 years. This helps you make your choice.

Mr. ROGERS. I agree with the Surgeon General, and I am sure Mr. Brown does, too, that we need to know this information and a comprehensive plan is a good idea and the Congress adopted it. This committee did.

I think the point we are trying to develop is that perhaps we also need some thought of a group within the Department presenting an overall picture for the United States and relating it for the committee.

Mr. COHEN. Very definitely we would conceive of our responsibility more and more to develop the totality of the information necessary for the whole health resources in the country, and it is not simply because of the factors that you mentioned of the medical school, but the point is that the Federal Government is going to be putting so

much money into both medicare and medicaid in the payment of actual services that the Federal Government has a real dollar interest as well as quality of care in being sure that (*a*) the services and facilities are available and (*b*) that they are not overbuilt because we are going to be helping to pay for them.

On the national point don't forget that under the legislation for the construction of medical schools and under the Nurse Training Act there still is a Federal responsibility and a congressional responsibility for determining the kind of priorities and emphases because what do you do with regard to the Medical School Construction and Educational Assistance Acts and the Nurse Training Act determines national priorities with regard to those manpower as well as construction aspects so that there is still that aspect remaining.

Mr. ROGERS. Let me ask a couple of questions on section 11(a) where it broadens the definitions of students eligible for loans. Does this put them in the category of no payment, or what is the purpose of this?

Dr. STEWART. What this does is correct an oversight, Mr. Rogers. The intent of the Nurse Training Act was to provide a grant to the school for the federally sponsored student. In that act the definition of federally sponsored student covered the contributing loan fund. The Allied Health Professions Act added the revolving loan fund, and since the language did not take into account that those students are not covered in the grants to schools, this is corrective.

Mr. ROGERS. In section 11(c) why is it that you need another higher education representative to the National Advisory Council on Education for the Health Professions?

Dr. STEWART. Mr. Rogers, I don't know the answer to that question.

Mr. ROGERS. Will you let us know and supply it?

Dr. STEWART. We will supply it for the record; yes, sir.

(The information requested follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON SECTION 11(c) OF H.R. 6418—MEMBERSHIP OF THE NATIONAL ADVISORY COUNCIL ON EDUCATION FOR THE HEALTH PROFESSIONS

The Veterinary Medical Education Act of 1966 amended Sec. 725 of the Public Health Service Act to add one member of the Advisory Council on Education for the Health Professions. The former membership of the Council was divided between four members from the general public and 12 members from among leading authorities in the fields of higher education. No change was made in this division at the time an additional member was added to the Council. The proposed amendment—Sec. 11(c)—would change the language of the second sentence of Sec. 725(a) so that the division of the Council would be between four members of the general public and 13 members from among leading authorities in the fields of higher education, the effect being that the additional member who was to represent the veterinary profession would come from among leading authorities in the fields of higher education instead of the general public.

Mr. ROGERS. I think that is all.

Thank you very much for your testimony and for your patience. You have been most helpful to the chairman.

Mr. COHEN. Thank you, Mr. Chairman.

Mr. ROGERS. The committee will stand adjourned until 10 o'clock in the morning.

(Whereupon, at 1:05 p.m., the committee adjourned, to reconvene at 10 a.m., Wednesday, May 3, 1967.)

PARTNERSHIP FOR HEALTH AMENDMENTS OF 1967

WEDNESDAY, MAY 3, 1967

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

The committee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Harley O. Staggers (chairman) presiding.

The CHAIRMAN. The committee will please come to order.

This morning we continue the hearings on H.R. 6418, a bill to amend the Public Health Service Act to extend and expand the authorizations for grants for comprehensive health planning and services.

Our first witness this morning will be John H. Venable, M.D., president of the Association of State and Territorial Health Officers.

Dr. Venable, will you take the chair, please, and identify yourself and the gentlemen that are accompanying you. You may proceed in any way you see fit.

STATEMENT OF JOHN H. VENABLE, M.D., PRESIDENT; RUSSELL E. TEAGUE, M.D., PRESIDENT-ELECT; AND ALBERT HEUSTIS, M.D., SECRETARY-TREASURER, THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Dr. VENABLE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I appear before you today as president of the Association of State and Territorial Health Officers, with Dr. Albert Heustis, of Michigan, our secretary-treasurer, on my right, and Dr. Russell Teague, our president-elect, on my left. This indicates the importance which we give to this legislation. We want to present our association's views on H.R. 6418, the bill to extend the authority of Public Law 89–749, to require the licensing of clinical laboratories which do business in interstate commerce, and sundry additional proposals. The burden of my statement to you today will deal with the extension of Public Law 89–749.

On October 11, 1966, it was my privilege to represent our association and the State of Georgia before this committee when hearings were conducted which resulted in Public Law 89–749. That brief hearing, the committee will recall, was necessitated by the need for immediate congressional action to extend the authority of the old section 314(c) of the Public Health Service Act, the basis for Federal support of public health programs throughout the States. At this point, I wish to express our appreciation to the chairman of the committee, Mr. Staggers, for scheduling these hearings on H.R. 6418. You gave us your assurance last October, Mr. Chairman, that you would take this action

and we are deeply appreciative of it. You may recall, too, that we promised on that occasion to present to your committee at this time the result of our studies over the past years relative to this grant program. I am now prepared to do so.

Our association believes that by the action which this committee and the Congress took last year in the enactment of Public Law 89–749 that you are convinced of the necessity for (*a*) the careful planning of health services which need to be provided to the people of this Nation, and (*b*) the need for flexibility in the grant arrangement between Federal, State, and local jurisdictions, whereby States and localities will have necessary freedom of action to expend these grants in a manner which will be most responsive to the health needs of their own particular State or locality. I shall not, therefore, press upon you our convictions that this was and is a necessary and proper action. We are looking now to the extension of this authority for the next 3 years; and it is my purpose today, together with my colleagues, to discuss with you in specific detail the level of health needs that we have found in our respective States and the level of Federal support necessary if these health needs are to be met.

We pointed out last October that the relatively small increase of but $6.5 million each for the formula and project grants would not enable us to make any significant impact on some of the needed programs which must be implemented. We agree with the comment of Congressman Watson, made at the time of my appearance, in which he expressed his view that a role of full partner did not seem to be accomplished when there was such a meager increase in the appropriation. You may recall, too, at that time it was the recommendation of the ASTHO that $100 million be authorized for the formula grants to States and an additional $75 million be authorized for the project grant authority—a total of $175 million rather than the $125 million which is authorized for health services in Public Law 89–749.

We have been very busy since the enactment of this law. We set about to make an assessment in each State of the total health needs. We asked each State health officer then to list these needs by priority, to report the amount of financial support available from State and local sources for the programs at the present time, and to program over the next 5 years the level of increased activities possible, taking into account available health manpower and anticipated increases in financing from State and local sources. We then asked them to report the level of Federal support that would be needed to carry on these programs at an optimum level. We asked further that each State report on three sepcific health programs: family planning, cervical cancer, and dental health, in order to provide a nationwide measurement of the problem level of these three health programs. This meant that in each instance we have received from each State a priority evaluation of health programs which could be funded through section 314(d) of the Public Health Service Act, the formula grants, consisting of not less than six areas and not more than nine. This careful scrutiny has revealed that we were much too conservative in our request of last October, because the surveys indicate that programs are needed and that we are in a position to implement programs at a level requiring $400 million annual Federal support. This is over and above State and local support which greatly exceeds the Federal contribution.

Let me give you some examples of what I am speaking of by reference to our own program in Georgia. For family planning programs, we have a potential caseload presently of approximately 210,000. Family planning services could be provided for 21,000 people with the expenditure of $196,000. We have State and local funding at the level of $146,000. We, therefore, would need $50,000 additional Federal support for this activity. In 5 years' time, when the caseload has increased to approximately 225,000, we can reach 70 percent of the objective or 136,000 with the expenditure of $1,380,000. It can be seen easily that there needs to be a great increase in the level of support from the Federal Government for this very necessary activity.

In respect to cervical cancer control, approximately 30 percent of women in Georgia are screened by private physicians. We have established a limited program, which has been budgeted and is being implemented for approximately 25,000 patients, which is only 4 percent of the total population with incomes under $3,000. The cost of this program presently is $56,000 for supplies and cytology readings. We could expand this program in 1968 to a level of $72,000 and in 1969 to a level in excess of $1 million. While the level of support from the State and local sources can be increased, it could not be of the magnitude necessary to implement the program which could and should be carried on.

In respect to dental health, of the approximately 1.7 million children in Georgia under 18 years of age, 1.3 million have experienced dental caries, which affect over 8 million teeth. Less than 35 percent have been treated, leaving almost 5½ million untreated carious teeth. Thirty percent of this population lives in areas not served by public water supplies, and 40 percent lives in communities where public water supplies still are nonfluoridated. We have a further problem with the shortage of dental manpower and its uneven distribution wherein rural areas and areas of economic need have the least availability to dental care. The ratio of dentists to the population of Georgia is approximately one to every 3,750, compared to one for every 1,750 for the United States as a whole. Our dental caries rates in the nonwhite population are approximately 20 percent less than in the white, but 94 percent of the nonwhite dental needs are untreated compared to 58 percent of the white. To correct this problem, we would like to fluoridate each year 100 of the 1,000 municipal water supply systems and 85 of the 425 schools with individual water systems. To accomplish this, our level of expenditure in 1968 would total $742,000 of which $120,000 would come from State and local sources, requiring a balance of $622,000 from the Federal grant.

Another priority in Georgia is the establishment of an aftercare program for State mental hospital patients. Approximately 10,000 patients each year are released through furlough or direct discharge from State mental hospitals. Each hospital operates an outpatient clinic, but many patients live great distances from the hospital, some up to 200 miles. At present, the pattern of offering assistance to patients released from mental hospitals is through county health departments. We are making some progress in establishing clinics in these county health departments staffed by a physician who reviews the progress of former patients and who changes and renews prescriptions as needed. Drugs are made available to the medically indi-

gent. At the present time, 12 of our county health departments operate such clinics, although most are not yet able to handle the volume of patients returning. The level of expenditure and the number of patients seen for the present fiscal year is approximately 750 patients with a drug expenditure approximating $50,000 and expenditure for personnel approximately $26,000. Of the 10,000 patients returning to the communities in 1967 from State hospitals, 5,500 are known to be without aftercare services other than minimal access by visitation of public health nurses, 3,750 can be seen at the outpatient department of the State hospital, and 750 can be seen in the present 12 aftercare clinics of county health departments. We plan and need to increase to a total of 45 the community care clinics. This number, serving each a population of not more than 100,000, would make statewide coverage possible. We also need to increase the range of services provided from the present emphasis primarily upon the supervision of medication to the total range of care necessary. This would require the services of a physician, preferably a psychiatrist; a mental health professional; a social worker or a nurse full time, public health nurse time equivalent to two full-time nurses; and a secretary. The level of this program presently is $169,000, all from State and local sources. If in 1968 an additional $400,000 could be realized from Federal sources, this could be increased together with the State and local funding, to a level of $600,000.

I might say parenthetically here, Mr. Chairman, that of the admission rate to our State hospitals, about 35 percent are readmissions. Most of these could be avoided if we had aftercare such as I am talking about.

Another of our serious public health problems is that of controlling tuberculosis. We have approximately 1 million persons in our State who have the tubercle bacilli in their bodies. Approximately 3.4 percent of the 1,269 newly active cases reported for Georgia in 1965 could be attributed to endogenous (internal) reinfections or breakdowns. We have a program in Georgia which attempts to follow cases of active tuberculosis who are not hospitalized to see that they are under medical supervision and are taking their drugs and other necessary precautions. We continue surveillance of inactive cases for 5 years to guard against reinfection. We also have prompt examination of contacts of active cases, medical examination and surveillance of suspects, identification and periodic examination of persons at greatest risk, and specific efforts to prevent children from becoming exposed to tuberculosis. The level of our support for fiscal year 1967 for this program is $1.7 million, of which $1.1 million is from State and local sources with a Federal share of $560,000. In our projected increase in the level of activity in tuberculosis control, at no point would the Federal contribution be greater than one-third of the total expenditure on this problem.

I believe these examples provide to you an idea of the specificity with which we have gone about our task of evaluating the health needs of our States, and the pricing out of the costs of the services which are needed to bring about bettered health conditions. Please understand that in each of these instances we are dealing with the application of known medical knowledge in making available to the people the fruits of research and experience which have been forth-

coming over the years. Not to apply our knowledge and skill is, in our estimation, a dereliction of duty and responsibility.

We, in Georgia, may by extrapolation illustrate the national need. We have carefully priced out nine high-priority programs and find that a realistic cost to meet these needs by 1971 is in the neighborhood of $20 million. Assuming that only one-third of this is a fair Federal partnership share, this would amount to $6⅔ million and, as Georgia's usual share of a national amount is approximately 2½ percent, the Federal appropriation should be in excess of $250 million for only these nine programs. But these nine are only part of the 50-odd health programs for which my department is responsible.

We urge upon you very seriously the consideration of increasing the level of appropriations authorized by Public Law 89-749 and contemplated under the bill presently before you to a level consistent with the health needs of the people of this Nation. It is our recommendation that Public Law 89-749 be amended so that the authorization for grants to provide health services, both for formula and for project, be increased from the present $125 million to at least $200 million for 1968, and that for 1969, $300 million be authorized; for 1970, $400 million be authorized; and for 1971, $500 million be authorized.

H.R. 6418 also proposes (on pp. 9 through 15) the licensing of clinical laboratories which engage in interstate commerce. Although our association has not had an opportunity to act upon this proposal, I feel confident that our constituent members, in great majority if not unanimously, support this proposal. I would like to suggest two points, however, which may need clarification. The first would make it clear that the Secretary would accept as meeting the letter of the law State laws or regulations relating to clinical laboratory procedures which are equal to or more stringent than those promulgated by the Secretary. Second, that the Secretary, via grants and contracts, provide financial assistance to official health agencies which are responsible for monitoring and consulting with these laboratories to the end that the health of our people can be safeguarded.

Now, Mr. Chairman, my colleagues here with me can speak from the standpoint of two other States, and if it is permissible, I would like for Dr. Heustis and Dr. Teague to speak briefly on this same matter.

Dr. HEUSTIS. Mr. Chairman, my name is Dr. Albert Heustis. I am the State Director of Public Health for the State of Michigan. I have held this position under Democratic and Republican administrations since 1948. While I, in my position as State director of public health, am very much concerned with the overall costs, I do feel that we have an obligation to present to this committee and to the Congress accurate levels of health need so that the committee and the Congress can make the proper decisions. One of the great expenses which could be reduced through careful investment is that of health facility services. I use the term "health facilities" very broadly to include hospitals and all other related facilities. In some information and suggestions which we prepared for our Michigan Legislature on hospital licensing that would improve standards by providing the State health department some strengthened ability to work with doctors, so that the doctors themselves might decrease the amount of time that people spend in hospitals, we discovered that if we could save one-half day—one-

half day on the average stay of patients in Michigan hospitals—we could have those that pay for that care of those folks $35 million a year.

This, Mr. Chairman, would be equivalent in Michigan to constructing a 2,000-bed hospital. This, we believe, is the type of thing that State health departments are capable of doing. By working with physicians in hospitals, by providing the stimulation, the guidance, the consultation, and, yes, even the push that I think is necessary to do this job, this is an idea of savings possible.

Now, we just can't do this all by ourselves. We need some help. Another way that we can help decrease the costs of medical care is by working with physicians and with patients to help them understand that for all health problems they do not have to receive care in what we generally refer to as an acute general hospital. In the metropolitan area of our capital city, a survey was made just before I talked to a group of visiting nurses at their annual meeting, which showed that less than 25 percent of the physicians in active practice in the greater Lansing metropolitan area ever used the the facilities of those agencies that were providing home bedside care, home health services. Again, if State and local health departments can work with doctors to teach them and to help them to understand what these services can offer, and can work with services so that they can provide what the doctors need for the care of their patients under the control of their own private doctor, I think we can help to save some money.

A third point in this general area is the yearly diagnosis of disabling chronic conditions. If we can help physicians through screening processes to suspicion—and I don't use the word "diagnosis", because diagnosis is a procedure for the physician—but if we can help them to suspicion those persons that have a greater chance of having some of our chronic disabling diseases, and can get to them the new technology that is now available, it certainly seems that we can accomplish something really important, costing a little money to be sure, but saving substantially greater amounts of money in the long run.

The fourth item that relates to improved health facilities services that would have a direct impact upon this cost where the really big money is, is improving the capabilities of nursing homes so that nursing homes may grow up to become more than storage facilities for our unfortunate older persons, but rather can take their true place in the whole framework of the health facility care institutions and really and truly carry on a more active service.

The second major point that I would make relates to strengthening services of local health departments, and one point with regard to the State health departments; that is, strengthening State and local health services. I read this chart on the plane coming down, and although it may not be readable to you, let me just describe it. This chart has several lines which go up almost to the top. They indicate for an entire year the incidence of measles. Just a short number of years ago a vaccine was developed. In fact, a couple of vaccines for measles were developed. We find a darker line that goes maybe a fourth of the way to the top of the chart that shows what happened last year. Then this year, with the help of Federal funds and with the help of funds appropriated by my own legislature and with the help of services provided by local health departments we vaccinated our children. This line is right smack along the bottom as far as it goes this year and

shows the improvement. If the committee is interested, I will get this in better shape. It just fitted right into what it seems to me you are interested in.

The second problem has to do with a fancy word—and I love to use it, because it shows that I did go to medical school and that I can use large words, even though I try not to—it is called phenylketonuria, and after I have said it once and impressed everybody, I like to say PKU. This is a disease in which a certain protein substance in newborn babies is not handled by the body easily and waste material from this protein substance builds up in the body and causes a certain type of mental retardation. Again using Federal funds and a combination of State funds and work by local health departments—and I bring out this partnership—we have been able this last year in Michigan to find seven youngsters with the potential of developing this disease. Let's talk about dollars and cents. We have an overall investment of perhaps $50,000 to $70,000 of everybody's money that is involved in the program which found these youngsters. We have a potential saving to everybody, again, of five youngsters at $5,000 a year in a mental hospital at a life expectancy of 20 years, $500,000. It seems to me that this is putting money where it will be a good investment, as far as health is concerned.

The last item has to do with a complementary activity to one in the bill. The bill proposes a system of interstate licensing of labortories, and I should like to report to the committee that in Michigan the State health department, the pathologists and the MD laboratory directors, the laboratory directors that are not pathologists have all agreed upon a State licensing bill; and this is now being considered by our own legislative committees. And, if we are to really carry out the intent of the Federal legislation of improving the quality of laboratory services available to the people, then again we need some help here.

I would point out in closing that there are at least two other items before the Congress in one place or another that would call for the expenditure of rather large sums of money—large as far as I am concerned. There is one somewhere along the line that would call for family planning expenditures of, I think, $15 million or so. There is another that would call for doing something about alcoholism to the tune of $35 million or so, and then the laboratory field.

It is our strong belief in State health departments that you gentlemen can get more for the Federal dollars that you invest in health if you invest them in this comprehensive health planning and health services bill. Again I want you to appreciate that, even though I am fully cognizant of the money problems, my job is to present the need and to try to give you and the people that I deal with in my own State the assurance and the knowledge that the money that they entrust to me is spent efficiently and economically.

Thank you very much.

Dr. TEAGUE. Mr. Chairman, and members of the committee, I am Dr. Russell Teague, the health commissioner for the State of Kentucky. I have appeared before you on numerous occasions in regard to health legislation. I am delighted to be here today to talk to you about the implementation of Public Law 89–749 of the last Congress.

You gave us an effective tool when you passed this bill last year, and we are here now to talk about the implementation of it. I endorse

and agree with the statements made by my colleagues here that all of these subjects that they have discussed are important to us in Kentucky. The intent of this law is to build into the Federal-State-local partnership a planning mechanism that will assure that we do a complete program throughout the country. There are weaknesses in our system. We have known of these. There are no weaknesses that cannot be solved with careful planning, and with funds necessary to do it.

This law in itself, without planning money or without additional formula and project money, does not give us the tools. It just gives us a mechanism and a mandate.

The CHAIRMAN. Excuse me, sir. There is a very distinguished colleague of ours and a gentleman who knows this field very well, from your State, who has to leave; and he would like to say a word or two to you before he leaves.

Dr. Carter.

Mr. CARTER. Certainly I want to congratulate your group upon your excellent presentation, and I want to personally welcome our distinguished representative from the State of Kentucky.

I regret very much that I am going to have to appear before the Senate Public Works Committee. I certainly want to extend a welcome to you, Dr. Teague, and to your colleagues.

Thank you, sir.

Dr. TEAGUE. Thank you, Dr. Carter. It is nice to see you, sir. I will be very brief and conclude my little statement since my colleagues have covered the problem so well. Congress has given the State and local health departments tremendous responsibility under titles 18 and 19 of the social security amendments. It is our job to see that high-quality care in our hospitals, nursing homes, and so forth, is carried out. We need to "beef up" our State and local health departments, and this bill before you today will give us the mechanism to get started on a plan that has long been delayed.

I am delighted to be able to come here and talk to you about this.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

Dr. VENABLE. Mr. Chairman, we will be glad to answer any questions, if there are any. Otherwise, our presentation is completed.

Mr. MACDONALD (presiding). Are there any questions for the panel?

Mr. DINGELL. Yes, Mr. Chairman.

I believe Dr. Heustis addressed himself to the question of licensing of clinics and the testing laboratories, and things of this kind. Am I correct?

Dr. HEUSTIS. Yes, sir.

Mr. DINGELL. Doctor, how many States have testing, have these laboratory facilities now, and how many have licensing requirements?

Dr. HEUSTIS. I cannot answer that, sir. We do not in Michigan, but we should have, and are going to try to get it.

Mr. DINGELL. Would it be fair to say that there are very few States that have that at this time?

Dr. HEUSTIS. Mr. Dingell, I am just not competent to answer that question. I do not know the national scene.

Mr. DINGELL. Speaking now on behalf of the Association of State and Territorial Health Officers, do you appear in opposition to the provisions dealing with such licensing in the legislation before us?

Dr. HEUSTIS. Indeed not, sir. The point that I was endeavoring to make—and I am not certain whether other circumstances kept you from hearing the entire comment—was that I view what we were trying to do in Michigan as distinctly complementary to what this legislation would carry out. We are very much in favor of the licensing of interstate laboratories by the Federal Government. And then at least I in Michigan am very much in favor of the licensing of those laboratories that carry out services within the State. I would certainly hope that if in Michigan we developed standards for the licensing of our laboratories that these would be at least equivalent to those adopted by the Federal Government, and if any of our Michigan laboratories serve the people in Ohio or Indiana or Wisconsin, that the Federal Government would accept a certification by us.

Mr. DINGELL. Now turning to that particular section before us, I note that there is no requirement in the legislation as to what the licensing shall constitute and what tests shall be applied by the Secretary in the licensing. I wonder if you have any feelings on that point. More specifically, do you feel, as a matter of good draftsmanship and good legislation, that we should impose some rather clear directions upon the Secretary in terms of carrying out his licensing of these clinical laboratories?

Dr. HEUSTIS. Well, I have to answer that, sir, in the context of my Michigan experience. In my Michigan experience, I always suggest to our Michigan Legislature that they try to define the overall purposes that they would like to see carried out in broad, general terms, and if the State director of public health does not carry it out to their desires that they get a new director of public health.

Mr. DINGELL. My concern is that I can find no direction to the Secretary with regard to what tests, what standards, what qualifications he shall impose at this time. And the absence of those clear directions on this matter troubles me greatly, and I wondered if you would comment about the absence of those directions to the Secretary.

Dr. HEUSTIS. I do not share your troubled feelings. I have the feeling that the Secretary, as a reasonable man, will call together interested parties; that he will not develop them in a vacuum. This has been the tradition of the Public Health Service, as I have dealt with them over the years through many Secretaries and a number of Surgeons General. I have a hunch that if we try to write details in legislation we either get ourselves a bill that is tremendously complicated or else we do things this year that are not scientifically sound within a couple or 3 years.

Mr. DINGELL. We might also get the legislation declared unconstitutional, if we fail to give some standards.

Dr. HEUSTIS. You have just again left my area of competence, sir.

Mr. DINGELL. It is fine to have you before us. We note your very long and fine service.

Dr. HEUSTIS. Thank you, sir.

The CHAIRMAN. Mr. Springer?

Mr. SPRINGER. Dr. Venable, are you the president of the Association of State and Territorial Health Officers?

Dr. VENABLE. Yes, sir.

Mr. SPRINGER. Are these gentlmen officers?

Dr. VENABLE. Yes, sir. Dr. Teague is the president-elect and Dr. Heustis is secretary-treasurer.

Mr. SPRINGER. All the ruling body is here, I take it, except the board of trustees.

Dr. VENABLE. We have an executive committee, sir. And we usually take all of our positions to the entire membership.

Mr. SPRINGER. As the director of the Georgia Department of Public Health, do you administer all the public health programs for the State?

Dr. VENABLE. Yes, sir. We are fortunate or unfortunate, as you may look at it, in Georgia to have probably the widest base of any State health department.

Mr. SPRINGER. I think that is very good. Do you administer mental health?

Dr. VENABLE. Yes, sir.

Mr. SPRINGER. Do you administer mental retardation?

Dr. VENABLE. Yes, sir.

Mr. SPRINGER. One thing that I have been wondering about is, could you not come here before this committee with one program instead of three programs, this program, a mental retardation program, and a mental health program?

Dr. VENABLE. I think the mechanism is built into Public Law 89–749 for making a single comprehensive program in each State, regardless of how the authority is delegated within that State. It makes less difference to me, since I am the authority, than it does in many States where they are fragmented.

Mr. SPRINGER. One of the problems that has bothered me and many people who have been before us as witnesses is that, apparently, as far as I can find out, the needs vary in the different States. Some of them seem to be in this field which we are discussing today. In my own State, it happens to be in the program of mental retardation. This is the last 24-month period. I don't mean these other problems have not been there. I am not derogating those problems. I am raising the question as to whether or not, if we put in under one program and at least leave some discretion to you as the State director as to where these moneys would be spent.

Dr. VENABLE. Are you speaking of the mental retardation planning activity now?

Mr. SPRINGER. No, I am talking in general terms about you, as an administrator of the State program in the State of Georgia receiving a sum of money and you determining how much should be spent in each program, instead of coming here with three programs and having everybody determine that this amount of money has to be allocated to this thing. This goes to the French system instead of the American system when you have money allotted. In the French system everybody has a piece of the taxes, has a piece of the appropriation, and the result of it is that you have a proliferation all over the place of an activity.

Now it seems to me that if you have been chosen as the director of your State, you ought to be able to take those funds and determine where you can do the best job. Does this make sense?

Dr. VENABLE. It makes a great deal of sense to me, sir. Yes.

Mr. SPRINGER. May I ask, Dr. Teague, does this make sense to you?

Dr. TEAGUE. Yes, indeed.

Mr. SPRINGER. How do you feel about it Doctor?

Dr. HEUSTIS. I am firmly on record as being absolutely in agreement with you.

Mr. SPRINGER. I want to be sure that we have this before the committee, because we are faced with this; and I think probably the reason that these others came up was because they had groups that felt in some States they were neglected. This is, I think, a point. And if you can get this over to your association, you can get your funds in a better scale here and can spend them better.

Thank you.

Dr. TEAGUE. Congressman Springer, I think we in our Association believe that the word "comprehensive" in Public Law 89–749 gives the opportunity and authority for us to put these programs back together that have been fragmented so long at the State and local level. I believe this is the intent of Congress in the passage of Public Law 89–749.

Mr. SPRINGER. Are you on record with this? Is this right, Dr. Venable?

Dr. VENABLE. Yes, sir.

Mr. SPRINGER. All right. Thank you.

The CHAIRMAN. Mr. Macdonald?

Mr. MACDONALD. I have no questions.

Mr. CHAIRMAN. Mr. Devine?

Mr. DEVINE. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Moss?

Mr. MOSS. No questions, Mr. Chairman.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

I am interested in the suggestion of licensing clinical laboratories, and it is my understanding from the testimony that only a small percentage of the laboratories are in interstate business. There are many intrastate laboratories that would not come under this licensing provision, is that not true?

Dr. VENABLE. That would be my judgment, Congressman Nelsen. I did not hear the testimony yesterday, and I would point out further that it would depend on your definition of interstate. There are a number of technicalities here that would have to be clarified before you could determine the volume.

Mr. NELSEN. Have you any knowledge as to the number of states that provide for licensing and control of intrastate laboratories?

Dr. VENABLE. No, sir. I do not. I happen to have personal knowledge of several States that are moving in this direction. Dr. Heustis has indicated that Michigan is. Georgia is moving. We have a bill in the legislature now for licensing all of our laboratories, and I happen to know of three or four others who are in the process of or moving in this direction, but I have not taken any census of the 50 States.

Mr. NELSEN. Well, in the event that a State does take action, a laboratory that is located within the State and operating in interstate commerce would also come under a State licensing provision, would it not?

Dr. VENABLE. That is correct, and that is one of the two points that I raised in my testimony. If our State standards are equal to or higher than the Secretary's we would hope the Federal Government could take our certification.

Mr. NELSEN. I ask these questions because it would seem to me that

your association would be moving in the direction of urging the States to take action, particularly in view of the fact that you are endorsing action by the Federal Government. Certainly it would seem derelict if at the State level you were inactive and coming here to the Federal Government because it is always easy to come and ask the Federal authorities to assume responsibility that maybe we have overlooked at home.

I want to thank the gentleman for his very good statement, and to thank his associates as well.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

It is good to see you, Dr. Venable, and your associates. I think the testimony is most helpful, particularly in pointing up overall the savings that can be accomplished with a proper investment of dollars in health at the right time.

Now this bill provides, of course, block grants, which is the principle we established last year when we passed the original act, but also project grants. And about the same amount of money, as I see it, would be allocated for project grants. What do you envision with this money?

Dr. VENABLE. Project grants, I think, are most effectively used in the demonstration of new methods of applying knowledge to test them, to try them out, to refine them before they are put under continuing fiscal support. This way you can try those things that have less than 100 percent chance, to be sure what effectiveness they do have, but should be always applied to those programs in their initial stages and then terminate them either by closing them out or putting them under continuing formula grant support.

Mr. ROGERS. Now, do you think that in project grants we need as much money as we do for the block grants?

Dr. VENABLE. I cannot speak for my association on this. My personal opinion is that the level of project grant support currently available is about as high or almost high enough but that there is a much stronger need for increase in the amount of support for the block grant.

I would hope we reach a stage where the project grant plateaus and the block grant continues to increase to whatever its real need.

Mr. ROGERS. When you have an emergency in any of your communities, perhaps a health problem, are you able to get into that and help meet that problem in a community?

Dr. VENABLE. Through our relationship with our local health department—we have one in each of our 159 counties—and the State resources, we are able to approach anything within recent experience: yes, sir.

Mr. ROGERS. For instance, if they have an airplane disaster, maybe an airplane crash, does the public health service get into that at all? Would you be called, or could you respond?

Dr. VENABLE. We always immediately offer our services. In our State, this is usually handled through the civil defense operation, the health part of which is in my department. But the general answer to your question is "Yes."

Mr. NELSEN. Does there have to be a declaration of an emergency by the Governor before you could do that?

Dr. VENABLE. No, sir.

Mr. NELSEN. It is just an automatic reaction. Would that be true in the other States?

Dr. TEAGUE. Just the same.

Dr. HEUSTIS. To go back to our more severe tornadoes in Michigan of a number of years ago, the one in the Flint area and the Grand Rapids area, and the one in the southern part of the State, almost before the wind had stopped blowing, through the alerting by the State police, the health department officials were there to check on the sanitary facilities and to see whether or not the folks in the local community hospitals had the supplies they needed, the blood they needed, and the other types of things, and to actually get in and roll up our sleeves, with no declaration by anybody.

This is just part of the job.

Mr. NELSEN. Do you get good cooperation from the U.S. Public Health Service on this?

Dr. HEUSTIS. Excellent.

Mr. ROGERS. Is there any problem there that you see?

Dr. VENABLE. Perhaps I am not the one to speak to this, since our regional office is in my city. It might be different if I were in another State in our region, but as far as I know it is the same excellent cooperation throughout the same region.

Mr. ROGERS. They have always responded?

Dr. VENABLE. Yes.

Mr. ROGERS. Would that be true in the other States?

Dr. HEUSTIS. Yes, sir.

Dr. TEAGUE. Yes, sir.

Mr. ROGERS. What about this business of keeping mental health still separate from other facilities? In other words, to continue our program of community mental health centers, which is a very excellent program. Should we start thinking about integrating the mental health services in with all other services, rather than keeping it in a category of separate service?

Dr. VENABLE. Mr. Rogers, this is a most complex question. I think the situation in each State should be carefully studied to determine what is the best administrative delegation by the State legislature for these authorities. I would testify that in my State I am certain beyond the shadow of a doubt that to have it combined is best. Now, when it comes to an appropriation of funds, grant funds or State funds, I think if they end up in a comprehensive or coordinated program, it makes little difference as to where the authority for the administration lies.

Mr. ROGERS. I was thinking more of delivery of service. If someone comes in to a clinic, should there also be a little mental health services in a clinic as well as dental and surgery services, and so forth?

Dr. VENABLE. The last study I know of in this regard was made in New York City, which is perhaps unique, but it showed that a person, in order to find all of the services which on the average that he needs, would have to visit more than two dozen different locations within the city. This, obviously, is hard on the person who needs service, and I would certainly say that the more services can be in any single place in which they are offered, the better it will be and the more economic it will be.

Mr. ROGERS. Is there any comment by the other gentlemen?

Dr. TEAGUE. I agree thoroughly.

Dr. HEUSTIS. Mr. Rogers, I would certainly say that the delivery of services to people at the local level is going to take some real health statesmanship, in spite of some of our organizational problems, to see that ways and means are found to work together so that these services are presented and made available to people in an accessible and easy fashion.

Mr. ROGERS. One last question, Mr. Chairman.

Do you see any difficulties in formulating a State plan in relationship to regional planning as to the heart, cancer, stroke program, the Hill-Burton program, the university medical schools expanding their facilities? Are there any problems involved which would cause any great conflict, that you see, or serious problems?

Dr. VENABLE. One of the oldest principles in public health, Mr. Rogers, is that if somebody else will do a part of your job, you can concentrate on that part that nobody else is doing. It seems to me that these programs of planning already established are simply doing a part of the job, and our problems are only in providing communication and cooperation and comprehensiveness between.

Mr. ROGERS. Comprehensive State planning?

Dr. VENABLE. That is correct.

Mr. ROGERS. You feel there will be no difficulty of conflict between regional planning and your State planning?

Dr. VENABLE. I think they are part and parcel of the same thing. The only problem is to be sure that we communicate and coordinate with each other.

Mr. ROGERS. Who is to have the final word on what is done, the regional planning group or the State?

Dr. VENABLE. I don't know that anyone would need to have the final word. I think with adequate communication and substantial responsible leadership that it would never be an issue which one or the other had to decide.

Mr. ROGERS. Would you share that view?

Dr. TEAGUE. Yes, Congressman Rogers, I don't see any conflict here at all. I happen to be a member of the regional planning council of the Ohio Valley regional medical program, which involves medical schools and health programs in Ohio, Kentucky, and the southern part of Indiana. I also operate the Hill-Burton program for my State and will be on the comprehensive health planning for Kentucky. I see no conflict. I see that this gives us an opportunity to build in a communicating device which would improve the services of all of them.

Mr. ROGERS. I would hope so, and think so. And this was intended, I am sure.

Dr. HEUSTIS. I would like to simply observe that I am quite certain that both of my colleagues will agree with me that one of the factors that would make sure the arrangement is going to turn out the way that they have expressed, and the way that you seem to prefer by your question, is the degree to which this Congress is willing to support financially the comprehensive health planning effort. Because, if the Congress chooses not to support this program so that it can really do

a good job, and if we work on a shoestring and don't product a plan that is workable, then we are in trouble.

But if we do have the opportunity and the wherewithal to really get in and to come up with a meaningful document taking all of these other things into consideration, then I can see really rosy days ahead for public health and for health in general, because when I use the words "public health" I use it to cover everything.

Mr. ROGERS. Thank you.

Mr. MACDONALD (presiding). Before I recognize the next speaker, I would like to ask one question.

Did I understand Mr. Rogers to ask you if members of your association showed up at plane crashes and did I understand your answer was, "Yes, you did?"

Dr. VENABLE. Mr. Chairman, I believe he used that as an illustration, and my interpretation was catastrophic emergencies of any sort: Storms, wrecks, plane crashes, floods, this sort of thing, as to whether public health departments participated in the services needed by victims of those situation.

Mr. MACDONALD. There was a plane crash in Maryland yesterday, about which I read in this morning's paper, in which one man was unfortunately killed and another seriously injured. I would not think that it would be within the purview of your duties to show up at an accident like that.

Dr. VENABLE. But if it were a jetliner, with a number of people, as in New Orleans recently, where it went into a motel, we would.

Mr. MACDONALD. It would depend on the size?

Mr. ROGERS. I think the chairman misunderstood, because we said where it could be classified as a disaster, where a large plane crashes.

Mr. MACDONALD. Mr. Broyhill?

Mr. BROYHILL. Thank you, Mr. Chairman.

Welcome to the committee, Dr. Venable. You are certainly a distinguished person in your field, and very well known. In your testimony you have stated that you feel that the committee should authorize this program from a level of $125 million up to $500 million by 1971. You have also stated that you feel that one-third is the fair Federal partnership in a program of this kind, which would indicate that by 1971 the States would have to come up with probably a billion dollars to pay for their share of the program.

Of course, all of the States have been having difficulty in coming up with additional revenues on the local level. Do you feel that this would present any problem for the 50 States to come up with approximately $1 billion to run the program?

Dr. VENABLE. May I clarify one point? I cannot pretend to suggest to the Congress that I was an expert on what percentage was a fair Federal share. I was simply using a third for illustration. Speaking from my own particular standpoint, I used the third only in the assumptions and in relation to tuberculosis, as you noticed. In my particular State the Federal share is in the neighborhood of a ninth at the moment, so there has been no problem in my State of exceeding with State and local funds any potential availability of Federal funds.

Some of the States, I understand, are not in this fortunate a situation. Dr. Heustis and Dr. Teague can speak from their own standpoint, but certainly more than half of the States would have no problem

meeting the two-thirds with a demonstrated need and potential physical soundness.

Overall, nationally, I would think the answer to your question is, No, there would be no more problem than there has been down through the years in developing funds from both State and local sources to meet the need.

Mr. HARVEY. Will the gentleman yield?

Mr. BROYHILL. I yield.

Mr. HARVEY. I would like to ask Dr. Heustis about the State of Michigan. We are both from there. I would like to ask him if the State could come up with more than twice what they are presently paying in the next 2 years in order to meet the demand?

Dr. HEUSTIS. Mr. Harvey, our big brothers in the Federal Government have a long way to go to be real partners with the State of Michigan in public health. The local appropriation for public health in Michigan is approximately $11 million. I am speaking, gentlemen, of public health excluding mental health, because public health is my field and in Michigan we have a separate department. Eleven million dollars local appropriation for public health. The State provides approximatey $2 million additional for local health work. Then in addition the State provides approximately $29 million for the operation of the State health department, approximately $10 million of which is to pay for hospital costs. If we exclude that and just talk about public health apart from hospital costs, we then have approximately $21 million of State and local funds to match, Mr. Harvey, this year $1.6 million which the Federal Government provides for public health service under the formula grant.

We try to get the State of Michigan and local health departments to do even better. We are relying on your vote and the votes of the other members of the committee to help the Federal Government become a better partner in this State and local venture.

Mr. HARVEY. I want to point out to the committee that Dr. Heustis has served with great distinction in Michigan under Governor Williams, Governor Swainson, and now Governor Romney.

Dr. HEUSTIS. May I add, Governor Kim Sigler also.

Mr. HARVEY. We are very proud of you, Doctor, and glad to have you with us.

Dr. VENABLE. Mr. Chairman, I have just checked national figures which I believe are accurate, and with $125 million currently authorized there is already $700 million of State and local funds appropriated in the 50 States. So that, as Dr. Heustis indicates as to Michigan and me in Georgia, and with this figure nationally, the Federal share is far below one-third at the present time.

Mr. BROYHILL. Thank you, Mr. Chairman.

Mr. MACDONALD. Mr. Ottinger?

Mr. OTTINGER. Thank you, Mr. Chairman.

I would like to join in welcoming you here. There is one problem of concern to me and to a number of my colleagues. While heartily supporting the idea of comprehensive planning for the future, we are disturbed over the fact that this legislation makes no provision to meet present critical emergency situations resulting from inadequate facilities. I don't see how you can have any participation in comprehensive

planning by a hospital that can't even meet the health needs of the community it serves.

The Public Health Service made a survey last year that showed that there were 143 hospitals in critical condition with average annual occupancy rates of better than 90 percent. Many regularly report occupancy rates of more than 100 percent. I wondered how you would feel about the need for the Federal program to provide a direct shot of emergency assistance to hospitals that are presently experiencing critical shortages and inadequacy in facilities in your States? The situation is being particularly aggravated by the growing demand for service resulting from the passage of medicare, which has added even more than expected to the hospital burden all around the country.

Dr. VENABLE. I believe that I am fairly expert in this area, since Georgia's Hill-Burton agency which is in my department has already in hand over $60 million worth of construction applications. And we are one of the States which matches Federal funds, so that the local pays only one-third of the cost. In State and Federal funds annually we have approximately $7 million, between $6 and $7 million, to put into hospital construction. You can see very easily that at the present levels of appropriations it is going to take us 6 years to meet the $60 million worth of applications that are valid, needed, and already submitted.

I think that it is absolutely necessary in this country, certainly in Georgia, to meet the need for increased public funding, both Federal and State, for hospital construction. How it should be done, whether through the legislation or modernization, whether by an increases in the regular Hill-Burton grant, or whether by some mechanism of guarantee of loan, what the fiscal mechanism should be, I cannot say.

Mr. OTTINGER. How much of that $66 million of applications in Georgia represent really critical shortage? Do we have the same kind of situation where some of the hospitals are actually having to put patients in the halls?

Dr. VENABLE. This is true primarily in our urban areas in Georgia, of which we have only about six. I cannot tell you off the top of my head what percentage of the $60 million is from urban areas, but each of our six urban areas is hurting very badly, and some of the middle sized, but very few of the rural.

Mr. DINGELL. If the gentleman will yield.

Would it be possible for you to give us some judgment of the State and Territorial Health Officers of the need for hospital construction and modernization of hospitals?

Dr. VENABLE. We would be happy to get this for you and submit it to the committee.

Mr. DINGELL. This is a question I went into at some length with the Secretary yesterday, and I must confess that I am rather displeased that we are not having something to update Hill-Burton at this time. Isn't it fair to say that there is a major crisis in terms of hospital needs in this country today?

Dr. VENABLE. I would agree with that statement.

Mr. DINGELL. Both in terms of new construction and in terms of modernization; am I correct?

Dr. VENABLE. Would you like us to submit this information in terms of new construction and modernization or a combined figure?

Mr. DINGELL. I think it would be better to have both modernization and new construction.

Dr. VENABLE. It may take us a little while, but we will do it.

Mr. OTTINGER. Considering the rather critical financial problems that we are facing in terms of keeping up existing Federal programs and meeting the rising costs in Vietnam, I think it's going to be difficult to get very substantal long-term increases in the hospital construction program at this time. I do think that we may be able to get some relatively modest sums for a program to resolve the most critical emergency needs across the country—perhaps as a part of this legislation. If it were possible to break down the long-term requirement from the short-term, critical need, it would be very helpful to us, indeed.

Dr. VENABLE. All right, sir.

(The information requested follows:)

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS,
Washington, D.C., June 30, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, House Committee on Interstate and Foreign Commerce, Rayburn Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: During the course of our testimony before your Committee on May 3 on H.R. 6418, information was requested which we were not able to supply but which we were asked to submit for the record of the hearings. It is my pleasure to forward to you the information pertinent to those questions.

Mr. Dingell asked for data on the need for hospital construction, both new construction and modernization or renovation of existing institutions. The Hill-Burton agencies of the states annually submit to the Public Health Service a thorough compliation of construction project requests, the estimated cost (both total and Federal share), and a comprehensive breakdown by institution, e.g., general hospital, tuberculosis hospital, and long-term care facilities. Additionally, information is provided relative to the number of related health facilities included in Title VI of the Public Health Service Act such as diagnostic and treatment centers, public health centers, state health department laboratories, and rehabilitation facilities. The most recent annual survey, which was as of October or November 1966, indicated a total of 2,858 projects requiring a total funding of $5,537,000,000 for fiscal years 1968 and 1969. The Federal share would be approximately $2,273,000,000 and would result in construction or modernization directly affecting 185,000 beds. The majority of these would be in general hospitals (approximately 130,000) with the remainder almost exclusively in long-term care facilities.

Because of our ability to utilize Hill-Burton funds both for new construction and for modernization or renovation purposes, a breakdown pointed to this differentiation is not included in this annual report. I have, however, conducted a survey of our state health officers and find that the situation varies greatly from one state to another. I should point out that we were dependent upon voluntary compliance with my request for information, and the following data is based upon reports from 42 states and Puerto Rico. For new construction, there is a need for approximately $1,356,000,000 for hospital projects which could be approved but are not funded as of May 1, 1967. Of this amount, $535,000,000 would be the anticipated Federal share.

Similarly, $1,196,000,000 is needed for modernization of which $488,000,000 would be the anticipated Federal share.

In addition, we were requested by Congressman Ottinger to supply information relative to "emergency" situations in comparison to projects planned over a long term. The lack of specificity of the term "emergency" makes evaluation very difficult. Attempts to generalize on the basis of hospitals with 90 percent or more of bed occupancy is not a sound criterion. As an example, the obstetric ward and pediatric ward of a hospital might be operating at a low proportion of capacity while, on the other hand, the medical-surgical portions of the hospital were operating at 100 percent capacity or dangerously close thereto. An overall figure would show the institution not occupied to 90 percent capacity and, hence, the picture would not reflect the true situation. I have taken the opportunity of studying the

legislative proposal of Mr. Ottinger and it is my opinion that our Association would be unable to support it, primarily because of the fact that it would be operative completely outside of the Hill-Burton plan for development for hospital and other health facilities. It certainly would be in direct conflict with the spirit and intent of the comprehensive planning concept by authorizing project grants from the Secretary of HEW to individual institutions. The Hill-Burton planning device, which gives great weight to occupancy rates, has worked well in taking into account the totality of health facility resources serving an entire community or communities, rather than simply making a judgment on an individual institution.

I hope this information will be of assistance to your Committee, and I stand ready to be of any further assistance in the future.

Yours truly,

JOHN H. VENABLE, M.D.,
President.

Mr. OTTINGER. Is the experience of your colleagues in this area the same as you have experienced?

Dr. TEAGUE. Mine are exactly the same as Dr. Venable said. I have about $64 million worth of applications on my desk. We just turned down $57 million of them and gave approval of the $6½ million that we get each year for construction. And at this rate it will take us 10 years to get caught up to meet the needs that our Hill-Burton plan has already identified as an existing need right now.

We are on record as favoring the Modernization Act of the last Congress, and all of us, I am sure, are aware of the need for additional funds. There comes a point in hospital construction where people wait for funds to be made available to them which tends to slow up the construction program which might have gone ahead without it. I feel that we are almost at the point now where some construction might go ahead if it weren't for people waiting for their Federal share.

Mr. MACDONALD. I am sorry, but the time of the gentleman has expired.

Thank you very much.

Dr. VENABLE. Thank you very much, Mr. Chairman.

Mr. DINGELL. Is it the position of you gentlemen that you are running into a problem of delay because of unavailability of Federal funds which is tending to slow down the program for hospital construction across the country?

Dr. VENABLE. Yes, sir. I think this is very true.

Mr. DINGELL. Is it a fact that you are faced now with a different problem, not new but certainly one which we have not attacked before, of modernizing and upgrading old hospitals that at one time were adequate and today have become rather greatly substandard? Is this a fact?

Dr. VENABLE. Yes, sir.

Mr. DINGELL. This is particularly so in the urban areas; is it not?

Dr. VENABLE. That is right.

Mr. DINGELL. This is also particularly true in areas which once were regarded as having not only adequate but perhaps the best hospitalization care in the country, the big cities; am I correct?

Dr. VENABLE. Yes, sir.

Mr. DINGELL. Isn't it also a fact that Hill-Burton today does not meet this particular problem?

Dr. VENABLE. That is correct. The amounts available are not sufficient.

Mr. DINGELL. Would you say that this is one of the major problems facing the hospital services in the country in providing an adequate level of hospital care?

Dr. VENABLE. Undoubtedly, it is one of the major problems; yes, sir.

Mr. DINGELL. I would like to treat very briefly the problem of Hill-Burton from the standpoint of it not being available for providing of funding for joint ventures among hospitals. Isn't it a fact that we can substantially benefit ourselves in terms of hospital services by permitting hospitals in the metropolitan areas to join together and provide services for a group of hospitals on a nonprofit cooperative basis? A number of hospitals, which would participate in devices like computer programing, perhaps, clinical services, perhaps?

Dr. HEUSTIS. Laundries.

Mr. DINGELL. I had particular reference to laundries. Perhaps even kidney machines, and devices of this kind. Isn't this something that is presently missing from existing regulations in Hill-Burton?

Dr. TEAGUE. No, sir. The present Hill-Burton program provides that this can be done. We just built a laundry to serve seven hospitals in the western end of our State out of Hill-Burton grants. The largest of the seven hospitals was the applicant with the clear understanding that it would provide central laundry, central purchasing and data processing services for all seven hospitals. We tried first to accomplish this by incorporating but found this led to denial of assistance so we proceeded this other way.

Dr. HEUSTIS. Mr. Chairman, there is one item that the committee certainly should consider. To get back to my interest in overall money costs, it costs somewhere between one-half to one-third of the capital construction costs of a hospital to operate it every year. Therefore, if in modernization and in new construction we can build for efficiency, we can amortize this money very quickly; and this can be another factor that can cut down on the overall costs of medical care which is probably at least in the health field, the biggest item that whoever considers the money in the Congress is going to have to consider.

Mr. DINGELL. I would like to know whether that facility you are discussing was built with Hill-Burton funds.

Dr. TEAGUE. Yes, sir.

Mr. DINGELL. I have been having quite a tilt with the Hill-Burton people, both Federal Government and State, with regard to a similar program that some of my hospitals want to engage in in the State of Michigan. They are advised that they cannot get assistance for a joint venture where they propose to set up a corporation to serve several hospitals.

Dr. HEUSTIS. Let's you and I go into that together, because I thought we had a project that fell through for reasons other than our own in our State, Michigan, where a number of hospitals wanted to have the same laundry and we thought this was a good idea. Let's get together with the specifics.

Mr. DINGELL. I sponsored legislation to do this, and the committee staff and my staff are presently working with HEW to find out whether it is possible to arrange to do this by a change in the regulations on this particular point. I would like to have your thoughts on this, because this is something that troubles me very greatly.

Dr. HEUSTIS. I will get it and share it with you, sir.

Mr. MACDONALD. Thank you, gentlemen, once again for a very fine statement.

Dr. VENABLE. Thank you.

Mr. MACDONALD. It is now my pleasure to call as the next witness the Honorable John A. Volpe, Governor of the Commonwealth of Massachusetts, and I will say before the statement the Governor is supposed to give that first I would like to welcome you here, Governor, as representing the Commonwealth of Massachusetts. You and I have a close relationship. Although we are not of the same political affiliation, we are fellow townsmen. I have known the Governor for many, many years. I have the utmost respect for him, and I know of his dedication and his interest in this field.

I would say to the members of the committee if they would please bear in mind the fact that I happen to know that the Governor has to be at the White House at noon, and if the questions are to be asked with that borne in mind, I think that it would be appreciated by all concerned.

Welcome here, Governor.

STATEMENT OF HON. JOHN A. VOLPE, GOVERNOR OF THE STATE OF MASSACHUSETTS

Governor VOLPE. Thank you very much.

Representative Macdonald and members of the Committee on Interstate and Foreign Commerce, it is certainly nice to come before the committee and particularly to have the presiding officer be a Representative from my own State and a dear friend of long standing.

It is a privilege to appear before this committee to express my support of H.R. 6418, the legislation to extend the provisions of Public Law 89–749, the Comprehensive Planning Act of 1966, and I certainly appreciate your courtesy in giving me this hearing.

Massachusetts, as you know, has a long tradition of leadership in the health field, and we are justifiably proud of the accomplishments of our great medical institutions and of our medical and public health leaders. One of the great heroes of the Battle of Bunker Hill was a physician, Dr. Joseph Warren, who fell mortally wounded at that battle while fighting in the line with the troops.

Our State health department, one of the first, if not the first, established in this country, will celebrate its centennial in 1969, and the 89th Congress passed a resolution inviting the World Health Assembly to meet in Massachusetts in 1969 in part as recognition of that historic fact, and I am pleased to report that the Assembly has accepted that invitation.

We have been having "firsts" in the health field ever since. We had the first State-operated sanatorium for the treatment of tuberculosis in 1896, and the first cancer hospital in 1926. And we believe that we are now pioneering in the field of mental health with the Massachusetts Mental Health Center which has established a pattern of care which is being followed in other parts of the country.

Your honorable body has recognized the value of this work, first by providing funds to assist in the construction of similar centers

throughout the Nation, and more recently by appropriating moneys to help staff such centers.

As this committee is well aware, great changes are taking place in the health field, not only in our ability to prevent disease and limit illness and disability, but in the expectations of people regarding health services.

It is now almost universally accepted that health is a human right. This means that not only should our citizens be protected from environmental hazards such as air and water pollution, but that high quality personal health should be available to all, regardless of income or place of residence.

That this committee is well aware of the dynamic changes which are taking place is evident by the importance of the health legislation passed by the 89th Congress, a good deal of which was processed by this committee.

I am not going to belabor a point with which you are so thoroughly familiar. Instead I am going to address myself to the impact of this legislation on a State such as Massachusetts and the importance of passing H.R. 6418.

For many years Massachusetts has been receiving Federal funds to assist us in the development of public health programs. These grants started with the original social security legislation.

These funds have been for the most part on a disease or program basis or for special population groups such as children or mothers-to-be or for venereal disease control or tuberculosis.

After World War II, Congress saw the need to expand the research effort in the health sciences and our great educational and medical institutions in Massachusetts have participated actively in these research programs, and I believe have made notable contributions.

Interestingly, despite the rapidly increasing expenditures for health services and health research, little interest was shown in planning, in the development of overall objectives, in the establishment of priorities in a systematic manner, in developing criteria to measure whatever progress we expected to make, and in utilizing cost-effectiveness concepts.

It may be that the size of the health problems was so great and there was so much to do that there was not enough general concern with the effectiveness of our activities and the development of priorities.

There has been some planning in the field of hospital construction under the Hill-Harris law, and a great deal of needed hospital construction was brought about in a rational manner. But the planning was largely limited to one type of health services, inpatient care in a hospital.

In any case, 4 years ago Congress appropriated funds for mental health planning to be allocated to each State on a project basis.

Our mental health planning project in Massachusetts was carried out over a 2-year period and, as a result of their recommendations, I was able last December, I might state, at a special session of our State legislature to have enacted a reorganization of our entire mental health department and program into what, I believe, is generally regarded as one of the finest such structures and programs in the country.

Since then Federal funds have become available for planning for mental retardation, and I expect a report on this activity very shortly.

We also have had a commission studying the vocational rehabilitation program of the Commonwealth and are doing planning in this area.

I mention these activities to indicate the newly awakened interest in planning in the health field and its importance in developing State programs.

There is one aspect of these planning activities which is disturbing, and this is, of course, planning on a piecemeal basis.

Certainly planning for hospital beds should not be separated from planning for other types of health services, such as out-of-hospital services, visiting nurse services, private physician services, or health department services.

Planning for mental health should be closely correlated with planning for mental retardation, and both need to be related to the other health services of the community.

The 89th Congress did recognize the need of comprehensive health planning, and Public Law 89–749 was enacted, authorizing funds to be distributed to the States and to local communities and local groups, both official and voluntary, to enable them to do comprehensive health planning to fit the various health programs into a coordinated whole.

As you know, the actual funds for this program have not as yet been appropriated and this is still just a concept, and I feel a sound concept, which needs an opportunity to be put into effect and to be developed.

There is another section of this legislation about which I should say a few words, and this is section 314(d) of the present law providing grants on a block basis rather than a categorical disease-by-disease basis.

Congressman Rogers, as you know, and his Special Committee on Investigation of the Department of Health, Education, and Welfare, of this committee, studied this matter and came up with many recommendations with which I am in accord, including the need of a firm base to support comprehensive health care.

We need to move away from fragmentation in the delivery of health services and to give the States the opportunity to establish their own priorities.

The entire grant program as it applies to Federal-State relationships has become a multivaried complex and confusing situation.

This legislation moves toward simplification of the grant mechanism in the health field.

I am pleased to note that President Johnson in his recent message on the quality of American government is taking steps toward a fundamental restructuring of the grant-in-aid programs.

This legislation has shown the way by providing for a comprehensive approach, rather than a fragmented piecemeal attack in a broad general area such as health services.

In conclusion may I say that I feel that the enactment of Public Law 89–749 by the 89th Congress was a most important and far-reaching health measure. One of the most troublesome problems facing government today, whether at the Federal or State level, is the rapidly rising cost of health care, and, I might add, other services as well.

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Sound planning will be an important factor in minimizing this rise in cost. We need to be sure that all of our health facilities are being used efficiently and effectively and that our resources which are not inexhaustible are being applied to the health problems with the highest priorities.

Gentlemen, I commend this committee for its support of Public Law 89-749 last year, and I urge the extension of this law by the passage of H.R. 6418 this year, to the end that the fullest comprehensive approach may be made to one of the Nation's greatest problems, public health, the health of our people.

Gentlemen, our commissioner of public health just left last evening for Europe to attend a meeting on the World Health Organization plans for coming to the United States and to Boston in 1969, and he is in full support of the statement I have just made.

Mr. MACDONALD. Thank you, Governor.

Once again, my congratulations for a very fine statement and one that, as I said earlier, I know is not just words but indicates your very deep interest in this field that you have demonstrated over the years.

Chairman Staggers.

The CHAIRMAN. Governor, we are happy to have you with us. We wish that more Governors would take interest in what is really going on in America, because after all, this does involve all of the States of the Union. We are only trying here to do a job for all the people, and we think that by working together, as this legislation suggests that we can do a better job, instead of just telling you what to do or you asking us, but working together in partnership. That is what this is, a partnership program. I want to congratulate you for taking the time. Not too many Governors in the United States do this today. I am hoping to have the Governor of my State here tomorrow. I hope that he will take the time to come and give us the benefit of his views.

Again I want to congratulate you and commend you and say thanks.

Governor VOLPE. Thank you, sir, for those comments. I can assure you that, although you may not find many Governors here, they are all very deeply interested in this total concept that this particular legislation so well enunciates, and that is, of course, the great need, as I indicated, if we are going to use the limited resources that are going to be available to us at both the Federal and State level and community level, as well to increase the services and programs that have taken place during recent years.

That is what we can envision ahead of us, unless we do something construction about a total planning job, not only in this health field, but in one of the problems that we are going to speak to the President about this noon; about this program of the States in being able to effectively deal with our State problems as they relate to the Federal programs. And the utilization of these funds in the most efficient manner in going to be necessary, if we really do a total job of planning. That is why I am so happy to be here to indicate our support of your efforts here.

The CHAIRMAN. Perhaps this can serve as a pattern for the other program. It is known, you know, as partnership. Thank you again.

Governor VOLPE. Yes, sir.

Mr. MACDONALD (presiding). Mr. Springer?

Mr. SPRINGER. Mr. Governor, I know that you have appeared before our committee before on one or two occasions, and I know of no State whose Governor is more interested in such a vital subject as health than you have been in your own State of Massachusetts. You have made a fine record especially in mental health. You are surely to be congratulated.

There is one thing I would like to ask you. Were you here to hear the testimony of Dr. Venable who is president of the Association of State and Territorial Health Officers, with Dr. Teague of Kentucky and Dr. Heustis from Michigan?

Governor VOLPE. I heard the very last part of their testimony.

Mr. SPRINGER. Now the principal question I put to them was do you believe that we would be better to have all of these programs in one, administered by the head of the general program for the individual States? I pointed out that mental health has a program, retardation has a program, now this program of planning. And they don't all do the same thing. But the point I was trying to make, and I think it is important, was that if we were to put all of this in one bundle and give it to the State, they can then determine their priorities in those States. Does that make sense?

Governor VOLPE. I would say insofar as the planning is concerned, in my opinion, it is the key to the success of all our efforts. If we don't properly plan, and the demands are going to be so great, we may well be spending for items which are not of the highest priority and not realize that perhaps there is an item of high priority.

I think, yes; in the actual operational field, staffing field and so forth, the mental retardation, the mental health programs themselves within these areas, one State might have greater needs in mental retardation because it has devoted itself perhaps more to the mentally ill and the mentally retarded.

It could be just the other way around in another State, so that I think there ought to be a great deal of freedom of operation or of the utilization of the Federal grants, within these fields without dectating exactly in which field or in exactly what manner these Federal funds would be used.

Mr. SPRINGER. Do you believe that perhaps we would be better if we came up with one program and had a formula that was fair and acceptable? We have in the Hill-Burton, and had no problem there of a grant to the State and then allowing the States themselves to administer these funds as they set fit to do.

Governor VOLPE. I think that, as Representative Staggers said a moment ago, we have to have a real partnership here. I would like to be able to say as a Governor, "Just give us the funds and we will take care of it and spend them right." But I think that the relationship which has existed, for instance, between the Bureau of Public Roads and our several States has been an excellent relationship, in that primarily they serve only as a supervising body that doesn't dictate exactly how each State shall carry out its road program. It does not try to impose itself in the taking of the bids and so forth.

It is, generally speaking, a supervisory body rather than a body that actually gets into the intricacies of the spending of the funds and there is an opportunity for latitude within grants in aid for the ABC system, for instance, as compared to rural roads or interstate.

But it seems to me that there is a point here where with some Federal supervision, not too much, and I don't think too much is needed, the bulk of the execution of the programs and the method by which the funds can be spent ought to be left, in my opinion, in the States' hands.

Mr. SPRINGER. Do you think these people came here on mental health and retardation because they couldn't get any attention anyplace else and they came here and we helped them out? Now we have established the workings of these programs and they are now recognized and it seems to me that we ought to bring these programs into one particular bundle of grants to the States and let the States determine their priorities. That is the question. You seem to be in general agreement on that principle, is that correct?

Governor VOLPE. That is correct, Mr. Springer. As a matter of fact, in my own State we are now in the process of trying to do a real planning job of our overall health services. We have a separate department of mental health, a department of public health, and we have a department of public welfare and a rehabilitation commission, and we are in the process of examining that total structure to determine whether or not we would not be better off by having a department of health and welfare, without education as you have here in Washington, and then through that one vehicle be able to utilize the kind of block grant that you are talking about in a more effective manner.

Mr. SPRINGER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Rogers.

Mr. ROGERS. Thank you, Mr. Chairman.

Governor, it is a pleasure to see you again. We have appreciated the cooperation that you and your State have always shown this committee in our studies. It has been very helpful to have the benefit of your operations and some of your thinking.

I was interested in your comment that you are looking now to see whether it should be one agency within the State to administer the program, and I would think as long as we are thinking of continuing and expanding this program of block grants, that we are going to in all of our States take a look at the administrative bodies there. Otherwise, I think it would be difficult for the block grant principle to work if it has to be divided up within the State into too many agencies. So that I am encouraged by your reaction and the fact that this partnership can be made a real working partnership. Thank you.

Governor VOLPE. Very good. Thank you.

Mr. MACDONALD (presiding). Mr. Devine.

Mr. DEVINE. I have no questions.

I would like to join my colleagues in welcoming the Governor and thanking him for a very fine presentation. We also appreciate having the benefit of your thinking in this area in which you have played such an active part.

Governor VOLPE. Thank you.

Mr. MACDONALD. Mr. Kornegay.

Mr. KORNEGAY. Thank you very much, Mr. Chairman.

Governor, I would like to join my colleagues in expressing my appreciation to you for coming here to give this committee your advice. Of course, realizing from your past appearances before our committee, as well as those of others from your State, that Massachusetts is cer-

tainly one of the leaders, we are always glad to have you and glad to see you. I know you have a reservation on your time so I won't trouble you with any questions.

Governor VOLPE. Thank you, sir.

Mr. MACDONALD. Mr. Ottinger?

Mr. OTTINGER. I have no questions, Mr. Chairman. I join in welcoming the Governor before us.

Governor VOLPE. Thank you.

Mr. MACDONALD. Thank you very much, Governor. It is indeed a great pleasure as always to see you. Thank you for the contribution made in this area.

Governor VOLPE. Thank you so much for your attention.

Mr. MACDONALD. The next witness will be Dr. Alan Miller, commissioner of the Department of Mental Hygiene, State of New York, accompanied by Mr. Harry C. Schnibbe, executive director, National Association of State Mental Health Program Directors.

The CHAIRMAN. Dr. Miller, will you give your name and representation for the record?

STATEMENT OF DR. ALAN MILLER, COMMISSIONER, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE, APPEARING ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; ACCOMPANIED BY HARRY C. SCHNIBBE, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Dr. MILLER. Mr. Chairman and members of the committee, and, if I may, a special greeting to the Congressman from New York, Mr. Ottinger.

I would like to introduce Mr. Harry Schnibbe, who is the executive director of the National Association of State Mental Health Program Directors.

My name is Dr. Alan Miller. I am commissioner of the New York State Department of Mental Hygiene. I am here today representing the National Association of State Mental Health Program Directors and speaking for the extension of the partnership for health.

I would like to begin by saying that we are here very strongly in support of H.R. 6418.

I would like to begin by giving you a little general background about that particular group of partners for health who are responsible administrators for the mental health programs in the States.

We see ourselves very much as health partners. The members of our association collectively are responsible for the administration of the largest portion of the residential and outpatient public mental health programs in the United States. As a matter of perspective a comment about the scope and size of these programs is, I think, in order.

I will cite some data to give you documentation of the scale of the programs with which we are collectively engaged.

One of the perhaps least equivocal measures of the scale is the amount of public expenditure within these programs. This year, for example, the State mental health and mental retardation programs in their budgets were almost 2½ times larger than all other State

public health programs, and in their budgets they are equal to the programs of the entire U.S. Public Health Service, including the National Institutes of Health.

In fiscal year 1965 the States appropriated and spent for mental health and mental retardation services $2.34 billion. In the nature of a dollar comparison, during that same year the States appropriated for all other public health, including general hospitals and specialty hospitals, university medical schools and community health programs, $1.03 billion.

To give you a comparative picture of the scale of mental health and public health programs, I could cite virtually any State. I could cite the State of Illinois. Their biennial budget ending June 30, 1967, for the department of mental health was more than $407 million, and during that same period the department of public health in Illinois had a biennial budget of just over $59 million.

The mental health budget State expenditures was seven times the public health budget, and this is not an atypical ratio.

Another measure of scale: The members of this association are responsible directly for the administration of 1,161 institutions and treatment facilities, both residential and outpatient, and are responsible directly for the care of one and a half million people each year.

Last year the payrolls in state mental health programs included 320,000 employees which is second only to General Motors and larger than the combined payroll of United States Steel and Standard Oil of New Jersey.

I might add that in New York State the number of people working in the department of mental hygiene alone, and I am not now including those working in our very important necessary local governmental partners, is over 50,000. If this were the extent of the responsibility of the departments and divisions of mental health, it would be, I think, itself impressive in terms of its scale, but this is far from the total responsibility of such departments.

I could summarize it, I think, for myself best by saying that the departments of mental health under whatever name, under whatever public administrative relationship, are the public health agencies in the field of mental health and mental retardation.

That means a number of things. It means being responsible for, as any health agency must be, a continued effort to know the state of the mental health and the resources available to the people in that State. It means responsibility for working with local government, supporting, counseling, reviewing. It means responsibility for quality control of services not only within the direct jurisdiction of the department and not only those which they are supporting but those which take place within the State. In New York State, for example, it is a statutory responsibility for the department of mental hygiene to review the quality of service in all public mental health facilities under any auspices as well as proprietary psychiatric facilities.

Our responsibilities include not only the direct provision of services but our concern for activities which are specifically preventive in intent. We are concerned with and we are concerned in and engaged in research. We are concerned critically with the provision of adequate number, adequate quality, and adequately trained personnel not only in our own department, not only in local governmental programs, but for all services in the State.

While I can illustrate most fully with reference to my own State, this is the nature of the responsibility in departments of mental health across the country.

I would like at this point permission, Mr. Chairman, to include in the record of this hearing some fact sheets which describe the scope of mental health programs in four, I think, reasonably representative States, my own New York; Maine, a smaller state; California; the State of Washington, and I think these fact sheets would give the Members of the Congress the concise but I think comprehensive picture of the dimensions of the program we administer in the States.

(The information referred to follows:)

STATISTICS ON MENTAL HEALTH PROGRAMS SUBMITTED BY THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

THE MENTAL HEALTH PROGRAM—STATE OF CALIFORNIA

State-Operated Facilities (Direct Services):

10 hospitals for the mentally ill (one of which serves mentally disordered offenders);
4 hospitals for the mentally retarded;
3 day treatment centers;
1 clinic for child phychiatry;
5 aftercare and preadmission screening units;
2 neuropsychiatric institutes;
2 centers for training in community psychiatry.

California reimburses counties for 42 Short-Doyle Community Mental Health Programs, which provide the following services:

Outpatient	all 42	Partial Hospitalization	10
Consultation	all 42	Mentally Retarded	6
Inpatient	22	Children's Program	12
Rehabilitation	20	Information and Education	35

Estimated number of patients under Department of Mental Hygiene care in the year ending June 30, 1967:

Hospitals for the mentally ill	51,500
Resident population, June 30, 1966	26,500
Admissions	26,000
Hospitals for the mentally retarded	14,500
Resident population, June 30, 1966	13,100
Admissions	1,400
Total, patients in resident care	39,600
Short-Doyle programs:	
Inpatient facilities	30,650
Outpatient facilities	84,000
Rehabilitation facilities	4,900
Neuropsychiatric Institute inpatient services (psychiatry only)	1,250
Day treatment centers	1,350
Neuropsychiatric Institute outpatient services	2,400
State mental hygiene clinics	1,650
Aftercare facilities	100
Indefinite leave programs:	
Mentally ill	9,000
Mentally retarded	1,300

(NOTE.—Of 192,300 patients, only 72,750 receive direct care from the State. The majority receive care from community based programs.)

The Department of Mental Hygiene has over 22,000 employees, and the 1966–67 budget includes:

	Millions
For support	$185.3
For capital outlay	6.7
To augment local programs	15.6
Total	207.6

THE MENTAL HEALTH PROGRAM—STATE OF MAINE

The Bureau of Mental Health Administers:
2 State Hospitals for the Mentally Ill
1 Children's Hospital and Retardation Center
5 Outpatient Clinics

In addition, under the Maine Community Mental Health Services Program, the Bureau provides State Grant-in-Aid funds (including classes for the trainable retardates) for up to 50 per cent of the operating expenses of local community mental health services.
15 Community Mental Health Programs
12 Mental Health Clinics
3 Towns utilizing services of out-of-state mental health clinic
18 Mental Retardation Programs (trainable)
6 Other community mental health projects

The entire program serves over 8,130 persons a year, including:
3,766 Persons at State Mental Hospitals (adult and children)
1,947 New Admissions
2,819 Resident patients at beginning of year
1,068 Persons at Pineland Retardation Training Center
1,716 Persons at State-Operated Community Clinics
1,135 Persons at Outpatient Clinics in the Community Programs
445 Persons in trainable retardate classes

THE MENTAL HEALTH PROGRAM—STATE OF NEW YORK

The Department of Mental Hygiene administers:
19 State hospitals for the mentally ill:
13 inpatient units for emotionally disturbed children;
8 narcotic addiction treatment units;
6 alcoholism treatment units;
2 day hospitals.
25 State outpatient treatment and aftercare facilities:
1 day hospital.

In addition, under the Community Mental Health Services Act the Department reimburses local community mental boards for 50 per cent of the cost of community mental health services in:
226 Outpatient clinics;
40 Psychiatric units in general hospitals.

The entire program serves well over 283,000 persons a year, including:
115,000 persons at State mental hospitals:
35,000 new admissions;
80,000 resident patients at beginning of the year.
27,000 persons at State schools;
21,000 at State-operated outpatient clinics;
45,000 at psychiatric units of general hospitals;
75,000 at outpatient clinics in the community program.

THE MENTAL HEALTH PROGRAM—STATE OF WASHINGTON

State Operated Facilities (Direct Services):
3 Hospitals for the mentally ill;
1 Treatment facility for emotionally disturbed children (provides residential and day care located at Western State Hospital);
2 Out-patient clinics for mental patients (located at Western State Hospital and Eastern State Hospital);
1 Neurological institute (located at Western State Hospital);
1 Tuberculosis unit for mentally ill (located at Western State Hospital);
1 Consultation unit (located in Seattle).

Total patients in *resident* care at state hospitals on November 1, 1966: 3,327.

The number of patients receiving some type of treatment from the Division of Mental Health during year ending June 30, 1966: 8,710.

	Patients served, 1966	Average daily population, 1966
Western State Hospital	4,040	1,770
Northern State Hospital	2,028	888
Eastern State Hospital	2,213	1,022
Total	8,281	3,680

On June 30, 1966, the Division of Mental Health had 2245 full-time employees, distributed as follows:

3 State hospitals	2,211
Mental health research institute	27
Total	2,238

During 1966, the total operating budget for the three state hospitals was $15,210,628.

Western State Hospital	$6,401,971
Northern State Hospital	4,450,121
Eastern State Hospital	4,358,536

The State of Washington provides part of the financial support for 15 community mental health programs and total financial support for one community center (Olympic Center).

The community mental health programs provide the following services:

Outpatient	20
Consultation	20
Children's Treatment Programs	18
Information and Education to the Public	20

Estimated number of persons receiving services from the community mental health programs during 1966: 3700.

In 1966 $233,978 was distributed to the community mental health centers by the State of Washington. Of this amount, $47,424 was derived from the federal government.

* * * * * * *

SERVICES PROVIDED BY WASHINGTON STATE FOR THE RETARDED

State-operated facilities, (direct services):
4 Schools for the mentally retarded.

	Patients served, 1966	Average daily population,[1] 1966
Lakeland Village	1,356	1,299
Rainier School	1,875	1,640
Yakima Valley School	268	250
Fircrest School	1,001	948
Total	4,500	4,137

[1] Includes small number of persons on a guest status.

On June 30, 1966, the schools for the retarded had 1584 full-time employees.
During 1966, the total expenditures for the schools for the retarded children were $11,024,263.

The State of Washington provides part of the financial support for 25 community day care centers. During the year ending June 30, 1966, $64,837 was expended on the community day care centers.

An estimated 500 persons received some service from the day care centers in 1966.

Dr. MILLER. The preceding figures describing the dimensions of our programs are important, Mr. Chairman, because mental health is the only category of illness specifically mentioned in Public Law 89-749, which is being extended by the bill you are considering today, H.R. 6418.

I think, therefore, that it is of some significance to know the proportions of the mental health programs in the States that warrant so special an identification in the law.

If for no other reason, mental health needs special mention, Mr. Chairman, precisely because of its immensity.

Our departments are frequently the largest in terms of payroll and work operations of any State governmental department. That is true in New York. We are also vulnerable in spite of our size with respect to participation in certain Federal public health programs, and I think an example is from the history of the formula grant program that during the past 5 years the categorical grant for the community mental health services as you made of $6.75 million which, if you were able to scale out according to each State, would be approximately $135,000 for each State. In New York State it was just under a half million dollars a year, but contrasted with combined local governmental and State governmental matched funds in New York State for community mental health servies alone of over $70 million. During that same period the categorical programs for heart disease and other important areas such as dental care increased steadily and the percentage of mental health categorical grants since 1948 has actually declined.

So, in brief, to recapitulate why mental health should receive some special reference in Public Law 89-749, I would say for one because State health departments are important, are in most States now designated by the States to plan for and receive Federal public health funds, but in only four States plus the Virgin Islands, Puerto Rico,

and the District of Columbia, does the health department have direct responsibility for the administration of the State mental health program, and in one of those mental retardation is in another agency; and, keeping in mind this scale and scope of programs, as I have briefly alluded to them, this does present a special problem.

In six other States the mental health program is under a health and welfare agency and in all of the other 44 mental health program rests in a variety of some other State agencies than the State health department. In 18 States as of the moment there are independent departments of mental health. In such a wide range of mixed authorities it is of utmost importance that if mental health is to share in proper proportion of the public health grants it must have, we think, at this time a special identification in the law.

Mr. Chairman, we wish to reaffirm our strong support of the extension of the provisions of Public Law 89–749 for comprehensive health planning. We endorse the purposes of that act which seeks to establish comprehensive planning for health services, health manpower, and health facilities at every level of Government and to broaden and make more flexible the Federal Government support of health services provided to people in their communities.

We believe firmly in the values of an effective partnership of State and local health and mental health agencies, intergovernmental collaboration, and cooperation between official and voluntary programs. We favor the continuation of the new Federal system of block grants for public health services in the States established in Public Law 89–749 last year.

This is an effective and efficient application of the principle of creative federalism and is a giant step forward in improving further the already excellent relationship that exists between the Federal and State Governments. The States need the flexibility to shift Federal grants support into health programs that they determine to be critical and Public Law 89–749 now gives each State that flexibility. The flexibility is dependent on at least two things: not only the law, but the regulations and the guidelines promulgated by the Federal Government and most importantly the comprehensive health planning to be done by the States.

The regulations and guidelines, if so drawn as to constrict, could suffocate a good program, but we think that the regulations and guidelines as they are now being developed and as I understand will be published very soon, appear to us to be entirely consistent with the purposes of this act. The comprehensive health planning is yet to be funded. We look upon the comprehensive planning as the most important phase in the new Federal block grant program.

The block grant by the Federal Government to the State will be disbursed within the State to programs with the most urgent priorities, in accordance with that comprehensive plan. The State mental health programs have just completed 2 years of comprehensive mental health and mental retardation planning, and as you know, the mental retardation planning is continuing and it is our hope that this enormous mental health planning effort and even more the capacities

which this developed within the States and the investment in the States in continued never-ending planning will be properly incorporated into the total planning of the States.

To some extent this will depend on the State agency designated to do the planning.

In New York State we are moving toward, in fact have established an interdepartmental agency for the development of a single comprehensive State health plan as required under Public Law 89-749. The chairman of this interdepartmental agency is to be the commissioner of health, and I as commissioner of mental hygiene am to be the vice chairman. The extensive responsibilities in the total field of health which are lodged in such other departments of State government as social welfare, the State department of education, the State university, the State office of insurance, will be respected in the composition of the interdepartmental health planning agency now being established in our State, and the Governor's office is also directly represented as well by members of his cabinet, by a representative of the office of planning coordination.

Mr. Chairman, we think very strongly in New York that comprehensive planning can best be achieved through a partnership among strong, clearly identified health, mental health, and other health-related programs.

The act and the amendments which you are now considering enhances significantly the capacity of States to meet the needs of their populations by effective comprehensive planning. The requirement for planning is a major step forward.

The tremendous demands for services inevitably militate against adequate financing of planning efforts in many parts of the country. The extension for 5 years of the authorization for Federal grants to the States for planning provides a means for doing what every administrator of health services wants.

We have looked to our members, our member States and attempted to canvass from them what their projection would be of special needs now not met in the mental health field and mental retardation which might provide, I think, some illustration of some of the uses to which the funds authorized could be put.

I am able to give you today a fairly detailed and explicit projection of the highest priority community mental health programs for which we will seek collectively Federal grant assistance in the next 7 years, assuming that this law is extended for that period of time by the Congress.

I would like to add that it was possible for the States to do this because they had been engaged in a comprehensive planning effort. Thirty-four States have given me descriptions of 160 programs which they consider to be of the highest priority in combating mental illness and mental retardation, and I have with me here the full description of the 160 projected programs with cost estimates.

I don't intend to burden the record with this information which is about 460 pages. However, I have prepared an analysis of the programs and estimates of costs to State and local governments and the amounts that the State mental health agencies are hoping to obtain from Public Law 89-749 through the State comprehensive health

planning apparatus. At this time, Mr. Chairman, I ask that the table I have prepared showing the mental health programs that will need assistance through Public Law 89–749 be made a part of this hearing record.

(The table referred to follows:)

MENTAL HEALTH PROGRAM ANALYSIS AND COST ESTIMATE (STATE-LOCAL-FEDERAL) FOR 34 PARTICIPATING STATES, SUBMITTED BY THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

General description of proposed mental health programs, 1967–73	Number of States proposing program	Projected State and local contribution	Projected request for Federal grants
Treatment programs for emotionally disturbed and mentally ill children and adolescents	17	$98,480,000	$57,912,000
Mental health information; diagnosis and prevention	17	24,299,000	11,770,000
Mental retardation, care, and training (including care of the mentally ill retardate and preadmission care for severely retarded on waiting lists)	15	96,282,000	44,383,000
Alcoholism treatment programs	15	26,315,000	14,862,000
Community mental health services	15	103,211,660	84,121,660
Training programs for professions and nonprofessionals	12	28,445,000	7,510,000
Aftercare programs (including halfway houses)	9	12,834,000	16,646,000
Suicide prevention and emergency mental health services	8	24,552,000	9,610,000
Automatic data processing (clinical information)	7	2,294,000	3,446,000
Alternatives to hospitalization	6	5,951,000	3,104,000
Research and evaluation of programs	5	9,899,000	8,476,000
Mental health services, rural areas	4	9,879,000	5,073,000
Partial hospitalization	4	39,400,000	22,732,000
School mental health	3	194,000	----------
Major mental disorders	3	8,358,000	10,826,000
Development of regional organization	1	347,000	332,000
Coordination of State and local services	1	1,900,000	1,000,000
Provision of mental health services to the high-risk nonrecipient element of the community	1	150,000	310,000
Establishment of case register for mentally ill and mentally retarded	1	623,000	875,000
Mental health program for low-income minority neighborhoods	1	1,800,000	1,725,000
Special problems	1	31,000	185,000
Technical assistance and consultation	1	185,000	157,000
Mental and emotional aspects of major social problems	1	(1)	(1)
Mental and emotional problems of living	1	(1)	(1)
Services to courts	1	(1)	(1)
State hospitals	1	(1)	(1)
Staffing aid to general hospitals	1	(1)	(1)
Total	----------	539,183,660	326,958,660

[1] Not available.

Dr. MILLER. You will note, Mr. Chairman, that the total 160 programs thus far, if put into action over the next 7 years, would need $539,183,660 of State and local support and $326,958,660 of Federal grant support as now projected by the States.

The Federal grant support for 1 year would average about $47 million, projected among the programs solicited. The total proposed health services authorization for fiscal year 1969 is for $70 million. The minimum 15 percent for mental health is $10.5 million. The disparity between what is needed and what is practical for the Congress to grant to the States considering the pressures from the national defense effort and other vital budget demands is obvious.

We wish to emphasize our support of all sections of H.R. 6418 including the 5-year extension of the comprehensive health planning grants, the increased authorization of $7 million for fiscal 1968, the extension of areawide health planning authority for 5 more years, the extension of authority for project grants between studies and demon-

strations, and the extension of authority for 5 years of comprehensive health services.

We support the request for $70 million for formula grants in H.R. 6418 for the fiscal year and support as fully the $70 million for project grants which will make it possible throughout the country to carry out demonstrations, pilot efforts, explorations of new areas.

However, it is to be hoped that in the near future when we can once again turn full national attention to our critical domestic needs, the sums allocated to the partnership for health program for formula grants will approximate, and this is an approximation, $1 per capita for $217 million per year. When the Federal share of the partnership for health program reaches that level, the Government will have taken another substantial step toward realizing the goal recommended to the Congress in 1960 by the Joint Commission on Mental Illness and Health which was created by Public Law 84–182.

The Joint Commission, in making its final report to the Congress, said: "We recommend that the States and the Federal Government work toward a time when a share of the cost of State and local mental patient services will be borne by the Federal Government, over and above the present and future program of Federal grants-in-aid for research and training."

Extension and expansion of Public Law 89–749, Mr. Chairman, could be considered as an action toward such sustained support, and we fully endorse such action.

We call for favorable consideration by your committee of H.R. 6418.

The CHAIRMAN. Thank you, Dr. Miller.

Mr. Schnibbe, do you want to make a comment?

Mr. SCHNIBBE. No, I have no statement, Mr. Chairman.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS. Thank you, Dr. Miller, for your statement.

Although we are delighted that you are supporting the bill, it seems to me that you are still supporting the idea of categorical designation which is somewhat contrary to the block grant approach. You don't think that the State people can put a proper evaluation on this to have a State comprehensive plan so that mental health can get a proper proportion in that State?

Dr. MILLER. As you know, this is perhaps one of the most difficult questions for us, and I am sure for the Congress. We endorse the principle and we endorse as a direction the provision to the States under this law of funds which can be spent at the discretion of that State.

It is our opinion that at this time because of both the scope and size of the mental health and mental retardation programs in the States and because of the administrative arrangements within the States and because of what may be still some different kinds of problems within the mental health and mental retardation field, that it is proper to maintain this general distinction.

I might add that even a category for mental health services in degree might seem to be a departure from block.

Mr. ROGERS. I think the Congress is willing to go along with this pro forma, but to develop these trends I think you are going to have to come into a total picture a little better and also I would not want to give the impression that the States are only getting about $135,000

average on mental health. Really the program is larger than that. I understand your category there. Actually the money has not decreased, although you say it has decreased from relation to other funds.

Dr. MILLER. The amount has increased, but not substantially.

Mr. ROGERS. We passed this community mental health bill. I think that is a substantial increase.

Dr. MILLER. Very much so.

Mr. ROGERS. Everything I can remember we have been increasing at least from the point of view of the Federal Government, and I don't want to leave the impression with the people here that the totals have been going down rather than up. I am sure this is not your intention, but I just wanted to make that clear.

Dr. MILLER. Quite true.

Mr. ROGERS. Thank you.

Thank you, Mr. Chairman.

Dr. MILLER. May I say that it is our view that with the experience of comprehensive health planning and a growing ability to relate the many parts of the program which are broader even than mental health or health agencies, that we would hope that the competency of the States to deal in a truly comprehensive way with a single fund would be an area to which we would strive.

Mr. ROGERS. Fine. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Miller, you think under the present circumstances then that this probably should not be combined right away, is this right?

Dr. MILLER. That is our opinion.

The CHAIRMAN. We should work it in gradually if we are going to do it.

Dr. MILLER. I would say that each year we would have a better base to know how these things could be more fully integrated.

The CHAIRMAN. I want to thank you for coming and giving us the benefit of your views. Certainly the magnitude of this burden on the community is great, and we, I think, as the Congress, recognize this. This is a burden, and we are trying to do something about it. There is a separate bill, besides this one, on the mental health program.

Dr. MILLER. Right. We very much appreciate it.

The CHAIRMAN. Thank you very much.

The committee will stand recessed until 2 o'clock this afternoon, and those witnesses who did not get on, if they want to submit their statements for the record, can do that or come back at 2 o'clock.

The committee now stands recessed until 2 o'clock.

(Whereupon, at 12:15 p.m., the committee recessed, to reconvene at 2 p.m., the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Paul G. Rogers presiding.)

Mr. ROGERS. The committee will come to order.

The next witness will be Dr. Lewis E. January, professor of medicine, University of Iowa, and the President of the American Heart Association, Inc., accompanied by Mr. Rome A. Betts, executive director; and Dr. Thomas W. Mattingly.

We are delighted to have you gentlemen with us and appreciate your indulgence in changing your time of testifying from the morning session to the afternoon. So we will be delighted to have your testimony.

STATEMENT OF LEWIS E. JANUARY, M.D., PRESIDENT, AMERICAN HEART ASSOCIATION, INC.; ACCOMPANIED BY ROME A. BETTS, EXECUTIVE DIRECTOR; AND DR. THOMAS W. MATTINGLY, MEMBER, LEGISLATIVE ADVISORY COMMITTEE AND COORDINATOR OF THE REGIONAL MEDICAL PROGRAM FOR THE METROPOLITAN WASHINGTON AREA

Dr. JANUARY. Thank you, Mr. Rogers, Mr. Blanton.

Mr. Betts is the executive director of the American Heart Association; Dr. Mattingly is a member of our legislative advisory committee and he is the coordinator of the regional medical program of Metropolitan Washington area.

We represent the American Heart Association, sir. We appreciate the opportunity to express our views to you. We filed a copy of our formal testimony with the clerk and we wish to speak somewhat more briefly.

The American Heart Association warmly supports the basic objectives of the Comprehensive Health Planning Act, Public Law 89–794, which is before your committee for renewal and possible modification.

We definitely do endorse the goals of coordinated planning, the expeditious and the economic use of Federal grants in the health field and the elimination of overlap.

We endorse the principle of greater flexibility in planning for and in providing for health services to the extent that they may be required by the various States.

We do not know whether or not your committee plans to revise the language of this act. We believe, however, that there are pitfalls that must be avoided to make certain that planning is efficient as well as effective. Therefore, we respectfully urge, as we did last year in testifying before the Senate Committee on Labor and Public Welfare, that the shortcomings which we feel endanger fulfilling the purposes of the act be made a matter of record.

The American Heart Association favors the concept of planning by the very-best-qualified experts available, and this, indeed, is provided in the act at the State level. But Public Law 89–749 does not provide the Surgeon General with an advisory council, a device which, in our opinion, has well served the National Heart Institute for many years and which more recently was adopted in the legislation which authorized the regional medical program, Public Law 89–239.

Therefore, we do recommend that the Surgeon General have access to advice and guidance from a group of health and public welfare specialists in reaching the important decisions on health planning envisioned in this act. Such an advisory council would, among other things, lift from his shoulders the obligation to evaluate many of the individual elements in many separate State programs.

If, on the other hand, as has been indicated, it is planned to administer this act through regional offices of the Department of Health,

with the assistance of regional health planning councils, then we would feel that the result we desire would be achieved.

This obviously could be the result of regulation rather than legislation.

The American Heart Association feels a deep concern, sir, for all of the agencies which are designed to combat cardiovascular diseases, and we wish to make as sure as possible that the vital programs in research and study of the National Heart Institute and the Heart Disease Control Branch of the Public Health Service go forward while, at the same time, there should be no conflict with the regional medical program.

We share the concern which has been expressed that we should avoid unnecessary duplication. We think, however, that it would be unfortunate to suspect duplication where, in fact, none existed. I mention this and use as an example the fact that some of us here today in testimony recently before another Congressional committee discovered that there was the belief there that the National Heart Institute myocardial infarction study program was a duplicate of the patient services oriented applied program of the regional medical group.

In our view this is not true. But if this misunderstanding prevailed, highly valuable research would be interrupted, delayed or suspended at great penalty to the American people.

We believe that the council of experts, the advisory council that I mentioned, which we support, would prevent this misunderstanding. As we read Public Law 89–794, there is no specific coordination spelled out between regional medical program officials and the State health planning council. We understand that this is planned, but we strongly recommend that either the act or the regulations for administering it should provide specifically for representatives from regional medical programs be included in the State Health Planning Councils. Also we think it would be wise to include representatives of the medical schools and of State medical societies in these State health planning councils, since, after all, in some instances the State medical society has been the group to take the initiative to organize regional medical programs. And in almost all places medical schools are intimately involved and oftentimes the center of such plans.

We believe also that it is not sufficient to specify that a majority of the membership of these advisory councils shall consist of representatives of the consumers of health services. We do certainly agree that such council should be composed of a majority of nongovernmental personnel, but that the consumers of health services should specifically include representatives from the voluntary health agencies, among others, because we believe that many of the major voluntary health agencies have special competency in health affairs.

What I have said about the State advisory councils would apply equally, of course, to the regional or to the national advisory council, whichever the case might be.

We further believe that the State health planning councils should have the authority to approve as well as to advise on plans of the state health agency. And we recommend that either the act or the regulations provide for this and also for consultation between State health planning councils and State health agencies in the preparation of the periodic review of State health plans.

80–641—67——8

At this point, sir, I would like to ask Mr. Betts to comment to you briefly on another aspect of the Public Law 89–749, having to do with the training of public health personnel.

Mr. ROGERS. Fine.

Mr. BETTS. Mr. Chairman, I am glad to be here representing at this instant both the American Heart Association and—to put on another hat, if I may for a moment—as a volunteer, like Dr. January and Dr. Mattingly, as chairman of the National Health Council's Committee on Continuing Education.

We are very much concerned with the ability of voluntary health organizations to engage in the training of their personnel. They come from a variety of backgrounds, some from the field of fundraising, some from the field of public relations, some from the field of business administration.

But now, in view of the fact that this Comprehensive Health Planning Act is going to place such a tremendous emphasis upon training in the principles of health planning, it seems to us that the act should very well be extended to make specific provision for the training not only of official personnel, but for those in the voluntary and private sectors as well.

We cannot overestimate the importance of this. As a matter of fact, before this came up for reconsideration this year, in one of our Continuing Education Committee meetings we urged that a kind of crash program be undertaken whereby these courses in the principles of planning be undertaken within each of the Public Health Service regions in order that these might be available to as many of our personnel in the voluntary health agencies as could take advantage of them.

It would strike us also as being desirable, in the preparation of the content for courses of this nature, to have representatives from the voluntary agency sector assist in the planning. I believe that the result might be more advantageous for all concerned.

There has been another idea that has occurred to a few of us which may or may not have relevance to your committee. Perhaps the mere novelty of the idea could be regarded as startling. This would be the possibility of extending the existing terms of the act for the exchange of official personnel between the Federal and the State level to perhaps make possible also the exchange of personnel between the official agency and the voluntary agency within the State organization.

Certainly one of the things that is in our judgment to be mandatory in the years immediately before us is a thorough understanding on the part of all the forces that are engaged in trying to improve the health of the American public to understand each other's problems, to get to know one another better and in this fashion to collaborate more freely and effectively in what they have to do.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much.

Dr. JANUARY. That concludes our testimony. We will be glad to answer questions.

(The full statement of the American Heart Association follows:)

STATEMENT OF THE AMERICAN HEART ASSOCIATION, INC., PRESENTED BY DR. LEWIS E. JANUARY, PRESIDENT

The American Heart Association warmly supports the basic objectives of the Comprehensive Health Planning Act (P.L. 89–749) which is before this committee for renewal and possible modification through H.R. 6418. Our Association applauds the efforts of the Congress through this legislation to stimulate coordinated community health planning, to encourage the most expeditious use of Federal health grants, and to close gaps and eliminate overlapping where they exist at the community level. We also endorse the Congress' principle of greater flexibility in planning for and in providing health services to the extent they might be required in the various states. We believe that, in this way, health services will become more readily available to all where and when they are needed.

We do not know whether your committee intends to revise the language of this Act. We believe, however, that there are pitfalls that must be avoided to make certain that planning is efficient as well as effective. We therefore respectfully urge, as we did last year to the Senate Committee on Labor and Public Welfare, that the shortcomings which we feel endanger fulfilling the purpose of this Act be noted for the record and receive the attention of this committee.

The American Heart Association favors the concept of State Health Planning composed of the best qualified experts available to consult with and guide health authorities in developing effective programs. We have therefore noted with some concern that P.L. 89–749 does not provide specifically for such a council of experts to advise and consult with the Surgeon General in determining the acceptability of health plans drafted by the states. We submit that such councils have functioned effectively in connection with the National Institutes of Health, and we are gratified to see that a Council to the Surgeon General is a part of the basic structure of the Regional Medical Program legislation (P.L. 89–239).

Therefore we recommend that the Surgeon General have access to advice and guidance from a group of health and public welfare specialists in reaching important decisions on health planning under this Act. That would lift from his shoulders the obligation singlehandedly to evaluate many individual elements in many separate state programs. If, as has been stated, it is planned to administer this Act through Regional Offices of a Department of Health, with the assistance of Regional Health Planning Councils, we would feel that similar results could be achieved. This, obviously, could be the result of regulation rather than legislation. It is our hope that the committee will agree with this view and will give it credence by including it in its Report on the bill.

The American Heart Association, as you know, feels a deep responsibility to serve in partnership with all agencies of the government combating the heart and blood vessel diseases. Thus, we are vitally interested in the ability of the National Heart Institute to carry forward its programs of research and study; we are interested in the services that are already being rendered by the Heart Disease Control Branch, and we are cooperating earnestly and hopefully in the planning and mounting of demonstration projects under the new Regional Medical Program.

We are anxious, of course, to avoid duplication of services. At the same time we must make certain that duplications are not suspected where they in fact do not exist. It would be most unfortunate, for example, if the Congress were to believe that the Myocardial Infarction Study Facilities program, a research project of the National Heart Institute, could be suspended because it duplicated certain patient-service activities under the new Regional Medical Program. Some members of the delegation testifying here today were confronted with this specific misunderstanding recently in testifying before another Congressional body. If it is possible for such misunderstanding to prevail, highly valuable research can be interrupted, delayed or abandoned at great cost to the American public. One way to prevent unjustified suspicions of overlap in the various medical programs, it seems to us, is to provide a system whereby experts in the medical field carefully inspect and weigh all state plans. We believe that the Comprehensive Health Planning Act, by specifically involving dedicated civilian specialists through the State Health Planning Councils, as well as members of the Surgeon General's staff at both local and national levels, could provide such assurance.

While Health Planning Councils are provided for at the state level, we believe that the formula for their make-up should be strengthened. It seems to us that there must be close coordination among all agencies to mesh existing health facilities with such new health services that might become available through the Regional Medical Program.

As we read Public Law 89–749, no specific coordination exists now between Regional Medical Program officials and the State Health Planning Councils. We therefore strongly recommend that either the Act or the regulations for administering it should provide specifically for representatives of Regional Medical Programs to be included in State Health Planning Councils. Obviously representatives of medical schools and state medical societies should be included in the composition of these State Health Planning Councils.

Additionally we believe that it is not sufficient that "a majority of the membership of such councils shall consist of representatives of consumers of health services". We believe, instead, that such councils should be composed of a majority of non-governmental personnel and, in addition to "consumers of health services", should specifically include representatives from the voluntary health agencies and medical schools.

We further believe the State Health Planning Councils should have the authority to approve as well as to advise on plans of the State Health Agency. We recommend that either the Act or the regulations provide for this and also for consultation between State Health Planning Councils and the State Health Agencies in the preparation of the periodic review of state plans required by the Act.

There is another important principle involved in this amending legislation. In testifying before the House and Senate Appropriation Committees last year, the American Heart Association observed that the Heart Disease Control Program did not have project grant authority. We declared then, and we believe now, that there is need for such a grants program within this body to support developmental work in such areas as coronary care units, special centers for the management of patients with strokes, and programs using modern computer techniques on a pilot basis.

It was our understanding that this authority was extended to the Heart Disease Control Program through Section 314 (e), clause (3) of P.L. 89–749. This clause is stricken by the terms of H.R. 6418 (cf. Pg. 7, line 25) and transferred to Section 304 (a) 2 (cf. Pg. 6, line 1). It would be our interpretation that the new language—dealing with "development of new methods or improvement of existing methods of organization, delivery, or financing of health services"—is intended to cover developmental projects related to the prevention and control of heart and blood vessel diseases and other related chronic diseases.

But we do not believe that this language is sufficiently explicit to assure the availability of project grants for this necessary developmental work. If a change in the language is not feasible, we feel that this meaning should be stipulated by the committee and included in its report accompanying the bill.

In making this recommendation we want to reconfirm our support of non-categorical project grants to be disbursed at the state level under health planning approved by the Surgeon General. However, we also want to guard against the loss of authority to issue developmental grants of a categorical nature as a result of transferring existing clause 3 to Section 314 (e) to new Section 304.

We also note that new Section 304 establishes a ceiling of $20 million on the projects carried out under its terms. This conceivably would make less money available for necessary developmental heart projects than might have been available under old Section 314 (e). In view of the great number of people suffering from the cardiovascular diseases, we are seriously concerned about this relatively low limit on grant appropriations for fiscal 1968. If the Heart Disease Control Program is to explore the very promising potential for the development of new ideas in the heart and stroke area, it is our firm conviction that substantially greater amounts of money should be made available for this purpose.

Finally, the American Heart Association agrees with the Congress that "desirable administration (of health services) requires strengthening the leadership and capacities of state health agencies . . ." We feel, however, that any training benefits made available for state agency personnel be provided for personnel of private, non-profit health agencies, including personnel of the voluntary health organizations. Such an arrangement would be mutually advantageous by providing comparable expertise for volunteer as well as for state and Federal personnel.

Mr. ROGERS. Mr. Blanton?

Mr. BLANTON. Thank you, Mr. Chairman.

Doctor, you seem concerned about the coordination of local, State, and national levels. Do you have anything specific in mind that disturbs you about this act on the coordination part?

Dr. JANUARY. No, not really; because we understand that it is mandatory that this coordination will take place. However, we do think that it would be advisable to specify that it must take place. Because we believe so completely in comprehensive health planning, we think it must be this, and we would not like to see in any area of the country an attempt at planning—particularly regional medical program and the other segments of health planning—without there being coordination.

Mr. BLANTON. Well, I think we all agree on this, but let me ask you this: Do you think H.R. 6418 is not clear enough or does not go far enough?

Dr. JANUARY. That was our belief.

Mr. BLANTON. Do you have any proposals that would make this coordination more explicit and detailed or are you just suggesting that we need to do more to it?

Dr. JANUARY. We would suggest, first of all, that the Surgeon General have an advisory council. However, if the law is to be implemented at the regional level, there should be a regional advisory council. Also, whichever council is in fact set up, specify that it include representation from regional medical programs in its area and that it include representation from medical schools, medical education, and from State medical societies. This would work very well, of course, at the State level. But I think at the regional level it could be implemented just as easily.

Mr. BLANTON. Well, what you are proposing in a sense is a kind of duplication, isn't it, a check rather than coordination?

Dr. JANUARY. Coordination—that with all of the ideas in planning, there be no unnecessary overlaps.

Mr. BLANTON. Well, I agree with that. What you are proposing is that the Surgeon General define this more clearly in this piece of legislation, and you do find that this piece of legislation does lack this coordination?

Dr. JANUARY. We think so; yes.

Mr. BLANTON. Thank you.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Brown?

Mr. BROWN. Doctor, the specific area of concern is what confuses me a little. There is language in this legislation which says the following:

> That this program is to provide for assisting each health facility in the state to develop a program for capital expenditures for replacement, modernization and expansion which is consistent with an overall state plan developed in accordance with—

And I think these are the important words—

> criteria which the Secretary determines will meet the needs of the state for health care facilities, equipment and services without duplication and otherwise in the most efficient and economical manner . . .

Do I understand your comment to suggest that you would like to have these criteria and the implementation of them coordinated at the State and local level with an advisory committee?

Dr. JANUARY. I think at the State level it is specified, there will be an advisory council. We would like to see it assured that on this council there will be a representation from the regional program in that State from medical education in that State, and from State medical societies.

Mr. BROWN. How do you feel about these criteria being drawn up in advance and some general outline given by the Surgeon General as to what the criteria for assessing State plans will be?

Dr. JANUARY. I think we would be very happy if this were a part of the regulations rather than part of the legislation; yes, sir.

Mr. BROWN. Well now, this is a significant point which you are making. You don't think it is necessary to have it in the legislation, but that it can be drawn simply by the Surgeon General to your satisfaction?

Dr. JANUARY. We actually do think it can be.

Mr. BROWN. And if there is at the State level some feeling that that is not appropriate, then what recourse?

Dr. JANUARY. Well, it scarcely seems to me that it would be considered improper at the State level, since we are talking so basically about any health plan which it seems to me must include physicians, must include medical education, and must include regional planning that is going on.

Mr. BROWN. In other words, you don't envision a plan drawn by the Surgeon General that would get local disapproval.

Dr. JANUARY. I would not, but perhaps Dr. Mattingly, who is involved here in Washington in regional medical plans, should comment on this also.

Dr. MATTINGLY. I think I can cite a parallel situation. When the National Heart Council was set up, and other councils in the National Heart Institute, there were included in that council representatives from the Veterans' Administration, from the Federal services, and I myself served as liaison officer for the Secretary of Defense for about 6 or 8 years. Having someone from these areas in that National Heart Council helped to coordinate activities and prevented duplication of grants made to these other agencies that might be under consideration in the National Heart Institute. For that reason the point Dr. January brought up here, from the standpoint of having a National Advisory Council to the Surgeon General, could avoid some of this. Certainly at the lower level these advisory councils should contain a higher percentage of non-Federal members on that and specifically include representation from the regional medical programs. If there happened to be a State in which there is a comprehensive model city plan, then I think there ought to be a representation from that group, too, because we could in reality have three so-called master planners and each one of them may want to assume the responsible authority unless they were fairly well delineated either at the State level or by something in the nature of laws.

Mr. BROWN. The question is, Do you feel that any criteria should be drawn up in advance?

Dr. MATTINGLY. I think involving as many States as it does, it would would probably be preferable rather than waiting for these things to be hopefully carried out.

Mr. BROWN. May I ask you a question with reference to the funds involved?

Actually there are two questions: The program, as I understand it, envisions ultimately a multibillion-dollar program. Do you think any provision for the States to absorb more of the costs of their comprehensive planning program should be made? In other words, should there be any provision in this legislation, as well as is in some others, for the Federal Government to stimulate a program and then withdraw from it?

Dr. MATTINGLY. I believe this has been sort of a pattern of a good share of our legislation and I don't think we ever do any harm by creating some incentive, if I understand what you mean.

Mr. BROWN. There is an incentive in this program, of course. The Federal money goes in and the State is encouraged to match it, but there is no termination of the Federal participation in the program envisioned in the legislation we now have before us.

Dr. MATTINGLY. Well, this is a hard question to answer. It depends upon many factors and this is one of the reasons that we believe that nonprofit organizations and that the non-Federal individuals should have a large representation, because these are the ones that can help stimulate the development of funds, other than continuous Federal support, or some change in Federal support.

I don't think any of us could very wisely predict what is going to be the need as time goes on.

Mr. BROWN. It occurs to me that there is a possibility here that as these programs become increasingly Federal or continually Federal, that is a participation of an extent that is envisioned to go on forever and get larger in terms of total dollars forever, that private voluntary health organizations may face a drying up of resources through which they operate or with which they operate.

Dr. MATTINGLY. Certainly the private sector of medicine should continue to play an important part in these areas. They should not ever completely turn them over to Government agencies.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. ROGERS. I was interested in your suggestion about the voluntary organization personnel. What do you think the initial cost might be if this were permitted?

Mr. BETTS. Let's take just our own organization as an example.

We have some 125 to 150 chapters and some 50 affiliates; in other words, about 200. If we took the executive directors of those 200 organizations at an average cost, for example, of around $250 a person, you are talking here of about $50,000.

I would suppose that there are some 15 other voluntary health agencies that would qualify or wish to qualify for this type of opportunity, so if you multiplied that $50,000 by 15, it would come not too far from what this type of training opportunity might look like in any given year.

Actually, I suppose it would be less, considerably less in any given year, because not all personnel would be able to take advantage of it

in one year. It could extend itself, therefore, I would assume——

Mr. ROGERS. Is there any prohibition against them doing it on a voluntary basis now?

Mr. BETTS. None.

Mr. ROGERS. They can now participate, but the cost must be paid by the local chapter?

Mr. BETTS. That's right. As a matter of fact, many of our local personnel do now take advantage of training opportunities in some dozen universities where courses of this type are presently conducted.

Mr. ROGERS. But you feel the Federal Government should get into this area?

Mr. BETTS. I think so in this particular instance, because this particular program is so obviously and so desperately going to be in need of qualified personnel, to make it work properly. I think that for this kind of a crash program I have suggested, it would be highly desirable.

Dr. JANUARY The manpower shortage in this area of health, however, is fully as great as it is in any other area, and it would seem to us quite wise to utilize all the people we can and train them so they can be used ideally.

Mr. ROGERS. You think the expense is too much on the individual chapters?

Mr. BETTS. Well, yes, if they undertake to do other parts of the training process; for example, of the courses that I mentioned presently being conducted throughout the country there are several in the field of executive management, there is one in the matter of consultation process, there is a third in the matter of personnel administration of management.

All of these opportunities, if pulled together, could be a pretty heavy drain on the training resources of voluntary health agencies without some supplementation—as a matter of fact, many of them now do take advantage of Public Health Service grants or training grants. About half, actually, of those who took these courses a year ago, which were roughly 300, did have advantage of these Public Health Service scholarships.

Mr. ROGERS. Tell me, what is the amount of money raised by the American Heart Association?

Mr. BETTS. Last year it was $34.6 million.

Mr. ROGERS. That is excellent. How is that broken down as to research and——

Mr. BETTS. About 36 cents out of the total national dollar goes to research. Roughly another——

Mr. ROGERS. Is that mainly universities or——

Mr. BETTS. Yes, or other similar institutions, teaching hospitals.

Mr. ROGERS. About how much is for administration, would you say?

Mr. BETTS. About 10 percent for administration, about 15 percent for fundraising costs, and the balance for our professional, public and community services—public education, professional education, and community service, which would leave you roughly 48 percent in those three categories.

Dr. JANUARY. This represented about $12 million in research from this, and this by the way, is the largest private support of cardiovascular research in the country.

Mr. ROGERS. Thank you. Mr. Van Deerlin of California wanted to question you.

Mr. VAN DEERLIN (presiding). I have no questions, sir. Are there any more questions of this witness?

(No response.)

Thank you very much, sir.

Dr. JANUARY. Thank you, sir.

Mr. VAN DEERLIN. Dr. W. B. Mason, the University of Rochester, representing the American Chemical Society, will be our next witness.

I welcome you to the committee, Doctor, and ask you just to go ahead with your presentation.

STATEMENT OF DR. W. B. MASON, ASSOCIATE PROFESSOR OF CLINICAL CHEMISTRY, SCHOOL OF MEDICINE AND DENTISTRY, UNIVERSITY OF ROCHESTER, REPRESENTING THE AMERICAN CHEMICAL SOCIETY; ACCOMPANIED BY B. R. STANERSON, EXECUTIVE SECRETARY, AMERICAN CHEMICAL SOCIETY

Dr. MASON. Mr. Chairman and members of the committee:

I am pleased to be able to appear before you today to present the views of the American Chemical Society on H.R. 6418, the Partnership for Health Amendments of 1967. My comments will be directed solely toward section 5 of this bill, which is separately identified as the Clinical Laboratories Improvement Act of 1967.

At the outset let me say we strongly support the intent of section 5.

With me here today is Dr. B. R. Stanerson, who is executive secretary of the American Chemical Society, which has its national headquarters here in Washington.

My name is W. B. Mason. I hold doctoral degrees in both chemistry and medicine, and currently am associate professor of biochemistry, pathology, and medicine (clinical chemistry) at the University of Rochester School of Medicine and Dentistry.

At the university I also am director of the clinical chemistry laboratory. In addition, I am a member and immediate past-chairman of the American Chemical Society's Committee on Clinical Chemistry, president-elect of the American Association of Clinical Chemists, president of the National Registry in Clinical Chemistry, and director-elect of the American Board of Clinical Chemistry.

Chemists are importantly involved in the operation of virtually all clinical laboratories. Currently, we estimate that there are upward of 8,000 individuals holding bachelors degrees or higher in chemistry or in a closely related field who, in one way or another, contribute to the essential public health services which physicians have come to expect from clinical laboratories. In addition, there are even larger number of individuals at the subprofessional or semiprofessional level in these laboratories who perform chemical procedures under close supervision. Combined, the two groups are responsible for more than half of all the tests performed in the Nation's clinical laboratories. It is for reasons such as these that our profession has a significant interest in section 5 of H.R. 6418.

Historically, the regulation of clinical laboratories and their associated technical personnel is of long-standing interest to chemists. As far back as 1924, representatives of the American Chemical Society

met with their colleagues from the American Medical Association and the American College of Pathologists and Bacteriologists to discuss mutual concerns in laboratory practice. Out of that meeting came unanimous agreement that there was a need to standardize the quality of performance of clinical laboratories, desirably through the enactment of legislation which would insure the development of competent personnel and suitable equipment.

Ever since that time, chemists consistently have advocated the licensure of clinical laboratories and their professional personnel. We have done so principally through the American Chemical Society, our national scientific and educational organization which was granted a charter by Congress in 1937. Today the society's membership numbers 107,000 individual chemical scientists.

The society's declaration of policy on the subject of licensure was updated as recently as last September by its board of directors and appears at the end of my statement. This policy, entitled "Principles of Legislation for Regulation of the Practice of Clinical Chemistry," has been widely accepted as the most current expression of chemists' views on clinical laboratory practice and regulation. In fact, a national organization of specialists in clinical chemistry, the American Association of Clinical Chemists, officially endorsed these principles within the past 2 weeks.

The first of the 11 principles in this document is particularly pertinent to the objectives of the bill under discussion. It reads as follows:

> The primary objective of legislation to regulate the practice of clinical chemistry is protection of public health. This may be accomplished either by licensing or otherwise regulating individual practitioners, or by granting operating permits to clinical laboratories whose professional and technical personnel comply with generally accepted standards of training and performance.

This makes it clear, I believe, that we in the chemical profession strongly endorse the objective of H.R. 6418 to regulate clinical laboratories which are engaged in interstate commerce. This, in our view, is legislation which is long overdue in terms of establishing national standards of performance and service by clinical laboratories, and we commend President Johnson for perceiving this need in his consumer's message of last February. Thanks to the Health Insurance for the Aged Act, giant strides are being made in this direction through the development of standards of performance required of independent laboratories seeking to participate in the medicare program.

Yet, this is not the final answer. For example, there has been difficulty at arriving at a common denominator of service which will permit most currently operating laboratories to participate in this program and, at the same time, maintain an acceptably high level of performance. In some jurisdictions, this problem is not acute because of the existence of State laws governing the operations of clinical laboratories.

But as is well known, only a handful of States, some 10 or 12, so far have been farsighted enough to perceive the need for such controls. Fortunately, many others, some 12 to 16, have been motivated to consider licensing legislation this year.

I noticed this morning there were several questions concerning legislation in several States. If the committee wishes, the American

Chemical Society will be glad to furnish this in a supplemental statement, since we have this available in our files.

Mr. VAN DEERLIN. That will be helpful.

(Supplemental information referred to follows:)

STATUS OF CLINICAL LABORATORY LICENSURE IN THE UNITED STATES AS OF MAY 1, 1967, COMPILED BY THE AMERICAN CHEMICAL SOCIETY

1. *States which have laws regulating clinical laboratories and/or directors* (11):

California
Connecticut
Florida [1]
Hawaii
Illinois
Maryland
Nevada
New Jersey
New York
Pennsylvania
Rhode Island

2. *States which have laws regulating only medical technicians* (2):

Alabama
New Hampshire

3. *States in which pertinent legislation has been introduced in 1966–67* (3):

Arizona
Florida
Georgia
Kansas
Maine
Massachusetts
Michigan
Minnesota
Missouri
Ohio
Oregon
Tennessee
Texas

4. *States in which consideration is known to have been given to the need for licensure* (4):

Delaware
Oklahoma
Washington
Wisconsin

[1] Covers only medical technologists. New bill to cover directors and all laboratories introduced in 1967 (see No. 3).

Dr. MASON. However, already it seems clear that another 3 to 5 years, if not more, may pass before all 50 States will have grappled with this problem.

Meanwhile, the health care of our Nation's citizens must proceed. Increasingly, this health care will be reliant upon scientific determinations performed in clinical laboratories under the direction of scientific personnel. Further, the degree of sophistication in such determinations often makes it desirable, even necessary, to transmit specimens of human origin across State lines in order to achieve expert results.

It becomes imperative, therefore, that some national standards of performance be developed without undue delay to cope with this situation, especially during the coming years while there is still a paucity of State controls for these laboratories. Even beyond the immediate future, the vast majority of chemists believe there will be a continuing need for an interstate licensing program which will be national in scope and which will impose broad standards best designed to serve the health needs of all our citizens.

Our specific comments on H.R. 6418 are very few in number, four to be exact.

First, the nature of the bill implies that the Surgeon General will receive broad authority to establish specific criteria for accreditation or licensure of laboratories. Presumably, such regulations would be cast in the same mold as the medicare independent laboratory conditions which have also come from the Department of Health, Educa-

tion, and Welfare. If so, we believe the approach contemplated by section 5 of H.R. 6418 is sound and worthy of support.

In this same vein, we strongly urge that should section 5 of H.R. 6418 be enacted in its present form, serious consideration should be given to the mechanism of medicare as a means for recognizing laboratories competent to engage in interstate commerce. Currently, for example, HEW is engaged in a vast program to designate laboratories which can qualify under medicare. If these same laboratories could also qualify under the proposed legislation, considerable savings of public funds should be possible. In our opinion, careful study would be required in order to justify the need for a separate licensing and inspection program to deal solely with the interstate commerce aspects of clinical laboratory practice. At the present time, we see no need for such a separate system.

Our second comment concerns a particular aspect in this regard not contemplated by H.R. 6418 is the matter of proficiency testing. This deserves special emphasis. It is difficult, if not impossible, to determine the quality of laboratory services being rendered in any particular instance without an objective evaluation of performance. Section 5 in the policy attached to my statement bears on this and reads, in part:

> Competency should be demonstrated by satisfactorily passing an impartial examination in clinical chemistry science and technology.

It generally is agreed that such an examination should include preassayed test specimens which the laboratory is asked to analyze. Chemists have used such specimens for many years and great improvements in the analysis of minterals and metals, for example, can be traced to systematic use of reference samples developed by the National Bureau of Standards.

Similar improvement in performance by clinical laboratories can be expected from a systematic program of proficiency testing. It may be noted, however, that reliable samples suitable for use as test specimens in such a program are extremely difficult to prepare. Even so, a successful program of proficiency testing would be well worth the effort and we recommend its inclusion in H.R. 6418 or in the administrative regulations subsequently promulgated by the Surgeon General.

Our third point: As a matter of principle, we would like to record our opposition to Section 353(i) which states:

> The provisions of this section shall not apply to any clinical laboratory operated by a licensed physician, osteopath, dentist, or podiatrist who performs laboratory tests or procedures, personally or through his employees, solely as an adjunct to the treatment of his own patients.

It has become increasingly clear that a generally low caliber of laboratory service results from the circumstances described in this section. Physicians traditionally use high school graduates, receptionists, nurses, or other such individuals to perform routine determinations for patients in their offices. Such personnel ordinarily are not specifically trained in scientific procedures or in the handling of equipment or specimens. Instead, they tend to follow cookbook manuals or operate under the direct supervision of their physicians who, in turn, have had little current practical laboratory training. While it is recognized that there are practical considerations which warrant inclusion of this exemption for 1967, we predict that the day will come when

every clinical laboratory, no matter where it is situated or who its director may be, will come under the purview of public law.

In anticipation of that situation, the American Chemical Society and the American Association of Clinical Chemists are on record in the accompanying policy statement:

Licensure should be required for all practicing clinical chemists, including those in the employ of Federal, state or municipal governments and those employed by physicians to perform tests on the physician's own patients, but not for those clinical chemists whose work consists exclusively of teaching or research.

Finally, we would like to comment on the effect of section 353(k), which deals with the rights of States to enact and enforce laws relating to clinical laboratories apart from the provisions of the proposed legislation. Our concern centers on the situation in which a State may enact a law that is more restrictive, at least from our viewpoint, than regulations which may be contemplated by the Surgeon General under H.R. 6418. This has happened, for example, under medicare.

States such as Georgia and Maine (and possibly others) have considered laboratory licensure laws which would restrict the direction and operation of a clinical laboratory to physicians. On the other hand, the Federal regulations clearly allow qualified scientists to participate independently within their own spheres of competence. There is, of course, a need for both physicians and scientists to provide these vital public health services. To deny the public the expertise of either group seems unreasonable and extremely shortsighted in view of today's technological developments. Hence, it would be helpful to assure in some way that such exclusions would not occur if H.R. 6418 is enacted into law.

In behalf of the American Chemical Society and my colleagues in the American Association of Clinical Chemistry, I again want to thank you for the opportunity of offering our comments on this highly important piece of legislation. We feel that it is not only desirable, but critically important to assure that the standards of health care provided through the services of clinical laboratories are upgraded and made uniform on a national scale. Section 5 of H.R. 6418 offers every promise of obtaining these objectives.

Mr. Chairman, that concludes our formal comments.

(American Chemical Society policy on clinical laboratory licensure, referred to in statement, follows:)

PRINCIPLES OF LEGISLATION FOR REGULATION OF THE PRACTICE OF CLINICAL CHEMISTRY, REVISED SEPTEMBER 1966, APPROVED BY THE AMERICAN CHEMICAL SOCIETY BOARD OF DIRECTORS

1. The primary objective of legislation to regulate the practice of clinical chemistry is protection of the public health. This may be accomplished either by licensing or otherwise regulating individual practitioners, or by granting operating permits to clinical laboratories whose professional and technical personnel comply with generally accepted standards of training and performance.

2. Protection of the public health by regulation of scientists or laboratories providing health services involves several disciplines in addition to chemistry; therefore, legislation should encompass these fields as well.

3. The need for specilaization in single fields of science should be recognized and encouraged. A scientist should be required to qualify only in those fields in which he seeks a license.

4. For purposes of licensure, clinical chemistry may be defined as the application of chemical science to materials derived from the human body in order to

provide factual data to authorized persons for the purpose of making a diagnosis, preventing or treating a disease, or otherwise assessing a medical condition. Since the performance of a chemical examination is an action separated from the application of the result by a practitioner of the healing arts, the practice of clinical chemistry is not the practice of medicine and should not be so construed.

5. Since the practice of clinical chemistry requires the exercise of independent judgment, the issuance of a license authorizing such practice should be based on good character and high standards of professional competence. Competency should be demonstrated by satisfactorily passing an impartial examination in clinical chemistry science and technology.

6. A majority of the members of a board for establishing competence of candidates for liensure should consist of scientists representing the several laboratory sciences related to health, but principal responsibility for examining the qualifications of candidates in a given laboratory specialty should reside with individuals competent in that field.

7. It is generally recognized that the practice of clinical chemistry occurs at three distinct levels, depending upon the extent of academic training, laboratory experience, and competency in general and specific laboratory techniques. In addition to high standards of moral character, practitioners should possess the following minimal qualifications at each level:

a. Director: (1) an earned doctorate from an accredited institution with a major in some branch of chemical science; and (2) certification by the American Board of Clinical Chemistry, or, subsequent to receiving the doctorate, the acquisition of four or more years of pertinent laboratory training and experience, no less than two of which should be principally in clinical chemistry.

b. Supervisor: (1) a bachelor's degree with a major in chemical science from an accredited institution; and (2) six years of pertinent laboratory training and experience, no less than two of which should be in clinical chemistry. For holders of a master's degree in chemical science, the requirement for pertinent laboratory experience should be four years, and two years for those with an earned doctorate in chemistry.

c. Technologist: (1) a bachelor's degree from an accredited institution with a major in chemical science; and (2) at least one year of practical experience as a clinical chemistry technician or trainee.

It is recognized that lower classifications occur among clinical laboratory workers, but such classifications would not ordinarily apply to professional chemists.

In order to provide for the orderly implementation of new regulations without impairing the availability of clinical chemistry services, provision should be made for waiver of the respective academic requirements for any person who holds a minimum of a bachelor's degree with a major in chemical science and, within one year of the date such regulations become effective, submits proof that he has been practicing clinical chemistry as a director or supervisor for a period of at least four years.

8. Provisions should be made for waiver of examinations for persons already qualified in another state, providing that requirements for licensure in that state are at least equivalent to those of the state in which licensure is requested.

9. Licensure should be required for all practicing clincial chemists, including those in the employ of federal, state, or municipal governments and those employed by physicians to perform test on the physician's own patients, but not for those clinical chemists whose work consists exclusively of teaching or research.

10. Licensure as a clinical chemist shall convey authority to practice in a clinical chemistry laboratory and to collect blood and remove stomach contents upon authorization by a physician or other person with authority granted under any provisions of law.

11. Since physicians and others authorized by law to use clinical laboratory data should be fully informed as to the nature of determinations available from a clinical laboratory, regulations should not proscribe the free dissemination to them of information concerning such services.

Mr. VAN DEERLIN. Thank you, Dr. Mason. I think you have raised some points that are going to call for serious consideration here.

Any questions of Dr. Mason?

Mr. BLANTON. Thank you, Mr. Chairman.

Dr. Mason, I don't know whether you are familiar with the instance or not, but is it not true that in the other body or a similar committee that someone brought a dog in that had been licensed as a lab technician over the phone for $1.75?

Dr. MASON. I have heard that report.

Mr. BLANTON. Is it really that easy to get a lab technician's license in this country today?

Dr. MASON. I think the point here is that it was not a license, but a certificate from a private registry. I am not familiar with exactly how that organization operates, so I cannot answer your question.

Let me state categorically that it ought not to be that easy.

Mr. VAN DEERLIN. It may have been a business license, may it not?

Mr. BLANTON. I don't know what kind of license it is, but the point I am trying to bring out, under the provisions of this act in the licensing of clinical laboratories for interstate commerce, would this licensing also affect the qualifications of lab technicians within the laboratory?

Dr. MASON. If the regulations as we understand them would follow those in medicare, then there would be considerable upgrading of the qualifications of all personnel in the laboratory.

Mr. BLANTON. We had some figures presented this morning that were startling as far as the inaccuracy of some of our clinical laboratories were concerned. In some instances they were as inaccurate as 40 percent.

Whenever we speak of 40 percent inaccuracy for a medical situation, then the odds against the patient were built up considerably because he was already in trouble or he wouldn't have gone to the doctor in the first place.

I have just been handed this picture of the dog referred to earlier, and this is in an investigation of HEW, by the Special Subcommittee on Investigation of the Department of Health, Education, and Welfare; Committee on Interstate and Foreign Commerce. It was before this committee, then, and the Senate committee.

Well, I do hope that this thing can be corrected and it is no joking matter whenever a dog can get licensed as a lab technician as far as the public is concerned.

However, I believe that the criteria is left up to the Surgeon General; is that correct?

Dr. MASON. That is as we understand, yes.

Mr. BLANTON. Well, your principal objection to the section 5 of this act was the fact that it did eliminate M.D.-operated laboratories as a component of a doctor's office; is that right?

Dr. MASON. No, our concern was the last point I made—our concern is that under the section 353(k), as it presently stands, the individual States could, if they so chose, enact legislation which would restrict clinical laboratories to M.D.-directed laboratories. As a chemical scientist and as a physician, I believe this is wrong for several reasons, the most important being that chemistry has developed astronomically, shall we say, in the last decade or two.

The operation of a clinical laboratory is a highly technical matter and you need people in charge who are competent scientists. It is very rare that a physician by the nature of his interests and by the nature

of his training is qualified as a chemical scientist and in a position to provide the very best sort of laboratory determinations that are required. Our concern is, as it has happened in Georgia and in Maine, where attempts have been made to prohibit chemical scientists, for example, from operating clinical chemistry laboratories.

Mr. BLANTON. I have no further questions.

Thank you, Dr. Mason.

Mr. VAN DEERLIN. Dr. Carter?

Mr. CARTER. Certainly I am all for better laboratories, and I understood this law was to provide for better laboratories in interstate commerce. It was not to go to intrastate, as has been suggested here. Since, further, I am a doctor from rural Kentucky, a country doctor if you will, and I have a technician in my office who has been to school, I am thankful that she has, but really I think that a lot of aspersions have been cast upon this field, and upon some of the States.

I regret very much the length gone to by this gentleman to cast aspersions on the technologists throughout our country. Personally, there is a lot of resentment on my part. I regret the State of Oklahoma licensed a dog; I don't know how that happened. I have a great deal of respect for that State. They have a wonderful medical school at Norman, and surely within time such possibilities will be remedied.

I don't feel that this happens very often. I can hardly conceive of as large a margin of error as 40 percent being made in almost every laboratory. It is true we have made some advancements in chemistry and a lot of these advancements have been made available to us in the medical profession, simple tests by which we can do cholesterol and blood sugars in our office. It is a great deal of help, and a help to our patients. It takes a lot of time if you are in rural Kentucky to send miles away for this service.

At the same time, we can train and send to school, and I have actually done that, sent technologists to school to learn on more than one occasion, and they do a creditable job. I should hate to think very much that their margin of error was as great as 40 percent and certainly I do not believe that.

I feel that so far as laws about this profession are concerned, they might be well left to the State.

In interstate commerce our Federal Government comes in, but certainly I shall oppose any attempt of the Federal Government to enter further into State enterprises.

Thank you, Mr. Chairman.

Dr. MASON. Could I reply to that, please?

Mr. VAN DEERLIN. Certainy, doctor.

Dr. MASON. I did not mean to imply that the Federal Government should enter into the State regulation of laboratories. The point I wish to make was that the States, we ought to recognize here that there is a possibiliy that States will enact legislation which would bar from interstate commerce the laboratories which are contemplated as being being qualified in this legislation and under the Surgeon General's rules and regulations.

Mr. CARTER. Well, of course, that is not a State function to fool with interstate commerce. That is not constitutional; it has to be done by the Federal Government, initiated by this committee and has to go through Congress, and we are all for that.

You realize that is a problem and it is a problem for the Federal Government. But you go further in this and you mention that technicians and laboratories follow cookbook manuals; that is almost guttersnipe language for you to bring before this committee and I deeply resent it.

Mr. VAN DEERLIN. Do you wish to respond at any greater length, Dr. Mason?

Dr. MASON. If I could change to a related, but slightly different topic, that is of the proficiency testing with regard to the error that exists in the laboratory determinations.

We need a proficiency testing program in order to find out what the error is. Now, we have heard the 40-percent inaccuracy figure, which you doubt and which I personally doubt, too, and I doubt that the error is that large because the testing programs that are designed to determine what the error is are really not what they should be either, and so we need to focus some attention on developing testing programs that will enable us to find out how large the error really is.

It might interest you, though, in New York State where we have a law regulating clinical laboratories and where we have a testing program, it appears that perhaps 25 percent of the laboratories throughout the whole of New York State do not make either BUN determinations or blood glucose determinations that are considered satisfactory by the State health department standards, and this has been looked at quite carefully now with reference samples that are thought to be quite adequate and I believe it is a fact that there is a substantial error in making these two common determinations.

I feel that those errors are not large enough to influence the practice of medicine very much. The difference between whether you have a BUN of 17 or whether you have BUN of 12 is not going to make any difference at all in how you manage your patient. But that is nearly a 50 percent error in the determination, if the true value is 12, so it would fall outside of acceptable limits by the New York State Health Department. So I think this practicality factor comes into these numbers we hear and we must keep that in mind.

Mr. CARTER. I am aware the State of New York has this system. We have a system of testing, certainly, in Kentucky, too. Each laboratory is required to send in specimens of the different substances which they examine so far as serology is concerned.

I don't know how deeply that goes in different laboratories throughout the State, but I do know this is true. They are required to submit certain tests to the State regularly and I am in sympathy with that. However, in order to help our patients, so many of the technicians and physicians who seem interested in helping people, I know I am—I have devoted practically a third of my life to helping them. It is certainly necessary to have technologists close by and usually within our own clinic, if you wish to give immediate and good service to them.

Thank you, sir.

Mr. VAN DEERLIN. Thank you, Doctor—Doctors. And I think that concludes the hearing for this afternoon. The committee will reconvene at 10 a.m. tomorrow to hear the Governor of West Virginia as the first witness.

(Whereupon, at 3:10 p.m., the committee adjourned, to reconvene at 10 a.m., Thursday, May 4, 1967.)

80-641—67——9

PARTNERSHIP FOR HEALTH AMENDMENTS OF 1967

THURSDAY, MAY 4, 1967

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

The committee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Harley O. Staggers (chairman) presiding.

The CHAIRMAN. The committee will come to order.

We will continue the hearings on the Comprehensive Health Planning and Public Health Act. This morning for our first witness we will have the Congressman from Minnesota, Congressman Clark MacGregor, who will briefly introduce his constituent who will appear later in the day. Mr. MacGregor is a very busy man, serving on one of the most important committees in the House—the Judiciary Committee—and he has to go to take care of his committee duties.

Clark, we are glad to have you with us and to give you the opportunity of saying a few words for your constituent who will testify a little bit later. I understand that it is Commissioner Bob Janes that you are here to introduce, so you may proceed.

STATEMENT OF HON. CLARK MacGREGOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. MACGREGOR. I thank you very much, Chairman Staggers and members of the distinguished Committee on Interstate and Foreign Commerce. I deeply appreciate this privilege of presenting to this committee one of my very close friends and a man whom I have admired and respected very much for his contributions to excellence in county government.

Mr. Robert P. Janes is the chairman of the board of county commissioners of Minnesota's most populous county—the county of Hennepin—in which is located the city of Minneapolis and a number of suburban communities.

The county now has a population of close to 1 million people.

I deeply appreciate this privilege, Mr. Chairman, because I understand you have accorded me the right to introduce Mr. Janes before this distinguished committee hears the Governor of the State of West Virginia. I am sorry that I cannot stay to hear the testimony not only of the Governor of your fine State, Mr. Chairman, but of Mr. Janes.

However, I have been privileged to receive copies of their presentations which I will carefully read. As the chairman has indicated, I am obliged to be before my own Judiciary Committee this morning.

I thank you very much and it is an honor for me to have the privilege to present to this committee the Honorable Robert J. Janes, of Hennepin County, Minn. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Friedel.

Mr. FRIEDEL. I think you have made a fine introduction.

Mr. SPRINGER. Mr. Chairman.

The CHAIRMAN. Mr. Springer.

Mr. SPRINGER. May I say to Mr. Janes if every county constituency had a fellow of Clark MacGregor's ability and insistence—and may I say he stays with us continuously on these matters vitally affecting health and some of the other things which are important not only to Minneapolis and St. Paul, but all of Minnesota—if every constituency in this country had a fellow who pursued these things as assiduously as he does, I am afraid we would never get it all done.

Mr. MACGREGOR. Thank you, Mr. Springer, for those kind remarks and you for your courtesy, Mr. Chairman.

The CHAIRMAN. We are glad to have you and I am sure that the Governor of West Virginia will understand that you have other pressing duties. In fact, I mentioned it to him and he said he didn't want to hold up your job and what you are doing.

We are glad to have you with us and I want to say, as Mr. Springer has, to your constituent that you are doing a fine job for the land.

Mr. MACGREGOR. Thank you very much.

The CHAIRMAN. It is now my high honor and great privilege to introduce the Governor of my State, but first I would like to introduce his very lovely, gracious, and charming wife. Mrs. Smith, would you please stand?

The proposed legislation that we are considering has attracted the attention of men in public life as well as the people who are engaged in preserving health. Many of the States are sending their chief executive to favor us with their knowledge and advice.

Yesterday we were fortunate to have the Governor of the great State of Massachusetts speak to us, Governor Volpe. Today I am proud and happy to introduce the distinguished Governor of my own State of West Virginia.

Governor Smith has built for himself an enviable record of accomplishment during his term of office. He has shown a deep interest and concern in every department and agency of public service, in roads, in education, in health. He has worked earnestly and effectively in improving and increasing public facilities of all kinds, as well as in developing the industrial potentialities of our State. He is finding the money to do the job, and using that money wisely and efficiently.

I have no hesitation in saying that Governor Smith has done more to bring West Virginia well up into the 20th Century than any man in our history.

Governor, we welcome you enthusiastically and we will listen with keen interest to what you have to say.

Mr. SPRINGER. Mr. Chairman, may I say I have heard of the fine work that Governor Smith has done in the field of health, mental health, in the State of West Virginia, and we are glad to have a person of that caliber come here. You should be equally proud of the fact that you have I believe the only person from West Virginia since I have been in the House that I can remember who is chairman of a

House committee in my time, and is doing an outstanding job, and I thought you ought to be aware of that in West Virginia.

STATEMENT OF HON. HULETT C. SMITH, GOVERNOR OF THE STATE OF WEST VIRGINIA

Governor SMITH. Thank you very much, Mr. Springer and Mr. Staggers.

Mr. Chairman, and members of the committee, I want to thank you for the opportunity to appear before this very important committee of the Congress of the United States. I have had the opportunity before to visit with you on other occasions regarding legislation affecting West Virginia and this Nation. But I feel it a double honor today to be here to discuss the progress that is being made in West Virginia in the development of health programs, and to appear before a committee whose chairman has done so much in my lifetime for West Virginia and for the entire Nation.

The senior member of the West Virginia delegation is well recognized throughout West Virginia as a leader and well respected and we are looking forward to great things from him in the future in our State.

Congressman Staggers, I just want to add my kudos for the good job that you are doing up here.

Mr. Chairman, one of the most critical needs of West Virginia, and one of the areas in which we are devoting as much attention as is possible in my administration (perhaps the most attention), is the improvement of the environment and improvement of the general health of our people.

West Virginia—like so many other States—is placing increased emphasis on the eradication of illness, but we are also seeking to improve or overcome the environmental causes of illness.

New and enlarged programs in the area of health sciences are being developed to bring improved health services to the people of West Virginia.

We recognize that the battle against disease is a never-ending one—but great strides today are being taken toward solving these problems and particularly with Federal participation—through the impact of Public Law 89–749, the one that we are discussing today and its amendments—even greater accomplishments can be realized.

The measure of the progress in health is not only in the quantity of beds in the hospitals, nor only in the number of ambulances in the cities, nor only in the number of doctors treating the sick. The progress is measured by the number of people cured, and by the reduction in incidence of diseases.

We can measure the failures, on the other hand, in premature deaths, unnecessarily protracted illnesses, disabling ailments, and in general, in the great waste of human resources and productivity.

Tied in with this of course are the efforts that we are making, as I say, in the environmental field—air pollution, water pollution, strict mine controls—all of these things tie together with it. But the Comprehensive Health Planning and Public Health Act of 1966, which is one of several extremely vital Federal programs in the area of health sciences, provides funds for the development of the very services

of which I speak, and has encouraged West Virginia, as I am sure it has encouraged other States, to develop blueprints for better provision of these services.

And with the beginning of the implementation of this act we in West Virginia are continuing our new look at the overall health objectives of our State. This matter of inadequate health services has been a concern of mine and ours for quite sometime, and in early 1966 I appointed a Task Force on Health in West Virginia, charged with making a complete study of the health needs, not only of today, but the health needs of tomorrow, the health needs of 10 years from now. This task force has pinpointed the areas that deserve the greatest attention, has made a great contribution toward the progress that we are now making and outlined the potential as well as the deficiencies in the health services field.

This study was underway, when your legislation was passed. I then took immediate action to implement that legislation, to develop a statewide health plan, to integrate all existing programs on health within the State of West Virginia, placing emphasis on the total development of health services without regard for the artificial geographic or political barriers.

One example of what has been accomplished in West Virginia has been in the regional cooperation area. We formed a Regional Health Steering Committee (under the stimulus of the Appalachian Regional Development Act), for nine counties in southern West Virginia, to provide a framework for effective interaction between the providers and the consumers of health services. This steering committee, which is composed of country officials, representatives of the medical profession, and the business and lay people of the area, has studied and is recommending to us coordination of present Public Health activities and introduction of new programs on a regional basis.

The program includes the construction and operation of three mental health and retardation centers; the expansion of comprehensive, community-oriented mental health activity; a survey and inventory (with an analysis of medical care and utilization patterns) of health services; the beginning of long-range regional planning for development and operation of an around-the-clock communication and transportation system that link the people of the area together in a manner that would provide continuing comprehensive medical care.

We have submitted a project to fund this under the Appalachian Regional Development Act.

I believe we are demonstrating that counties and people in counties can cooperate and progress on a regional basis in the development and establishment of health programs and facilities. This is one that was underway, to more effectively use the advances that have been given to the States.

In the planning field, under Public Law 89–749, I established and created a West Virginia Health Planning Agency, which is responsible directly to the Governor. It was charged with the responsibility for the continued revision and refinement of the proposed State plan submitted by the task force, in order to keep it consistent with changing health needs and capabilities for meeting these needs.

To this planning group we have appointed representatives of the Departments of Health, Mental Health, Welfare, Workmen's Com-

pensation, Commerce, Public Institutions, and the Division of Vocational Rehabilitation within our Education Department, and representatives from the State road commission.

We are joined in this by the West Virginia University Medical Center, which is becoming one of the Nation's outstanding research and training facilities. To advise this planning group, which is the working arm, we have created the West Virginia Health Planning Council, which will be composed of government and community leaders, representatives of the medical profession, and consumers of health services in general.

This advisory body will be selected from those that are serving on what we have created in West Virginia, the nine regional councils, and in each of these regions there will be a health planning council. Each of these councils in the nine regions, which correspond to the overall statewide comprehensive plan, is charged with the evaluation of the total health needs of each area and to recommend the actions necessary to meet the problems of the region to the council, to the State, and to the advisory board, and back to the Governor's office for coordination.

I am hoping to use from my original Task Force on Health many of the members who served on that body for over a year in preparing their recommendations.

Again it should be noted that our coordination for programs in the area of health services will be directly through the office of the Governor. Because the State health planning agency crosses departmental lines and we must have a point of focus, we believe that the wisest course is to concentrate the activities of that agency with the Governor's office.

In addition, we feel that this is necessary because of the existence of the other programs in the health sciences area, such as the heart, stroke, and cancer program which is being administered by many medical schools throughout the Nation, and in West Virginia by the West Virginia University.

We find that this additional coordination is needed because these projects also involve the overall State health plan. On a statewide basis it is necessary that one single agency coordinate the entire activities involving health sciences and the logical place for this coordination in West Virginia's form of government is in the Governor's office.

I think it is proper that I should point out that I am a great believer that this program is going to be a bellwether or a leader in perhaps the funding of Federal aid to States' programs.

This program, which is the first to my knowledge that shifts from the categorical aid pattern of Federal grants for Public Health Services to a block grant approach, allows a flexibility that is not possible in any other program.

It is going to give us the flexibility needed to provide for the health of West Virginia citizens. It is going to give us the means to effectively implement what the Congress wishes us to accomplish, to put proper emphasis on health programs so that it can be moved from the one of today, emphasis which is perhaps out of date tomorrow, to shift it to new and pressing problems as they develop in each State.

The steps that we have taken under the 1966 law have really started to move. We have already our State health plan. We have directed

the people in our offices to get the job done, and what only remains is the funding of the act fully. I urge that this important step be taken.

We agree with the Association of State & Territorial Health Officers that in order for the program to be fully effective the project should be funded in the amount of $200 million during the fiscal year 1968. In each successive year the appropriation should be increased to meet the needs and see that it is really effective.

The authorization period should be increased. We have already recognized in the Appalachian regional program that the 2-year funding program is really inadequate in many respects and many parts of it need to be reauthorized at this time. This is causing considerable problems. In the long run, funding of a program of this nature for less than a 5-year period is kind of wishful thinking rather than looking at it realistically.

Without becoming involved in a long philosophical discussion about State and Federal relations, I think it only appropriate as a member of the executive committee of the National Governors' Conference and as the present States cochairman of the Appalachian Regional Commission, that I tell you that I find the States are increasingly aware of their own responsibilities in development of new programs, and I believe that the action of the Congress in the comprehensive health program legislation is one that is going to permit the States to take even more effective action in their quest for overcoming illnesses and disabilities of the citizens.

As I said before, it is truly a great step forward in the field of Federal-State relationships in funding of programs for the Nation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Governor Smith. I think that your statement was a fine one and I am certain that all who are not here today on the committee will later read it in our record and I am sure it will be of help to us when we come to mark up the bill.

I would like to just ask one or two questions, if I might. One of the concerns of this committee is the shortage of doctors and other health personnel.

Would you please tell us about the programs we have in West Virginia to get health services for people in rural areas and poverty areas?

Governor SMITH. As I mentioned before, one of the major programs is development of this regional program, which is now in nine southern West Virginia counties. This is a program that is being developed to get the people to the doctors as well as to get the doctors to the people.

It provides for transportation and communication so there will be doctors in the major areas, and provides ways and means whereby we can transport or get the patient or the ill person to a doctor as soon as possible or to a medical center or hospital as soon as possible.

At the same time the West Virginia State Medical Association, in cooperation with West Virginia University, is embarked upon a program of attracting doctors to these areas. Many of the counties in West Virginia are working with the State in developing what we call a county medical office.

Except in one county now, we do have an all-county medical center, and we are trying to have it staffed to provide the aid to the people

in these counties, not only in dental services, but also in the field of general medical care, particularly in the prenatal cases—things of that sort.

The CHAIRMAN. You say that the university too is cooperating in trying to help in this?

Governor SMITH. That is right.

The CHAIRMAN. West Virginia is somewhat unique among the States that have approved a State planning agency, since of the 18 States, West Virginia is the only one where the State planning agency is in the Governor's office. Would you care to comment further on the reasons you chose this approach? The reasons may be helpful to other States in deciding what agency should be designated.

Governor SMITH. We chose the approach of putting the agency planning control in the Governor's office because we found that the long standing categorical ideas of what fitted together and what had to be done, based upon titles, was not necessarily so, and did not provide effective administration. We have approached it from a functional planning viewpoint in West Virginia.

We are changing all of our budgetary arrangements to try and provide so we know what the function is, not on the basis of its title, but what it is supposed to do. In order to cross the statutory definitions and the longtime conceived ideas of what an agency should do, it was necessary that we look at a new approach. In order to do that, we funded the comprehensive State planning program right in the Governor's office, and because of that, we were able to overcome, let us say, perhaps agency jealousies, if you wish to use that term and preconceived ideas and notions, and to provide a central direction to every agency towards a common goal.

Thus, we have been able to establish a program in West Virginia under our comprehensive State plan, looking at West Virginia from the standpoint of areas and people, the needs of the people in those particular areas, the economy of the area, to forget the county lines in this approach, except it is just a boundary for one of the area regions to make it easy to set up, to direct the organization of State government, to plan a reorganization of State government and because of the powers of the Governor's office to move toward the regional approach, and to find ways and means to implement these programs.

In this we save money. We have a long way to go, but it is most effective in the field of health, because of the differences of opinion on mental health and various problems that come with the professionals and their approaches. In order to provide a balance in it, it seemed most desirable to place this control in the Governor's office.

The CHAIRMAN. Very fine. As I said, this might be helpful to some of the other States. You mentioned the level of funding in your statement. I noticed and the bill does propose to increase the funds for formula and project grants for fiscal year 1968 from $125 million to $140 million.

Also the cost estimates furnished to the committee for fiscal 1969, 1970, and 1971 for formula and project grants total $193 million, $210 million, and $430 million respectively.

Yesterday one of the witnesses proposed considerably larger amounts than these, but under the circumstances do you think in view

of the present tight budget situation that the sums requested are reasonable?

Governor SMITH. I think there is always a need for money, Mr. Chairman, in every field, and this committee has the same problem that any executive has or any legislative body of dividing it up as to where the needs are.

I think that in this health planning program we have an opportunity to move ahead rapidly and I would hate to see it be the one that is sacrificed in order to accomplish some other, which in my opinion would not be quite as worthwhile. I think that this program has the greatest opportunity of enabling States and counties and those who are most interested in seeing that health needs are met, to move ahead more rapidly, I would hate to delay this planning and slow it down, because it is like building a road. It takes a considerable amount of planning before you get the road started, and I think that the funding must be proper to enable the planning; to move ahead rapidly. Then we try to get some of the nuts and bolts and the things that are necessary into action.

The CHAIRMAN. Thank you. Mr. Friedel.

Mr. FRIEDEL. I have no questions. I just want to say that I listened to your statement with very great interest and I want to compliment you for the fine work you are doing. With your health plan, your task force, the way you started, you are really taking advantage of the program and getting the show on the road. I want to compliment you.

Governor SMITH. Thank you, Mr. Friedel.

The CHAIRMAN. Mr. Springer.

Mr. SPRINGER. Governor, I think you have made an excellent statement of your position and I want to congratulate you. Thank you for coming this distance, as busy as the Governor of any State is, to spend this morning with us. I did want to ask you this because it certainly has bothered me a great deal.

You recommend $200 million here for 1968. The Association of State and Territorial Health Officers recommend $200 million for 1968, $300 million the following year, $400 million the following year, and $500 million for 1971.

That would be a total of $1,400 million. Applying this formula it would mean that the States themselves on a two-thirds—one-third basis would have to raise themselves $2,800 million for this program alone in the next 4 years.

Do you think the States can do that?

Governor SMITH. It just depends upon how serious they are about moving ahead in the field of health planning. I think that the States are capable of raising this money if they wish to do it.

Mr. SPRINGER. This is a problem that has bothered me a great deal because I find that some States don't do it. Heart, stroke, and cancer is another example where the matching simply isn't being done, and we are not on the road of the predictions that we hoped for 2 years ago when this program was before us, even when we reduced it from $970 million to $440 million in this committee, largely because we felt that they could not raise these matching funds, which has turned out to be true.

It has been a very disappointing program so far.

Governor SMITH. May I say this, sir?

Mr. SPRINGER. Yes, sir.

Governor SMITH. I think that on the authorization and the matching funds, of course funding programs is pretty much up to the State to come in to the extent it cares to, but those of us that want to take full advantage of it should be permitted to take full advantage and those who can't and don't, that is their problem.

I think that the Congress, looking at it from the Nation as a whole, has two approaches: One is that it can do it itself, or it can get the cooperation of States, and counties, and so forth to do it with them. There are two ways to do that.

One is to hold out a lure or a plum, and if you match you get it. Some bite and some don't. And the other way is just to say you have to do it, and go ahead.

Well, that is the way it works in the road programs; the way it works in all of these programs; and the big problem that I found since I have been Governor and when I was Commerce Commissioner is the impositions that have been laid down, perhaps by Congress, in saying, "This is the amount that this State can get," and so forth, so that when the time comes that you need to get some more money you can't get it because you moved faster than your neighbor, and so you are all kind of "bound" into a common low level.

One of the great advantages that we have had, and I wish to put this plug in for my Appalachian regional group, is that in section 214 fund, which are funds of this nature, by operating through that Appalachian organization we are able to switch funds from one State to the other as the need arises. And so the total authorization is not lost, but the State that needs it gets it at the time it needs it, with the promise that it will pay it back to the lending State from future funding of the act.

So if you have moved faster, you get it from your neighbor Governor's account and if you are little slow the next year you give him back his share next funding period.

To answer your question, I see no problem in the States raising the $2,800 million for this program if the States are as interested as West Virginia. And I know West Virginia can raise our share because we are interested in this program; and I think the country is.

Mr. SPRINGER. May I ask this question much along the same line because I am pursuing this in an effort to see if we can come up with something solid before we get into executive session.

We have these matching programs: Hill-Burton, mental retardation—these are all matching—mental health, medical education, construction loans, nursing homes and scholarships, allied health professions, heart, stroke, and cancer. That is eight programs of matching in addition to this one.

I would guess this probably—I wouldn't guess—would be another $2 billion. Do you see the kind of gigantic proportions we are getting into?

You raised a question here about Appalachia, and I am not familiar with that because I am not in that area, but I have wondered as I watched these in the last 3 years of these gigantic sums of money, and these aren't peanuts, as you well realize—when you are talking to the Federal Government these are sizable amounts of money—whether or not you are able to absorb this amount of money. I don't think there

is any question about the worthwhileness of the program, but we have HEW rushed in the first day and they had no figures.

Today I have the figure in front of me and I am giving this to you pretty straight as to what they want. I realize that any agency is going to ask for a lot more money than they expect to get—that is only human—I presume on the theory that the Legislature is going to cut you down anyway, so ask for a big figure, but I think we ought to have some real hard evidence here that there is a need for these sizable sums of money in these fields and I think probably the most argument in the committee will be whether or not these amounts are needed more than whether or not the program is really worthwhile.

Governor SMITH. It has been my experience in working with the aviation program, with which you are all familiar, too, that the biggest problem you run into is that you put a certain amount of money in that has to be used by a certain period of time.

Then there is a great move afoot to try to find something to use that money up in a hurry. It is just like you say, sir, you can just run so fast and you can spend so much money. You just can't get it spent. There is just so much that can be built in a certain length of time.

So my personal opinion is that I would favor a longer run for the authorization over a longer period of years with the amount of money being reappropriated within that total limit if that would be necessary.

Mr. SPRINGER. I think the suggestion in the light of what you say may be good, but we have had experience and we have never authorized a thing for longer than 3 years.

We had unfortunate experiences back 15 years ago when I came on this committee of a lot of wasted money by authorizing for 5 years. We should have been supervising that program. At the end of the third year we had to have a hearing again to determine what that program was doing, and you as the Governor realize the importance of caution and checking on a program every once in a while to find out just what everybody is doing.

We have done that and it has been extremely helpful to us.

Governor SMITH. We have an annual review. I think it is a little different.

Mr. SPRINGER. Thank you, Governor. It is an excellent statement.

Governor SMITH. Thank you.

The CHAIRMAN. Mr. Rogers?

Mr. ROGERS. Governor, I read your statement. I am sorry I didn't get to hear you give it personally. I think what you are doing in your State is excellent. It certainly seems to be what we had in mind for the States to assume the responsibility in this field, and we do hear something about West Virginia on this committee.

Governor SMITH. I am sure you do.

Mr. ROGERS. I am interested in knowing something about how this is working out in your planning. How soon do you anticipate having a State plan.

Governor SMITH. We have a State plan now in regard to the general comprehensive plan. Let me put it this way. We have divided the State into areas. We have applied the "nine regions approach" to our organization of State government, planning our funding of roads and everything in the health area too—all on a regional basis.

In March of 1966 I appointed the task force I referred to for comprehensive health planning, and asked its members to make its report

tie into this nucleus of the new plan from our State planning agency. So from that standpoint we have it in being.

As far as the actual implementation of details into the health area, the committee is just now picking up from the task force's work and we anticipate that we should have the preliminary guidelines and goals set out within the next 4 or 5 months, just about the time it would be funded.

Mr. ROGERS. So you would be ready to move?

Governor SMITH. We expect to be ready as soon as HEW is ready to fund us and Dr. Slavin, who is heading this and who is a special assistant to me, was in Charlottesville yesterday working with the regional office of HEW. It is a matter of close liaison in the establishment of the guidelines so that we don't spin our wheels by getting and doing something that is not going to be useful.

Mr. ROGERS. As I understand from your testimony, you have set up an agency within the Governor's office to do the planning?

Governor SMITH. That is right.

Mr. ROGERS. But you have used an advisory council and you have them use an advisory council from your various regions.

Governor SMITH. That is right. It is a statewide advisory council and regions are represented on it. We hope to be able to pull together the best thinking of the medical professions, the lay people, the road people, everybody that has a stake in this comprehensive planning for health because what affects health affects the whole gamut of State agencies and every State agency has an input into it as well as every county health agency.

Mr. ROGERS. In your estimation, how much of the Appalachian program is devoted to health in your State? What moneys would be devoted to health?

Governor SMITH. I think the total authorization for the health demonstration units for Appalachia is somewhere around $89 million for the 13 States—and that is $89 million out of $1.1 billion of the total authorization.

It appears that in West Virginia we will be allocated somewhere around $18 million for construction and the operation over a 5-year period with a matching basis after the second year with this nine-county unit once we get the demonstration unit established. It is strictly a demonstration program. It runs for so long and quits.

Mr. ROGERS. Under that program can you also build hospitals?

Governor SMITH. This demonstration provides that you can do it, but basically we are talking about the use of people rather than buildings in our program. Hospital construction in West Virginia is primarily Hill-Burton, aided through the Economic Development Administration (EDA). We have been able to get some loans and some grants to help some of the Hill-Burton money along. But basically the demonstration in this nine-county unit is primarily to show how we can effectively use the facilities we now have, find out what is lacking, and try to create those facilities we find are needed which would probably call for some construction. But as we have been using Hill-Burton funds for matching for county and regional medical units, some of this demand is met as we go along.

Mr. ROGERS. Governor Smith, is the expenditure of OEO funds which you get in the Appalachian program for health coordinated through HEW?

Governor SMITH. OEO doesn't have very much in the health field. The Appalachian health money of course has to be coordinated through HEW if it is going to touch the public health field, but most times also it has the input of a Hill-Burton grant or something has to go into it, so you get an interrelationship between all these programs. Of course, this is one other advantage of trying to put the creative effort through the Governor's office because then you can find out where these inputs are and if something is going wrong you have an opportunity to stop it; if going right you find it necessary to move ahead.

Mr. ROGERS. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman. I wish to thank the Governor for his very good statement. I may mention that in my office one of the girls is from West Virginia.

Governor SMITH. Very good. I'm glad to hear that.

Mr. NELSEN. Very accomplished, and as has been mentioned, we frequently hear about the great wonderful State of West Virginia from the gentleman to my right.

I wonder, Governor, have you been able to use the funds that have gone to your State? Have you been able to match in all instances the funds that have been available to you through these various programs? Do you find it difficult?

Governor SMITH. We have been able to meet the needs as they occur. We are anticipating some problem as the road program develops under Appalachia. The cost of building roads is going up and what we had anticipated 3 or 4 years ago would take care of the need is not going to be enough.

I think Congress finds that out too.

We have that problem of matching, but we have a rather unusual device in West Virginia to help meet such situations. In my first budget, I requested a million and a half dollars to be appropriated to the Governor's office for the purpose of matching and aiding Federal programs.

Our legislature only meets for 60 days in one year and 30 days in the other, so in this interim period when it is not in session and we have a program that needs matching I have the funds right in my office to do that.

So we have never had any problem until the next legislature got back.

Mr. NELSEN. I notice you mentioned the need of moving slowly and of avoiding the waste funds. It seems to me that often this use-it-or-lose-it type of thing in many programs, in elementary schools and others, has caused a situation where we are often in haste without even fully justifying the programs, fearing that if you don't use it you lose it.

In aid programs we used to make loans and many times a loan was put under stop order because all of the funds were not immediately needed, but never lost to the one that we were dealing with. It seems to me that in some of these Federal programs there might be some merit to providing that if a State is moving carefully it would be complimented and protected in so doing. This might be an area where

some thought could be given on our part in the way of handling these programs.

Of course you have fiscal years and budgets and all that to do with, but it would seem to me there might be some merit to that. Would you have any ideas or suggestions about that?

Governor SMITH. I don't know how it would be done. I am not that familiar with the Federal fiscal program. It appears to me the more careful planning to begin with, the less we are going to have wasted as it goes down the line.

I think the old theory, "haste makes waste," is sometimes applicable, but the arrangements that we have in some of these programs, the ability to do exactly what you are talking about, is in this program.

One of the great things that could be done—I don't think it ever will be done—would be a consistency of how these programs are administered. If we had them all on the same type basis it would be a great help, but I suspect that that is wishful thinking.

Mr. NELSEN. I am sure you would agree to breaking down these new departmentalized block grants and moving toward the flexible approaches and improvement as to the Federal Government's handling of these things.

Governor SMITH. I think it really brings about the fact that the States want to do these things and you give them a chance and I think they will do it.

Mr. NELSEN. Thank you very much for your very good statement. Thank you.

Mr. VAN DEERLIN (presiding). Mr. Murphy.

Mr. MURPHY. Governor, I would like to add my voice to Chairman Staggers' and other committee members who congratulated you on your statement.

Does your State legislature meet every year?

Governor SMITH. It meets for 60 days in the odd years and 30 days in the even years.

Mr. MURPHY. And of course the appropriations for the State go through your——

Governor SMITH. Are appropriated annually.

Mr. MURPHY. Have you had any difficulty in your State legislature getting funds to match the Federal funds?

Governor SMITH. None at all. As long as they are effective and we are doing the job we have no problem. We have questions asked as usual, which I think would be true in any legislature, but, as I said earlier, we have been able to meet the demands of the matching, based upon our own needs and our own estimates.

In some programs we haven't brought everything in them because we haven't felt it was necessarily applicable to West Virginia, but those in which we have, we have had no problems at all.

Mr. MURPHY. Have you had an increase in the last 5 years in your State health department staffing?

Governor SMITH. The State health department has continued to grow constantly. Of course, our biggest problem in staffing the State health department has been the inability to attract to government those who are really qualified for the salaries we offer.

We are, in general, trying to boost the salaries so we can maintain and retain the doctors and skilled personnel that are required in the State health department.

Mr. MURPHY. That seems to be a problem on a national basis. Have you expanded the State medical schools to train more doctors and more medical personnel?

Governor SMITH. West Virginia only has had a State medical school in the State since 1952. It graduated its first doctors in 1960. It hasn't been expanded because it was really just getting up to its ability to graduate the 66 or 76 that it is set up for as medical doctors, and to be producing 75 dentists and 200 nurses that are scheduled for that program.

It has not been expanded since its original start. It has just grown to where it was supposed to be.

Mr. MURPHY. The State has had to rely on outside medical schools?

Governor SMITH. Up until 1952 students were getting 2 years of medical instruction at West Virginia University and then completed their courses at the Medical College of Virginia under a contract arrangement with the medical college.

Mr. MURPHY. Many Governors have stated that they have a gravitation from the rural areas of their doctors into the urban areas and thereby creating a vacuum of qualified medical people in the rural areas.

Is that true in West Virginia?

Governor SMITH. I think that is true in West Virginia. We have several counties in which we do not have a qualified medical doctor, and that is one of the problems that has been involved in this regional approach in southern West Virginia. Instead of getting the doctor to the patient, we are going to try to bring the patient to the doctor.

Mr. MURPHY. We have tried in some Federal programs to gear them to having doctors stay in rural areas under some Federal training programs.

Would you advocate an increase or a greater assertion on this type of program?

Governor SMITH. The thing that I always imagine and visualize and what we are going to have to do in the rural areas, is to establish, well, if you are going to use the Navy's vernacular, a corpsman, out in the area with a small staff of a nurse or a small unit where they could probably diagnose the case and then have the ability to get the patient to the area where the facilities are for the doctor to give the proper health care.

You can't build a hospital every place. Costs of hospitals and medical services, the skills, the training, and the equipment that are needed are such that you have to go to a regionalized approach, so I would advocate that the Congress, if it wishes to get into this, create these satellite training or satellite examining units in the rural areas, and then beef up the strength of the medical center so that the person who is brought there can get the finest of care.

Mr. MURPHY. But it is your opinion that it is essential for the Federal Government to participate in these medical health programs right with the States and try to resolve some of the health problems particularly in rural areas.

Governor SMITH. The rural States are usually States that have financial problems and unless you have this assistance—the muscle and financial strength of the Federal Government—it would be impossible to do the task.

Mr. MURPHY. Governor, in New York we have a very controversial action called Medicaid under title XVIII or the Medicare Act that was passed.

Has your State legislature enacted any legislation similar to the New York notion?

Governor SMITH. No, sir. The only thing that we have done to implement title XVIII is to extend the program that we had originally. We were in the original Kerr-Mills act. We were one of the States that were in that, so we have kept that going. We have just added to it some of the provisions to pick up the dependent children up to age 21.

We have not gone any further into that, into the Medicaid end of it.

Mr. MURPHY. You haven't established an income level for people to be eligible for that particular title?

Governor SMITH. No, sir.

Mr. MURPHY. Thank you very much.

The CHAIRMAN. Dr. Carter. I might say this is a medical doctor we have on the committee.

Governor SMITH. I understand he is from our neighbor State of Kentucky, too.

Mr. CARTER. Governor, I certainly want to compliment you on your excellent presentation and on your keen insight into medical problems in rural areas particularly.

Certainly I should hope that you would be able to get more organizations into those rural areas, but in case that is impossible under a plan such as yours, and it is to be hoped, as I see it, I think your idea of getting patients to the doctor is extremely good because it will certainly increase the amount of work more doctors can do and also provide aid for those in distant areas. Thank you, sir.

The CHAIRMAN. Thank you, Dr. Carter. Mr. Ottinger.

Mr. OTTINGER. I am glad to have you with us, Governor. This program in one of its major components calls for long-term planning for hospital facilities. We have in many States, however, critical shortages of hospital facilities at the present time.

Can you give us any idea of what the situation is with respect to your own State?

Governor SMITH. I couldn't make a guess, but it seems to me the task force on health reported that we would have a shortage of some 5,000 hospital beds by 1980. That is the figure that runs through my mind. I refer to the type that would be suitable for medical care at that particular stage in our history.

We have been running a shortage in the field of—there are three different classes of care. I am just trying to think of the one it applies to. It is not the intensive care that would come in the hospital, the critical case, but the "convalescent" care. Maybe that is the term I am thinking about.

The Hill-Burton funds that we are using now are primarily diverted to the building of those units that meet that particular need. I would be glad to give the committee a complete breakdown on the report of the Task Force on Health and a complete breakdown on this situation on what exists and what we anticipate it will be in 1970, 1980, 1985, through the years.

Mr. OTTINGER. Are there hospitals to your knowledge in West Virginia that are really in a critical condition where they get emergency cases and they actually have to put them in the corridors, where people

have to wait for substantial periods of time before they can gain admittance?

Governor SMITH. It would be only a rare instance that they couldn't handle an emergency case, but there is presently in most of the hospitals in West Virginia a delay in making hospital bed space available to the doctor who wishes to have a patient admitted.

It is probably true all over the State of West Virginia at the present time.

Mr. OTTINGER. Has this been aggravated by Medicare to a considerable extent?

Governor SMITH. I saw a report the other day that there was only one hospital in the State in the Medicare program which attributed part of its overload to Medicare. That was the Appalachian Regional Hospital in Beckley, where 38 percent of their case load was Medicare patients and they are running about five percent over their rated capacity, to they attributed that 5 percent to it, 38 percent to Medicare—but it could have been just the other way around.

I don't know whether that would be an accurate statement or not.

Mr. OTTINGER. What has been your experience with Hill-Burton? Is it adequate?

Governor SMITH. Hill-Burton funds have never been fully adequate. We have never had enough allocated to West Virginia to meet the demand each year that we have been able to provide of the matching funds from local communities for hospitals.

It has always been a matter of rationing the Hill-Burton funds to those areas that have the most pressing demand. This year, for instance, we could have used three times the amount of Hill-Burton matching money that was available.

Mr. OTTINGER. Thank you very much. It is always a pleasure to have you with us.

The CHAIRMAN. Thank you, Mr. Ottinger. And I might say that my friend in New York had a special reason for asking about the hospitals because he is trying to get a program into this bill, and I think this is good.

Mr. CARTER. Mr. Chairman.

The CHAIRMAN. Yes.

Mr. CARTER. Might I add a little to this?

The CHAIRMAN. Yes, surely.

Mr. CARTER. Certainly in Kentucky, and I feel sure in parts of West Virginia, but I know that Kentucky hospitals in rural and mountain areas are terribly overcrowded, and I know further in our State we do have insufficient Hill-Burton funds. I think in this field there should be an increase in the amount made available. I could point out there is one hospital I know quite well which was built in 1953.

An addition was made in 1964 and still there are patients in the halls in that hospital because I have been there and I have seen them.

This condition exists largely throughout the mountainous area of my district.

Governor SMITH. We have the same situation in certain places, Weston, for instance. There is a great need for a hospital there and the Hill-Burton funds ran out and people don't have the money and right now we are trying to find ways and means to build that unit so desperately needed in the central part of West Virginia.

Mr. CARTER. Hill-Burton funds now are providing in some places only one-third of the amount needed.

Governor SMITH. Sometimes I think it is even less. It squeezed out less than that sometimes.

The CHAIRMAN. I might say that a little later today we will have a witness from the American Hospital Association representing them. I am sure that he will be able to answer on all the facets of this.

I think you have done very well, Governor. Mr. Watkins.

Mr. WATKINS. Mr. Chairman, it is certainly a real pleasure to see the distinguished Governor of the State of West Virginia and to hear him make his plea before our distinguished and wonderful chairman.

I am sure that you two don't have too much time to get together, but I do admire you as Governor of your State coming in here to talk to us about money, money, money—which is a great item on the Hill today in every category.

Certainly your cause is a worthy one and I think there are very few legislators and I think there would be none in my estimation, that don't have the fullest sympathy for every Governor from every State that is trying to make the progress that is needed in mental health and in the care of our people, but you are to be admired and I hope that we will see more Governors in here rather than sending in one of their heads of their departments to talk.

I respect you very much for giving us your valuable time. I would like to ask a question that Mr. Springer practically covered from the money angle, and I assure you that we are always interested in giving you as much as we can, but I think you are going to have to take a little cut the way things are going with the war and other things that are happening.

I would like to ask you about one matter, information more for myself. In your State you have a conflict of interest between the local municipalities where they have their health bureaus and now a new thing, that is perhaps not too new, but in the State of Pennsylvania there is a demand from the public that we have the health services handled by a coordinator, by a doctor and a staff that the counties have to set up to handle the affairs.

Is it necessary in your opinion? You just can't continue in every municipality to have health bureaus and then to have a county setup which I understand in my counties are going to cost something like $200,000. That is the county of Delaware and Chester County, Pa.

What is your thinking on that? Which is the most important? It seems to me a general feeling that it is hard to get to the bottom. Which is the best? You can't have both in my opinion, or can you?

Governor SMITH. We have kind of a coordinated effort because State funds are used in these county medical centers. We fund it on the basis of a coordinated effort. If it is a municipality of any size we make it a city-county unit, and if there is no large city or community we make it a county unit, so we fund it that way and I would say that is the only way it could be done.

It should be one unit.

Mr. WATKINS. Should be one unit.

Governor SMITH. Yes.

Mr. WATKINS. Which one do you approve?

Governor SMITH. Basically ours are county units, and of course, as I say, in this nine-region approach we are trying to get away from the county units. We are trying to get to regional units—nine of them.

I found that the imaginary county lines that were so great and useful on various occasions in our history seem to be obsolete, out of date, today, and people move too fast and people don't live by county lines. They don't pay any attention to them practically, so we are trying to make our planning on the basis of where the people live and the county line in the middle still doesn't make any difference.

Mr. WATKINS. In other words, you prefer regional, or a county, or local?

Governor SMITH. Right. I prefer regional. It is money saving. It is economics. As you know here, you can't afford to give something to everybody; all you would like to.

Mr. WATKINS. That seems to be the trend today and every idea costs an awful lot of money.

Let me ask you one other question and then I will certainly not take up any further time.

Do you have any control in the State of West Virginia of your hospital charges?

Governor SMITH. No, sir.

Mr. WATKINS. Do you think in your opinion that perhaps States will have to get into that? I find that again in the State of Pennsylvania in the district in which I live that a hospital roughly runs anywhere from $42 to $65 a day.

In your opinion, do you think that there has to be some regulation by the State on the cost in hospitals?

Governor SMITH. Not unless it gets into the range that you consider a hospital like you would a public utility. I am basically just opposed to the idea of fixing prices on anything.

Mr. WATKINS. I can appreciate your opinion. I am not for fixing prices. I don't like the idea of fixing prices myself, but it gives me pause when the situation is running at leaps and bounds, and I remember just recently that the cost of a hospital room was $22 a day not too far back, and I was in Pennsylvania in the State senate, and where the State only contributed I think something like $10 a day.

Now they contribute $22 and the latest figure that I had on cost per patient, the room service, and all that went with it, and that is only, in other words, a registered nurse and perhaps a practical nurse with an attendant, indicated the cost went up without the registered nurse to $55 to $60 a day.

Somewhere along the line I just wondered in your experience as Governor whether you don't think you are going to have to look at this. I am not speaking for the State of West Virginia. I speak in general.

Governor SMITH. I think if it keeps bouncing as far as it has—and statistics indicate medical services to be the most rapidly rising item in the cost of living—that there is going to be a demand for someone to look into it, and if it is going to be looked into I would feel that the State should look into it, rather than the Federal Government.

Mr. WATKINS. I do too. I really truthfully feel there is something wrong with this system and I think that the cost is adding too much. One patient came to me who had a broken arm in an automobile acci-

dent. Of course, they made various tests to find out if anything else was broken, but he came out of the hospital after 3 weeks with a bill of $1,592 for the services rendered.

Thank you, Governor. It has been most interesting to listen to you. From a personal standpoint I know my State. I wanted to have your thoughts about it.

The CHAIRMAN. Mr. Kornegay.

Mr. KORNEGAY. Thank you, Mr. Chairman. I don't have any questions for Governor Smith. I just want to welcome him to the committee and congratulate him and commend him for the fine job that he is doing in the State of West Virginia in the area of public health, and for the fine job he is doing to find some of these answers to these difficult problems we have.

I also want to say how much I enjoy serving with the chairman, one of the outstanding citizens of West Virginia, Mr. Staggers.

Governor SMITH. Thank you.

Mr. KORNEGAY. Thank you, Governor.

The CHAIRMAN. Thank you, Mr. Kornegay. Mr. Brotzman.

Mr. BROTZMAN. Thank you, Mr. Chairman. Just a short observation. I would like to express my thanks, Governor, for coming up here. Obviously if we are going to significantly change our system of allocation of money it is axiomatic we in Congress have to rely quite heavily upon you gentlemen that occupy the Governors' chairs across this Nation.

This is a philosophy that I endorse heartily and believe in greatly. I think we have an opportunity under legislation such as this to prove that this system will in fact work.

I join my colleague from Pennsylvania in stating that I wish there were more Governors down here telling us how they intend to resolve these problems or what kind of progress they are making in their particular State. It is significant that you are here today and I would like to thank you for your candid testimony.

I have one short question relative to your heart, stroke, and cancer program. Would you tell what you know about how it is working in your State presently and what progress you are making?

Governor SMITH. I am sorry that I can't give you full details on that. It has been handled primarily through the West Virginia University Medical Center and it would be one that we could get a report on.

I noticed from just casual observation that it seems that there is some progress being made, but I couldn't give you any details, although I would be glad to give the committee a summary to be included in the record here.

Mr. BROTZMAN. I think we can probably get an answer to this from other witnesses. You intend to integrate the heart, stroke, and cancer program, as I understand your statement, into your overall State plan for health, is that correct?

Governor SMITH. We hope to integrate everything, including the tubercular field, input everything into this, so we are talking about comprehensive health planning.

We are talking about an across-the-board effort—from the sanitation program to the final care and disposal of the body, if you will, in the cemetery.

Mr. BROTZMAN. How about the areas of alcoholism and drug addiction? Do you consider those to be health problems?

Governor SMITH. Oh, yes, sir. We have been handling the alcoholism problem in a division of our department of mental health. We treat it that way and are trying to handle corrections, which is part of this too. We are going to care for alcoholism as an illness.

Mr. BROTZMAN. As I said, we are glad that you came here and I hope that some of your colleagues will follow that example. I think we really have a chance to move ahead and this is the way it is going to happen—by exchange of ideas such as we are doing here today.

Governor SMITH. Thank you, sir.

The CHAIRMAN. Mr. Pickle.

Mr. PICKLE. I have no questions, Mr. Chairman, but I would like to compliment the Governor for his fine statement.

Governor SMITH. Thank you, Mr. Pickle.

The CHAIRMAN. Mr. Brown.

Mr. BROWN. Governor Smith, it is nice to see you. I think we have something in common between Ohio and West Virginia. We have a lot of mountaineers who have become Buckeyes in recent years, and we also I think share a common interest in southeastern Ohio with some of the developments which you have undertaken in West Virginia.

I wasn't privileged to hear your statement, but I have read it since coming in and I was very much impressed with the progress you are making in West Virginia through your administration in getting comprehensive coverage of the medical problems in your State.

I am glad to see that you have undertaken a regional view and I presume that regional view encompasses not just regions within West Virginia, but regions such as the Ohio Valley where I happen to know, for instance, in Gallipolis the medical center there serves Point Pleasant and many other areas which are in West Virginia.

I would ask you only to comment in one sort of combination question. I think we all have to concede that money is power and that the Federal Government by putting money into these programs can exert a certain amount of influence and power over the States by influencing the emphasis which States may give in their comprehensive plan to certain facets of the medical problem, the health problem.

Do you foresee any possibility that the comprehensive plan which you have undertaken could be financed in the future by the State itself? Really what I am asking is should we consider in this legislation the prospect of an expanding Federal contribution for a time and then a diminishing Federal contribution so that the State ultimately can take over the funding of some of the areas in which the Federal Government will be assisting in financing through the grants considered in this program?

Governor SMITH. One of the great problems that you have in State government is that there is a great demand for people to buy into a package without knowing what they are going to come out with in the end, such as many of these programs we have had were financed 90–10 and then 50–50 and next year it is supposed to be out. One of these being the on-the-job training program under MDTA.

We have been through that. The Congress has had to come back and change it to 100 percent several times to make it work because of the fact that the States finally couldn't do it.

I think that the best approach is that the Congress ought to say that, "This is the part we are going to pay in this from now on," either 20 or 30 or 10 percent—and when you buy a package you know when you are talking about it to your legislature that 10 years from now it is not going to be something else.

I think it is a great disservice to give anybody 90 percent one year, and then say 3 years from now we are going to cut it to 50–50, to 40–60 or something like that. Perhaps you are cognizant of the problems of a department of welfare, welfare matching of State aid, where there are seven or eight different percentages allocated for a task within that one funding program.

It would be so much simpler if we were really going to get 60 percent from now on instead of 90–10, 50–50, 70–30—all these various figures. So I would propose if there is any planning, that you plan to give the same ratio across the board.

Then the State can manage to stay right with that same theory and the legislature would know that 3 years from now they are still going to have to put up 20 or 30 or 50 percent, whatever it is.

Mr. BROWN. Would you prefer to have a reduced ratio if it were a constant ratio?

Governor SMITH. I would rather have a reduced constant ratio than to have the great lure, if you want to put it that way, of 100 percent for 2 years and then 50–50. The end result is that you get a great demand from communities and various people, saying, "Well, here, you have to take advantage of this," and then 2 years later you ask, "Where are you going to find the $5 million to keep this going every year from now."

Then they rear up and say, "We can't do it," and we just create another problem.

Mr. BROWN. You think they don't think of this in advance.

Governor SMITH. I know they don't. I have been on that side of it. I have been caught in that same thing. I think it would be a much better proposition to fund it at a flat percentage rate across the board, and know that this is what it ought to be.

Mr. BROWN. I think this is one of the great problems we face. I am not sure I agree with you thoroughly that the Federal funds should be appropriated for all the States and local communities in the country, but I think it is a fact we have to consider. If I may ask one other question in this connection, I have had a little concern about the criteria which are in this legislation left in the hands of the Secretary of Health, Education, and Welfare to write a future date for the funding of the Federal grants to the States.

Would you share my concern that this gives the Secretary great power which may establish criteria that wouldn't adequately take into account the problems of West Virginia, for instance, versus Ohio or Pennsylvania or Colorado?

Governor SMITH. I would look at it the other way. I believe that this is the only way that you could take care of the problems of West Virginia versus Ohio, by leaving the criteria to the Secretary of HEW to set.

Mr. BROWN. You think it would be helpful to have the Secretary establish some broad criteria in advance so that——

Governor SMITH. I understand they are now working on a proposal for guidelines. We have had our representatives meeting with

them. As long as the State will counsel and advise and get into the act I think it is fine, but if they abrogate that privilege then, of course, you create another problem.

Mr. BROWN. You would want the assurance then that the States will have the opportunity of counsel and advice, that the Secretary will listen to that advice?

Governor SMITH. Yes; hopefully.

Mr. BROWN. Thank you.

The CHAIRMAN. Mr. Adams.

Mr. ADAMS. I have no questions, Governor Smith, but I do want to compliment you on an excellent statement and also to state how much those of us who are on this committee admire the courage and the ability of West Virginia's contribution to this committee and to the Congress.

We appreciate your being here and particularly we appreciate the fact that the Governors of the States are now beginning to accept the position that they have a substantial executive function in terms of the Federal programs and, frankly, we would like very much to shift the administration of many of these programs to the States, and this is one of the first steps in doing it.

We appreciate your being here. I think your statement is excellent. That is all that I have, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Adams. Mr. Kuykendall.

Mr. KUYKENDALL. I say to the honorable Governor of West Virginia it is wonderful to have you with us. I particularly admire several of your statements about both your willingness and determination and I think ability to handle several of these problems on the State level. I happen to have a personal liking for your statement that you are against price fixing in any form.

It doesn't have anything to do with these hearings, but I like it. I would like for you to take off the Governor of West Virginia cap and put on your cap of your position in the Governors' conference if you will. You spoke of the requisites of the program that you would like to have being fixed in such a way as to not penalize a State that was able to move forward quickly and the fact that the funds ought to be available over a long and permanent period of time and you mentioned the Federal highway fund as being an example of the way you thought it would work.

I happen to agree with you, but we have a problem here that I would like you to comment on if you would.

In the matter of health it is not like a highway. Except for the times that I drive through your beautiful State on vacation I don't really worry much about your highways, but your people's health, whether they be in West Virginia or Michigan are my concern.

Now, as I say, I don't worry about your State. That is an understatement; yes. I think this committee would feel pretty much the same way. It is not one of those things that we ignore. Even if the State doesn't live up to its responsibility we still feel the plight of these people, so do you feel that the example of States like West Virginia in the Governors' conference is going to serve to motivate these other States to rapid enough activity to really take care of the program as it was intended?

Governor SMITH. I would say that the fact that the Governors' conference has established an office here in Washington to try and keep

better informed reflects my belief that every Governor is more constantly aware of what the other States are doing.

For example, there is an example of a good sense of motivation in education. An example is usually the best way of teaching. I think that because of those States that take an active interest, the others will adopt it as soon as possible. As far as the conference is concerned, there is usually a free and frank discussion of what we are doing in each State with the other Governors.

All of us have learned something from each other, so I think there is the forum to learn what we are doing and how effectively it works. For example, if in Michigan there are certain things there I would like to do I will follow the work George Romney might be doing, or what Mills Godwin is doing in Virginia, or Otto Kerner is doing in Illinois. There is a mutual exchange.

That is one effect. I don't think motivation alone is all that it would be. "Here is a fellow doing a good job. Why don't you do as good a job as he does?"

Mr. KUYKENDALL. That is pretty potent.

Governor SMITH. Sometimes it is. Philosophically they don't agree, but otherwise——

Mr. KUYKENDALL. But to get to another question, in the matter of Hill-Burton funds we are all aware that the Hill-Burton funds are pretty much intended for general hospital beds and we have a very outstanding children's hospital in Memphis. They went out and raised $2,100,000 hoping to get matching funds on Hill-Burton. This hospital is one of the Nation's pioneers in the open-heart surgery of children.

Because of this you might say narrow specialty, it simply doesn't look like they are going to get the funds. They are sitting there with half of the funds raised.

Do you feel that Hill-Burton should expand into these areas of specialized hospitals for specialized care?

Governor SMITH. I think that the Hill-Burton concept was devised so many years ago to have general hospitals. At the time it was appropriate to that particular time, but since the initial impact of Hill-Burton, hospitals have become more specialized. Because of the fact that the hospital you mention is a children's hospital it serves a great segment of the population, not only in that area, but of the Nation.

The Hill-Burton fund ought to be available for the construction of any hospital or any unit that pertains to taking care of the people.

Mr. KUYKENDALL. I have to agree with you. I was quite frustrated. We are kind of stuck, you might say. You didn't mention this. The distinguished doctor from Georgia mentioned it yesterday and I had to leave before I had a chance to ask him this question.

He mentioned in their statewide conference planning in Georgia a study of fluoridation. Has this been mentioned? Have you studied it at all in your State?

Governor SMITH. We have had quite a debate about fluoridation.

Mr. KUYKENDALL. There is always a debate about fluoridation.

Governor SMITH. The State health department through its sanitation department made an analysis, made recommendations, and we publish a statement in regard to it, but as far as what it will do and so forth there is no objection raised by the State health department and there is no control placed on it.

Mr. KUYKENDALL. I was actually intending to ask you is this case more political, and I am sorry I didn't get a chance to ask the doctor yesterday, if you had arrived at any ideas as to how to solve this political hotbox on fluoridation.

Mr. Pickle is gone. I grew up close to Mr. Pickle's district. One of these areas had natural fluoridation and, like myself, you see people down there 60 and 70 years old without a cavity. I happen to be one of those who have not had cavities and I am sure a champion, and yet I can always start a fight on the streets of Memphis by just bringing up the term.

I am hoping you have some answers.

Governor SMITH. No; we have the same fights.

Mr. KUYKENDALL. Thank you.

Mr. WATKINS. Will the gentleman yield?

The CHAIRMAN. Yes.

Mr. WATKINS. I say that there is a mutual admiration between the Governor and my distinguished colleague on the question of rate fixing. For a matter of clearing the record, my opinion wasn't on rate fixing, but there is one thing that I would like to call to my colleague's attention and also to the great Governor of the State of West Virginia that there better be some control of the expanding costs of these hospitals or you are going to break the whole wagon down, and I am sure that I don't put it in a form of price fixing, but there must be a real interest from the States to find out and set costs on these hospitals or all of the programs are going to start falling, because hospital costs jumping from $22 a day to $60 a day need some explanation and if I were Governor I think I would want to know it.

Governor SMITH. Thank you.

The CHAIRMAN. Mr. Devine.

Mr. DEVINE. I have no questions. I would like to welcome Governor Smith here before the committee and, having heard the comment of my fine colleague from Pennsylvania, I heard someone say the other day that if everybody climbs in the wagon who is going to pull it.

Thank you, Mr. Chairman.

The CHAIRMAN. Governor, I again want to say that we appreciate your coming. Since this bill is known as a partnership for health I am hoping that other Governors of the United States will come in and testify as you have and answer questions.

I think you have done an excellent job in fielding all of these questions on a broad front—just as fine a job as any person who has ever come before the committees. I want to congratulate you and say you have added immensely to this record. We appreciate your taking the time and coming up and giving the benefit of your advice.

I think it will mean a great deal when we start marking up the bill.

Governor SMITH. Thank you very much Mr. Chairman. If there is any additional information that we can furnish to the committee for the record at any time, I hope you will call on us.

The CHAIRMAN. Thank you very much.

Our next witness is Dr. J. B. Stocklen, National Tuberculous Association.

Mr. VAN DEERLIN (presiding). Welcome to the hearings, Dr. Stocklen. Will you proceed with your statement, please.

STATEMENT OF JOSEPH B. STOCKLEN, M.D., REPRESENTING THE NATIONAL TUBERCULOSIS ASSOCIATION

Dr. STOCKLEN. Thank you, Mr. Chairman and members of the committee my name is Joseph B. Stocklen. I am a doctor of medicine and I am a resident of Cleveland Heights, Ohio, which is a suburb of Cleveland.

My official position is tuberculosis control officer for Cleveland and Cuyahoga County. I am here today to present testimony on H.R. 6418 for the National Tuberculosis Association. I am a member of the board of directors of that organization. I filed a statement with the committee and will try to give a very brief summary of the content of this statement.

The National Tuberculosis Association is the oldest voluntary health agency in the United States, and has affiliated associations throughout the country. Our specific interest, of course, is in the control of tuberculosis and other respiratory diseases, but we pride ourselves on a long record of being interested in general health.

We know, for example, that tuberculosis occurs in poor populations where the incidence of other disease is high and when we have a population which is relatively free from other diseases, we don't have tuberculosis. The National Tuberculosis Association supported the legislation which led to Public Law 89–749, because we were fully aware that persons had to be free not only of tuberculosis but other diseases to have a healthy population.

Our support was only qualified to the extent that the new grant program would allow for continuation of sufficient funds to lead toward our goal of eradication of tuberculosis. The Public Health Service several years ago recognized the complexity of the problem of tuberculosis, the fact that it is a disease which occurs in one of two ways.

In the first place, some persons who become infected with the disease, that is, inhaling the organisms that float around the air, come down with it immediately, and this is particularly true of children, but other persons come down from old infections.

In other words, a person may have a dormant infection for 50 years and then come down with the disease without ever having come in contact with it again. Since we have 30 million infected people in the United States, eradicaton of tubuerculosis is going to require a program of long surveillance. So in 1963 the Surgeon General of the Public Health Service appointed a Task Force on tuberculosis control whose function was to outline the type of campaign needed to eradicate this disease.

Persons in public health recalled that some years before, medical science had perfected a cure for syphilis. This was probably as effiective a cure as we had for any disease. One large massive dose would render the person not only noninfectious, but also cure him.

We became complacent about syphilis and I think you know what happened. The disease increased and is continuing to increase. This failure led to recognition that it wasn't enough just to know the medical facts about a disease, but that the social facts identified with a disease must also be taken into account.

Tuberculosis is preventable. We have good drugs; not as good as some for syphilis, but they can cure most cases. Yet, last year we had about 8,000 deaths and 50,000 new cases. It is rather shocking to realize that we have some 40,000 active cases in hospitals, some 60,000 active cases outside hospitals.

The task force recommended a certain level of appropriations for project grants for tuberculosis control and money has been made available in line with these recommendations. The Public Health Service has developed an excellent program aimed at caring for active cases outside of the hospital and identifying those persons who have been infected who are most at risk of breaking down with the disease. In the opinion of the National Tuberculosis Association the program has been highly successful.

The task force plan called for a recommendation of $25 million for the third year of an accelerated program which is fiscal 1968. Actually only $17½ million has been authorized in the 1968 budget.

With the advent of this legislation and the change in the method of financing, funds to support control will come from project grants for all health services for which $70 million is proposed this year. If we were to get the amount recommended by the task force on tuberculosis, which we feel is vitally needed, this would amount to over a third of the total $70 million.

We believe that there should be sufficient funds for other programs. Even if only the $17½ million which has been earmarked were received, this amount would still be a quarter of the $70 million. Either other programs will have to suffer or the tuberculosis program will have to suffer unless the authorization for all project grants is increased substantially.

I would think they should be increased to the neighborhood of $100 million.

We believe that it isn't just a matter of controlling TB but of eradicating it. As long as there is a person with TB then we have a hazard to the whole population. So our goal is one of the eradication and not simply of control.

The National Tuberculosis Association has also been interested in recent years in other respiratory diseases because they are very closely allied to tuberculosis.

I am referring particularly to chronic bronchitis and emphysema. These are diseases which the medical profession has somewhat neglected over the years. They were assumed to be diseases of older people that just naturally occurred; they were alleged to be degenerative types of conditions.

We have reason to believe now that chronic bronchitis and emphysema are not naturally occurring degenerative diseases, but they are probably affected by environment. There is unquestionably a relationship between chronic bronchitis and emphysema and cigarette smoking. Whether it is caused or not no one can know for sure. There very probably is a relationship between air pollution and emphysema.

In Great Britain, where air pollution has been a way of life since the industrial revolution these diseases occur far more frequently than they do in the United States. However, the mortality rate from emphysema in this country is alarming; it has doubled every 5 years since 1950. This may be a matter of reporting and recognition of the

disease, but we think there has been an actual increase. We don't know much about emphysema, what causes it, how much of it really there is, but I think it is time that we must find out.

This legislation, H.R. 6418, will provide funds to help us find out more about this disease, to disseminate information to the medical profession, to screen the population, and to really attack this problem as it should be.

In summary, the National Tuberculosis Association wishes to emphasize its unreserved support for the concept of Public Law 89–749, for comprehensive health services based on cooperative planning with all concerned groups.

Such an approach is long overdue and it offers the only logical solution to our fragmented system of delivering public health service.

However, we must express our deep concern that the needs of patients with TB and other pulmonary conditions may not be adequately taken care of unless greatly increased funds are authorized under this legislation for both the formula and grant programs.

Mr. Chairman, I want to express appreciation for myself and on behalf of the National Tuberculosis Association. I deeply appreciate this opportunity to appear before this committee and give this statement. We will of course be very glad to supply any additional information that we can.

Mr. VAN DEERLIN. Thank you, Dr. Stocklen. Your full statement will of course be carried in the record.

(Statement referred to follows:)

STATEMENT OF THE NATIONAL TUBERCULOSIS ASSOCIATION, PRESENTED BY JOSEPH STOCKLEN, M.D.

The National Tuperculosis Association endorsed the principles of the Comprehensive Health Planning Act when this legislation was proposed last year. Support of the legislation which resulted in P.L. 89–749 was consistent with NTA's traditional efforts to strengthen health department services for protection of the public health.

As an organization dedicated to the eradication of tuberculosis in the U.S., the NTA Board of Directors qualified its support only to the extent that tuberculosis control efforts would continue to receive the amount of Federal support deemed necessary in the December 1963 report of the Surgeon General's Task Force on Tuberculosis Control.

In February 1967, the NTA Board adopted the following resolution relating to P.L. 89–749:

The NTA Board of Directors supports a supplemental appropriation of $9 million as authorized for planning purposes for fiscal 1966–67 in order that the planning aspects of the legislation can be implemented without delay.

It supports an increased authorization for formula and project grants for 1967–68. An amount should be authorized which will permit the scope of Federal financing for tuberculosis control recommended as necessary by the Surgeon General's Task Force on tuberculosis for accelerating the campaign to eradicate the disease. Increased Federal financing is also urgently needed for initiation and expansion of activities to control other chronic respiratory diseases, such as emphysema, which are increasingly significant as causes of disability and death.

TUBERCULOSIS

Tuberculosis remains the major communicable disease problem in the United States, a fact which is the more unacceptable in view of the availability of methods to control it. The Surgeon General's Task Force in 1963 recommended a ten-year plan to accelerate control activities. From evaluation of past experience they believed such a program could only be accomplished by the appropriation of substantially increased Federal funds.

They recommended that major Federal financing be by means of project grants which could be concentrated where the problem is most critical—in the poor enclaves of large urban areas where tuberculosis has continued to flourish and in other areas of poverty where special factors have combined to deny people those improvements of the environment which have helped vanquish the disease in the more fortunate. The House Committee's report which accompanied P.L. 89-749 describes the use of project grants as clearly intended for such situations.

However, elimination of categorical tuberculosis grants could well result in a severe loss of support for tuberculosis control. The Congress by its generous appropriations in the past few years indicated its concurrence with the recommendations of the Task Force. In the current fiscal year the Tuberculosis Program, PHS, received almost $15,000,000 for project grants.

According to the Task Force report, the amount of project grant funds which should be committed to tuberculosis control in the third year of the accelerated plan, which is 1968, is $25,000,000. Funds would remain at this level for an additional three years until, hopefully, progress in reducing the tuberculosis problem would make possible a reduced Federal appropriation. The Federal budget for 1968 includes $17,500,000 for tuberculosis project grants, $7,500,000 less than recommended for the third year of the Task Force Plan.

Formula grant funds have also given valuable support to tuberculosis control; in fact, they were the bulwark until project funds furnished a crucial boost to basic methods of control in many areas. Project grants have furnished a way to concentrate efforts in tuberculosis control not possible under formula funds. But tuberculosis services are now and must be increasingly in the future an integral part of total health department services. Even if tuberculosis is eventually reduced to the status of a minor disease, control efforts cannot be relinquished; they must always be maintained to guard against possible resurgence. It is unfortunate that the same handicap posed by inadequate authorizations for project funds exists for formula funds.

Authorizations recommended last year by the Administration and the Senate for PHS grant programs for comprehensive health services were almost double those finally approved in P.L. 89-749. With the amounts originally proposed, it would have been reasonable to assume that States could obtain funds sufficient to finance tuberculosis control activities in the magnitude necessary for an eradication campaign. However, with the competitive pressures of other established programs and with the identification of new health problems, it seems unrealistic to accept the fact that tuberculosis control can continue to receive the intensified support it needs from such insufficient appropriations as are now authorized.

In our opinion, the increase proposed in H.R. 6418 for project and formula grants is not enough to assure the level of support for tuberculosis control necessary to fully implement the Task Force plan. Without substantial Federal funds to support tuberculosis control, a combination of factors will result in neglecting a disease whose true significance is not understood by the public. An editorial in a recent issue of the Canadian Journal of Public Health referred to tuberculosis as the "Great Delusion," pointing out that progress has been far outstripped by the optimism and premature relaxation of physicians. Stating that one recent small outbreak of tuberculosis in Canada cost $500,000, the editorial stressed the need for continuing public support.

As a part of its program to control a communicable disease, the National Tuberculosis Association also wishes to express its support of the section of H.R. 6418 which provides for improving the quality of laboratory services. A recent survey by the NTA of laboratory services for tuberculosis patients indicates that great deficiencies exist in these services in many areas. Few State health departments are able to provide routine surveillance of laboratories which perform tests of sputum to determine presence of tubercle bacilli—a fact which poses a serious question as to the reliability of results of these tests in many nonofficial laboratories.

Advanced techniques which shorten the time of sputum clutures, and which can thereby bring the patient under medical supervision sooner, are lacking in about half of all State health department laboratories. In many States, adequate tests to determine if the newly diagnosed patient's infection is resistant to the commonly used drugs are not available. Delay in prescribing other effective drugs for the patient who may have such resistant organisms can be very serious for his prognosis.

Adequate laboratory procedures for tuberculosis are important for the patient's well-being and for the protection of the public health. For these reasons, the NTA is eager to support the provision of H.R. 6418 relating to strengthening of laboratories.

CHRONIC RESPIRATORY DISEASES

The NTA concerns itself with control of respiratory diseases other than tuberculosis. In recent years, much of its program emphasis has related to chonic respiratory diseases because of their sharply increasing toll. The problem in respect to tuberculosis posed by the low authorization ceilings of P.L. 89–749 also affects programs to control other respiratory diseases.

The rapid rise in mortality from many of the chronic respiratory diseases, particularly emphysema, is a comparatively recent event. Little is known of the cause of chronic obstructive pulmonary disease; many factors may be involved. No specific prevention or cure is available. Palliative procedures which can be helpful have not been made available in the average community.

Intensive care units for relief of breathing difficulties are most often located in hospitals where use is usually confined to persons in respiratory failure who may have come to this point of distress because of another condition. Some communities have established breathing and inhalation clinics for persons in a chronic state of pulmonary insufficiency but these facilities are limited in number. The vast majority of physicians do not feel competent to handle such respiratory diseases. Because of the recent emergence of these diseases as disabling conditions, most medical schools have not had the opportunity to give appropriate attention to instruction of medical students on the diagnosis and treatment of these diseases.

The death rate from emphysema has more than doubled every five years since 1950, and the trend in death rates from other chronic respiratory diseases has also been upward. Between 1964 and 1965, emphysema deaths increased from 15,796 to 18,644, an increase of over 2,800 in one year. Emphysema has become the second most frequent disease for which workers are retired for disability prior to age 65; disability benefits for persons affected by this disease cost $90,000,000 annually.

Because of such trends, a Chronic Respiratory Disease Program was created in the Public Health Service a few years ago. A limited number of States have initiated administrative units within State health departments to deal with chronic respiratory disease control, but a greater recognition of the seriousness of these diseases is imperative. An administrative focus for attention to this problem must be created within State health departments. Impetus can then be furnished for extending help to the medical community and expanding services to patients, such as establishment of referral units for physicians for consultation in diagnosis and treatment. Where such facilities have been provided as pilot programs, they have met a critical need. More educational programs directed both to the practicing doctor and the public are urgently needed. Such activities must be increased and they must be integrated as part of the overall framework of health services consistent with the stated purpose of P.L. 89–749.

In order to encourage the incorporation of chronic respiratory disease programs as part of ongoing services it will be necessary for some States to show the need for these services through demonstrations. One of the purposes of project grants is support of services to meet health needs of national significance and development of new methods of control. The demonstration of programs to control chronic respiratory disease clearly falls within this purpose. In view of the insufficient funds authorized, however, it is questionable if enough demonstrations can be launched to contribute in any significant way to the amelioration of the problems of patients with chronic pulmonary conditions. In the opinion of the NTA, the unrealistic amounts authorized in P.L. 89–749 seem to run counter to the very ambitious purpose of the legislation which is to achieve comprehensive and effective health services through increased Federal support.

SUMMARY

The Surgeon General's Task Force on Tuberculosis Control of 1963 made a plea for accelerating our fight against this disease while available therapy is still effective. The acceleration made possible in all States in the past few years through increased Federal financing must be maintained.

In October 1966, a Task Force of experts convened by the Public Health Service and the National Tuberculosis Association stressed the critical situation

in which patients with emphysema or other conditions of pulmonary insufficiency find themselves because of the lack of facilities and personnel for management of their condition. States and communities must start to assume leadership in solving this serious problem by initiating demonstrations of control methods and by coordinating efforts of all groups to bring maximum relief to patients.

The concept of comprehensive health services preceded by adequate planning is unreservedly endorsed by the National Tuberculosis Association as a rational approach to more complete and better organized health services. Our belief in the inherent value of the concept does not preclude our concern that the needs of persons suffering from tuberculosis and other respiratory disease will not be met under the new grant program in the light of the relatively small amount of funds provided for in the current pending legislation.

The National Tuberculosis Association, therefore, requests that authorizations for the Public Health Service formula and project grants be at a level sufficient to ensure that the accelerated tuberculosis campaign will be maintained and that the critical needs in chronic respiratory disease control will begin to be met in public health programs throughout the country.

Mr. VAN DEERLIN. Mr. Springer.

Mr. SPRINGER. Dr. Stocklen I think it is an excellent statement. I am very much interested in finding out what your group is interested in and why you are so interested and also the extent of your work. I think you have made an excellent statement.

Thank you very much.

Dr. STOCKLEN. Thank you, Mr. Congressman.

Mr. VAN DEERLIN. Mr. Ottinger.

Mr. OTTINGER. No questions.

Mr. VAN DEERLIN. Dr. Carter.

Mr. CARTER. No questions, Mr. Chairman.

Mr. VAN DEERLIN. Mr. Brotzman.

Mr. BROTZMAN. No questions.

Mr. VAN DEERLIN. Mr. Brown.

Mr. BROWN. I am pleased to have the opportunity to greet you and I also have no questions. Thank you very much.

Dr. STOCKLEN. Thank you.

Mr. VAN DEERLIN. You seem to have done a most impressive job, Doctor. Thank you very much.

Dr. STOCKLEN. Thank you, Mr. Chairman.

Mr. VAN DEERLIN. Dr. Donald J. Caseley, Medical Director of the University of Illinois Research and Educational Hospitals, appearing for the American Hospital Association.

Mr. SPRINGER. Mr. Chairman, I think Dr. Caseley's work is known throughout the entire medical field and he is a man of considerable stature and he has done a grand job in the position he is in and to be representative of the University of Illinois at Champaign-Urbana. He doesn't happen to be there, but we nevertheless, Doctor, are glad to have you as an expert in this field and we welcome you.

STATEMENT OF DONALD J. CASELEY, M.D., ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION; ACCOMPANIED BY VANE M. HOGE, M.D., ASSISTANT DIRECTOR, WASHINGTON SERVICE BUREAU, AMERICAN HOSPITAL ASSOCIATION

Dr. CASELEY. Thank you sir. Mr. Chairman, as you have been kind enough to note, I am here in my capacity as the chairman of the Council on Government Relations of the American Hospital Association and I am representing that association.

I am fortunate to be accompanied this morning by my colleague, Dr. Vane Hoge, the assistant director of the Washington Service Bureau here in Washington of the AHA.

It is our understanding that H.R. 6418 would amend the Public Health Service Act on a broad front (1) to extend and expand the authorization for grants for comprehensive health planning and services; (2) continue grants to schools of public health; (3) provide new authority for research and demonstration; (4) provide for the cooperation of the Federal Government with the States in emergencies; (5) provide for licensing of clinical laboratories engaged in interstate commerce; (6) authorize the use of volunteers in health care facilities; (7) authorize cooperative activities between the Public Health Service hospitals and community facilities; (8) remove the authority of the Commissioner of Education to accredit programs of nurse education; and (9) incorporate certain other technical changes in the bill.

I shall not address myself to all matters covered under the bill, but I will comment only on those provisions which are of primary interest and concern to the hospitals of the country.

The American Hospital Association has supported, in general, the comprehensive health planning amendments of 1966. The association has followed closely the developments of the program within the States and has urged hospitals at the State level to become involved as deeply and as appropriately as they can in the planning activities provided under the law. It is realized that this whole program is only in its developmental stages.

We have, however, become increasingly concerned with the vagueness of the language of the act in respect to planning activities. The act provides for the designation or the establishment of a single State agency as the sole agency for administering or supervising the administration of States' health planning functions under the plan. At present there are about 80 regional health facility planning agencies established throughout the country. Most of these have had substantial support from the Federal Government. They are voluntary in nature in that, except for their technical staffs, the membership of such councils is principally volunteers and uncompensated workers in the field. These planning bodies are made up of leading citizens interested in health affairs. They have no statutory authority but exercise leadership in determining the health needs of the area.

These groups are greatly concerned as to their future role and the lack of assurances in the statute as to their having any role. We believe that planning for health facilities and services will be most effective if it is performed by local groups. It is most essential that the citizens exercise health leadership in local regions of a State and participate actively in the planning decisions if such decisions are to be effective.

Accompanying this statement as attachment A is a set of principles developed by the American Hospital Association which we believe will serve as guidelines for the development of planning organizations within the State.

Also submitted as attachment B is a protocol for health care planning covering planning by the individual health service institutions and organizations; interrelated planning by the areawide planning

agency; and interrelated planning by a State planning agency. We hope these documents will be helpful to the committee in its consideration of these amendments.

Therefore, we urge that section 314 of Public Law 89-849 be amended so as to require the states to use voluntary regional or areawide health facility planning organizations within the state which have demonstrated their competence.

A second matter of growing concern is in respect to the comprehensiveness of the planning apparently required by the statute.

Planning in total health affairs is really a new science. There are many aspects where the methods and means are yet to be demonstrated. We have advanced to the point where there is a good deal of expertise in planning for health facilities, services, and personnel.

We believe it would be unfortunate to delay planning developments throughout the Nation by requiring that planning in all areas must involve a comprehensiveness going far beyond the planning for services, facilities, and personnel.

We would hope, therefore, that the problems involved in requiring totally comprehensive planning would be recognized by this committee in its report.

Subsection (a) (2) of section 2 is a new amendment providing assistance to individual institutions for developing a program for capital expenditures, for replacement, modernization, and expansion which is consistent with an overall state plan developed in accordance with criteria which the Secretary determines will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner, and provide that the State agency furnishing such assistance will periodically review the program developed for each health care facility in the State and recommend appropriate modification thereof.

The intent of this whole paragraph is unclear. If the assistance is to be provided in the form of grants to assist the individual facility to develop the plans, that would be highly desirable.

We recognize it is essential that the regional plans within the State must encompass the planning by the individual health entities. If the assistance referred to is in the form of consultation on the request of the institutions, this might be desirable.

However, if what is intended by this paragraph is total control over individual institutional planning by the State, we think it is unworkable and an unwise provision.

The States have neither the manpower nor the facilities for undertaking any such large scale consulation, and planning bottlenecks would almost certainly develop.

We recommend, therefore, that the language in this section be appropriately clarified so that the intent of the amendment is clear, and so that consultation with the state not be mandatory.

PUBLIC HEALTH SERVICES

Subsection (d) (7) of section 2 appears to provide for specific allocations of funds for mental health services. This provision seems inconsistent with the overall intent of the law which we understand is to move away from categorical grants and the accompanying manda-

tory requirements upon the States and toward providing general purpose grants for health purposes permitting the States to make specific expenditures on the basis of State determination of need.

If the whole approach to general purpose grants is to be successful, the mental health activities should be required to conform to the program.

RESEARCH AND DEMONSTRATIONS RELATING TO HEALTH FACILITIES AND SERVICES

This section authorizes the Secretary to establish a new center for research in health services and apparently broadens the scope of such research.

We believe the overall establishment of such a center is desirable and the broadening of research potential should also be beneficial.

The bill would also, however—and this is the point we wish to emphasize—repeal section 624 of the Public Health Service Act. This is the section which pertains specifically to the promoting of research in hospital design and administration.

The American Hospital Association strongly urged the inclusion of such a section in the Hill-Burton Act. We have continued to strongly support the appropriation of funds for this section. The hospital field alone represents a capital investment of about $20 billion and an annual expenditure of about $13 billion. The amount of research now being directed toward improvement in facility planning and administration is grossly inadequate in relation to the problems which exist.

We are convinced that the amendment proposed in H.R. 6418 removing this authority from the Hill-Burton section of the Public Health Service Act will result in a marked deemphasis on such research and in the hospital field.

Under the greatly broadened scope, as proposed in the bill, the competing pressures for research funds will, we believe, inevitably result in the deemphasis of the greatly needed hospital facility research.

We strongly oppose, therefore, repeal of section 624 of the Public Health Service Act, and we urge the retention of the research programs now an integral part of the Hill-Burton Act.

In order to increase the effectiveness of the research program in the Hill-Burton program, we urge that the act be amended so as to augment and strengthen the Federal Hospital Council by the addition of two recognized and experienced research persons to the council.

COOPERATION WITH STATES IN EMERGENCIES

This section authorizes the Secretary to provide for the cooperation of the Federal Government with the States in the event of emergencies resulting from natural disasters. I might add parenthetically that this has a very personal meaning for us in Chicago at this particular time.

Hospitals inevitably become the focal point for community action and for the organization of community health services in the event of such disasters. The provisions provided here should strengthen materially the ability of hospitals to function in such emergencies.

We urge the adoption of this section of the amendment.

CLINICAL LABORATORIES AND IMPROVEMENTS

This section provides for the licensing of clinical laboratories engaged in interstate commerce.

We believe that there is a limited need for this provision as it applies to hospitals in that most hospital laboratories do not engage in interstate commerce and that the great majority of such laboratories are fully competent.

We recognize, however, that there are situations under which some official control would be desirable and the association does not, therefore, oppose this provision. We suggest further that if this provision is to be enacted, it should include all laboratories which engage in interstate commerce.

We are concerned, however, over problems that may arise in the implementation of this amendment. In carrying out his functions under this provision, the Secretary is authorized to utilize the services and facilities of any Federal, State, or local public agency or nonprofit, private agency or organization.

In order to prevent multiple and unnecessary inspections for licensing purposes, we recommend that laboratories in hospitals which have been approved by the Joint Commission on Accreditation of Hospitals be exempt from inspection by another agency in order to qualify for a license.

VOLUNTEER SERVICES

Section 692 of the bill authorizes the Secretary or his designees to utilize the services of uncompensated volunteers in the operation of any health care facilities or in the provision of health care. The American Hospital Association has always strongly advocated and encouraged the use of unpaid volunteers in its member hospitals.

We believe that the use of such volunteers in Federal institutions is a highly desirable step, and we recommend the adoption of this section of the amendment.

SHARING OF MEDICAL CARE FACILITIES AND RESOURCES

This amendment would authorize the Secretary to enter into agreements or arrangements with schools of medicine and other health schools, agencies, or institutions for the exchange or cooperative use of facilities and services on a reciprocal or reimbursable basis between facilities of the Public Health Service and non-Federal facilities as will be of benefit to the training or research programs of the participating agency.

This amendment relates primarily to equipment, space, or personnel which because of high costs, limited availability, or unusual nature are either unique in the health care community or are subject to maximum utilization only through mutual use.

We believe that this provision will be beneficial both to the facilities of the Public Health Service and to the non-Federal facilities in their community, and we recommend that this provision be adopted.

MEDICAL CARE FOR FEDERAL EMPLOYEES AT REMOTE STATIONS OF THE PUBLIC HEALTH SERVICES

This section of the amendment would authorize the Secretary to provide medical, surgical, dental treatment, and hospitalization for Federal employees and their dependents at remote medical facilities of the Public Health Service where other medical care and treatment is not available. This section would also authorize the Public Health Service to receive reimbursement for any such treatment from Federal employees and their dependents who are not otherwise entitled to this care.

The association recognizes the medical necessity for this provision and recommends its adoption with the proviso, however, that no major expansion of facilities be authorized specifically for this purpose.

ACCREDITATION OF NURSES EDUCATIONAL PROGRAMS

This section of the amendment would amend section 843(f) of the Public Health Service Act by removing the authority of the Commissioner of Education to accredit programs of nursing education. This would place the accrediting authority of such nurse education programs entirely in the hands of nongovernmental organizations.

Although the authority of the Commissioner of Education to accredit such programs may be seldom, if ever, used, we believe its retention in the law is desirable. The association is, therefore, opposed to this section of the amendment and recommend it not be adopted.

Mr. Chairman, we appreciate the opportunity of bringing the views of the American Hospital Association to the attention of this committee and request that the attachments accompanying this statement be made a part of the record of these hearings.

Thank you.

Mr. VAN DEERLIN. This will, of course, be done, Dr. Caseley.

(Attachments referred to follow:)

ATTACHMENT A

PRINCIPLES TO GUIDE DEVELOPMENT OF STATEWIDE COMPREHENSIVE HEALTH PLANNING

(Approved by American Hospital Association, February 1967)

1. Planning should be a continuing process of the providers of health service, stimulated, guided, and assisted by the areawide planning agencies, subject to constant review and revision, and incorporated into the statewide planning program (see below for Protocol for Health Care Planning Within a State).

2. The institutional providers of health services must take part in planning, not only for their own institutions but also for the total community in which the institutions are located.

3. Health planning areas of appropriate size should be defined in most states, and existing areawide planning agencies used where recognized as competent, or new ones established to concentrate upon comprehensive health planning within those areas.

4. The areawide health services, manpower, and facilities planning agencies should be concerned with the total spectrum of health activities, but should place primary emphasis on planning for personal health services, manpower, and facilities, and should relate to and coordinate with specialized planning groups, such as water pollution and air pollution control boards, and with traditional

public health services, such as communicable disease control and health education.

5. Effective incentives and controls must be developed within each state to insure meaningful implementation of planning. Health care institutions, in keeping with their role as main providers of health services, should be fully involved, along with consumer groups, both in the planning process and in the development of appropriate incentives and deterrents.

6. Institutional members of the American Hospital Association should recognize that areawide planning for health and hospital services is essential and it is strongly recommended that they actively stimulate and participate in the development of effective voluntary areawide planning agencies and support the establishment of control procedures that may be required on a local basis to assure compliance with a plan by all health institutions and agencies and to assure the availability of an appropriate range, variety, quality and amount of health services to the people of the area.

ATTACHMENT B

PROTOCOL FOR HEALTH CARE PLANNING WITHIN A STATE

(Approved by American Hospital Association, February 1967)

Three levels of planning are suggested within a state: (1) planning by the individual health service institution, organization, agency or group; (2) interrelated planning by the areawide planning agency, and (3) interrelated planning by a state planning agency, assisted at the state level by an advisory council that is fully representative of consumers and providers of health care.

I. INDIVIDUAL HEALTH SERVICE INSTITUTION, ORGANIZATION, AGENCY, OR GROUP

1. A formal planning unit should be established within each health service institution, organization, agency, or group to concentrate upon developing services and programs.

2. Planning by such a unit is the foundation of comprehensive health planning in the community, area, and state. It should be done in relation to the demonstrated needs of the persons to be served.

3. Trustees, medical staff, and administration should be included in the membership of the planning unit.

4. Staff should be assigned to the planning function as an integral part of regular administration.

5. The planning unit within the hospital should maintain regular and close working relationships with the areawide health planning agency and with other health service institutions, to avoid duplication of effort, equipment, or facilities required to meet community health needs. Final decisions should be based upon agreement with the areawide planning agency and other health service organizations located in the planning area.

6. The planning unit should not be directly involved in programs of construction.

II. AREAWIDE HEALTH PLANNING AGENCY

1. An areawide health services, manpower, and facilities planning agency to deal primarily with personal health services should be used or established wherever there is an area, whether intrastate or interstate, of sufficient size and density to support a full-time professional staff.

2. The areawide planning agency should be permanent, and its activities continual.

3. The areawide planning agency should be concerned with the total spectrum of health activities.

4. The areawide planning agency may, but need not necessarily, serve as the coordinating agency for all health planning within the area.

5. It is desirable that the areawide planning agency be nongovernmental and be fully representative of consumers and of the providers of health care within the area who will be called upon to implement the programs that result from planning.

6. Existing health planning agencies that are recognized as effective should be utilized within the defined area of service.

7. Financing should be adequate; it may be entirely local and nongovernmental or may be a combination of nongovernmental and governmental funds but financing should not come from a single source.

8. The areawide planning agency has responsibility in two directions:

(*a*) It should contribute to planning within each individual service institution, organization, agency, or group, through information, consultation, and interaction leading toward responsible decision-making based upon area need and related to other action within the area, and through the bringing together for action and final decision the planning efforts of all of the individual health service units in the area.

(*b*) It should contribute to the state planning effort the elements arising out of the necessities of its area, initiating recommendations for approval of projects that demonstrate adequate planning to meet the health needs of the people in the service area.

9. The areawide planning agency should have an adequate and qualified full-time staff.

10. The membership of the areawide planning agency should not be too large; committees being used to carry out special tasks and thus involve more persons in the planning process.

III–A. STATE HEALTH PLANNING AGENCY

1. It is desirable and necessary to designate a coordinating agency for health planning in the state. This may be either an effective existing state agency, or a new agency designed to bring together the planning efforts of the various health organizations, agencies, and groups within the state.

2. The state health planning agency should be responsible for developing a plan for the planning of the total spectrum of health services, manpower, and facilities in the state, covering both governmental and nongovernmental planning activities; for bringing together the results of the planning efforts of the areawide planning agencies and other agencies throughout the state; for the setting of priorities within the state and for action on program recommendations from the various planning agencies within the established priorities.

3. The state health planning agency should make effective and continual use of a statewide health planning advisory council (See III B).

4. The state health planning agency should set policies; establish administrative methods, including an appeals mechanism; and provide for review and approval or disapproval both of the processes of planning and of the projects recommended to it.

5. The state health planning agency should provide for cooperative working arrangements among governmental or nongovernmental agencies, organizations, and groups concerned with health services, manpower, and facilities; and for cooperative efforts between such agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, and rehabilitation.

6. The state health planning agency should develop, in cooperation with state-level agencies from other states, the necessary interstate arrangements to provide for planning as needed for health districts and planning areas located within two or more states.

III–B. STATEWIDE HEALTH PLANNING ADVISORY COUNCIL

1. A statewide health planning advisory council should be established on a permanent basis to assist the state health planning agency.

2. The advisory council should be made up of lay and professional members, selected for their leadership qualities, who represent the total state. These should include representatives of providers of service, of consumer organizations and the public, and of areawide health services, manpower, and facilities planning agencies.

3. Members of the advisory council should be selected for their ability to evaluate planning presented for their advice by the areawide health planning agencies and to recommend its effective implementation.

4. The advisory council should not be too large but, as is recommended for the state planning agency, should use committees to carry out special tasks and involve more persons in the planning process.

5. Consideration should be given to establishment of the advisory council as a statutory entity to assure the most effective, balanced use of highly qualified leaders to provide guidance to the state health planning agency.
6. The advisory council may be staffed by the statewide health planning agency.
7. Financing of the advisory council should be independent of the institutions, organizations, agencies, or groups whose programs it will review.

Mr. VAN DEERLIN. Mr. Springer?

Mr. SPRINGER. I have no questions. Dr. Caseley's statement speaks for itself. It is an excellent statement. You have brought up two or three points here that have not been touched on in any other statement or discussed before this committee from any other witness.

Dr. Caseley, thank you very much for coming here and spending this time with us. You may be assured that your views will receive every consideration when this matter comes to be debated.

Mr. VAN DEERLIN. Mr. Ottinger?

Mr. OTTINGER. Thank you, Mr. Chairman. Thank you for a very excellent and interesting statement, Dr. Caseley. I have been very much concerned about the existing shortage of hospital facilities which in many areas of the country is in a critical state. I have introduced legislation to meet this problem and I intend to offer it as an amendment to this bill we are considering.

The Public Health Service last year made a survey of hospital facilities throughout the country and found that by its standards—primarily based on an annual rate of occupancy of 90 percent or greater—some 143 hospitals throughout the country were in critical condition.

In our own area we have a hospital with an emergency situation where the patients who are accepted actually have to stay in corridors. The delay in giving people medical attention is very serious. There have also been newspaper articles reporting dangerous health hazards to people resulting from the length of time they have to wait to gain admittance for examination in hospitals.

I would like to know how your association would view a one-shot endeavor to directly finance some of the critical needs for facilities? Personally I would support a longer term and larger effort to overcome the problem of hospital shortages throughout the country. I think however, that with the financial situation we find ourselves in in this country today, I think we would be unlikely to get a massive program started at this time. Nonetheless, I think we ought to make a start—particularly with respect to the most critical situations.

I don't know whether you had a chance to see the legislation itself. It is a comibnation of direct, emergency Federal grants and loans. We would be very anxious to have your views on it.

Dr. CASELEY. I have indeed had a chance, Mr. Ottinger, to review the legislation and there is no doubt that there are geographical areas in the country where there are instances of acute overcrowding. This is only one facet of the hospital establishments broad problem areas. Modernization of particularly the urban, the older major hospitals is critical, but possibly if there is one thing that supersedes all other problem areas it lies in the acute shortage of manpower.

Actually the thing which gives the administrators of hospitals worries bordering on acute anxiety neurosis is the day by day wonder whether we are going to be able to keep the institutions we have

totally operating. When a new hospital is opened in a metropolitan area I am sure that subconsciously each hospital director and each board of trustees secretly wonder how they are going to cope with the problem of obtaining key employees; so I would say that while your concerns are real and valid, to provide the staffing for improved, increased, and advanced hospital facilities, is an increasingly difficult problem.

We have the concerns for modernization which are equally pressing and more critically how we are going to man and staff the institutions that we presently have.

Mr. OTTINGER. Do you have any suggestions for us in terms of your manning, the staffing problems? Do you think the Federal Government has a role in trying to assist in fulfilling those needs and shortages?

Dr. CASELEY. The Federal Government I think has stepped in at a critical time and is fulfilling a very key role in the development of manpower. If I had a criticism it would be that maybe it is a half a decade late, but the support for medical education, for nurse education, for the allied medical sciences, all representing specific bills aimed at rectifying in partnership with the States and local facilities and the private section of educational establishment, I think this kind of partnership is going to be the best hope on which we can look toward resolution of this problem.

There is probably nothing more frustrating than trying to attract into a critical field such as the health establishment, people of competence. The brains of the country is in competition with a booming economy. The present manpower shortage, which is of olympian dimensions, affects the hospital field more than others because it has traditionally and historically been invested with a sense of philanthropy in which even the employees of hospitals have philanthropically helped to subsidize the institutions themselves.

I share your concern with the rapidly increasing hospital costs, but I would point out that maybe the American public should retrospectively be thankful that this thing didn't occur earlier and that they did have the benefit of this subsidization of the institutions by the employees themselves.

They are now demanding obviously their fair rewards in competition with all other elements of the economy.

Mr. OTTINGER. Do you think our efforts in this regard then are adequate at the present time?

Dr. CASELEY. To the extent that there is always a problem of interdigitating the Federal effort with the local effort, and this is progressing well, I think that we probably have right now sufficient funds to do the job.

This must, however, be an expanding effort because as we become geared up the allied medical sciences, for example, find new educational outlets. As more universities are willing to take on a baccalaureate program, and colleges, and associate arts degree programs, then the place for additional shared funding will undoubtedly be more dramatic and I think the need will be increased.

Mr. OTTINGER. So far as the Federal Government is concerned, do you feel the same way on facilities, that the Hill-Burton program is adequate to take care of the present needs and that we can afford to

wait for the President's Commission to study the overall problems for renewal and changes in Hill-Burton in 1969?

Dr. CASELEY. I think, sir, that the Hill-Burton program has never been adequate to fulfill the full spectrum of the needs which are represented by the entire hospital field. As you well know, the major emphasis in the early stages of it and rather all through the program has been toward rectifying the large gaps in institutional needs in the more rural areas.

The needs that we see generating in the suburbs and in the urban areas for modernization, as I have mentioned previously, really emphasize the basic inadequacy of the funding of Hill-Burton.

There is a much bigger job to do than there are resources available to do it.

Mr. OTTINGER. Thank you, Mr. Chairman.

Mr. VAN DEERLIN. Dr. Carter.

Mr. CARTER. I appreciate your excellent statement very much, Doctor. How long have you noticed this shortage of manpower in your hospitals? How long have you had this complaint? You say you have a shortage of manpower in hospitals throughout the country. How long have you had this shortage of manpower which we have been speaking of?

Dr. CASELEY. My experience in the hospital field dates back to 1947 and we were beginning to generate shortages in certain critical and newly developed areas of the highly technical fields then.

The nurse shortage really began to become one of national concern in the 1950's. It has been aggravated on a compounded annual basis I think since. This, doctor, would be my response to the evolution of the critical shortage.

Mr. CARTER. In what field particularly do you have these acute shortages now?

Dr. CASELEY. Nursing I think stands out as the No. 1 area of concern. Now, let me preface my remarks. I am excluding from this the physician shortage because I am talking about the hospital as an organic institution.

Nursing is obviously the single most highly critical item. Technicians, both primarily in the more sophisticated areas, the newer developments in diagnostic, biochemistry and hematology, this sort of thing, therapists, and actually clerical workers become a very, very critical item of shortage as we reframe and restructure the work of the nursing personnel and divest the nurse of everything conceivable that we can in the way of clerical and other duties to let them be truly the patient's nurse, and so I can say, I am sure without any fear of contradiction from my colleagues, that the shortage is general and that there is no area in the entire hospital field that I can think of where there is a plethora of workers.

Mr. CARTER. Have the Government training programs along these lines helped you very much in training clerks? I notice in some hospitals we do have training programs throughout our country for clerical aids and different types of technical help within the hospital.

Have they been of assistance to the hospitals?

Dr. CASELEY. These have been of major assistance and I think there is another area of support from the Federal Government that should be alluded to. The Manpower Training and Development Act has

provided a platform or framework in which the lower echelons of workers could be trained, taking that rather extensive problem off of the backs of hospitals.

In Illinois I happen to serve on the Governor's commission on that and we were able to incorporate many of these areas of health subprofessionals, ward clerks, and clinic clerks, nurses' aids, and technicians, surgical technicians, into programs which were basically funded under this program and they have been most helpful, very, very well received.

Mr. CARTER. Have the hospitals taken full advantage of the Manpower Development and Training Act?

Dr. CASELEY. They have a voracious appetite for gobbling up the output of these programs and no time lies between the completion of the programs and when these people are offered employment they are in a position to accept employment.

Mr. CARTER. Certainly I can see the need of continued use of this excellent program to help in securing aid in your hospitals. I realize you have great problems. We too are bothered at the present time because of the escalation of the costs of hospitals.

Would you tell us why you think the costs have escalated so tremendously?

Dr. CASELEY. I think, Dr. Carter, that I alluded to one of the basic reasons a little earlier in my response, the fact that all workers in hospitals found themselves in salary and wage brackets which were noncompetitive with the industrial and commercial sectors of our economy, and as long as there was even a modest oversupply of manpower to fulfill the total requirements of our economy we hospitals could get by with this depressed general wage structure, but with the virtually full employment which characterizes this year, last year, next year, we are in total competition with the automobile industry, with the steel industry, with all the service functions, and we cannot attract workers into the field and expect them to accept the wage which is less than that which they can get in the economy as a whole.

For example, our nurses are educationally in a comparable position let's say with elementary school teachers. You all know the escalation of the salary scales of teachers. I happen to have served both on a board of education for a high school and director of a hospital collaterally and I have had the opportunity to see these vie with one another in the upward spiral.

It is this which I think is accepted as the principal reason why hospital costs have gone up. One can't certainly conclude a statement on this subject, however, without alluding to the almost explosive introduction into the hospital field of the advances in medical care which have in themselves been almost equally important factors in increasing the cost of hospital care.

Mr. CARTER. What about the increase in costs in the materials which you use in the hospitals, equipment, for instance? Have they gone up very much?

Dr. CASELEY. All of these items have gone up at about the same rate that the wage rate of the economy in general has propelled upward in their manufacturing requirements.

Mr. CARTER. I should think they have gone up even more perhaps, the prices of the goods which you necessarily have to buy in hospitals,

in proportion to the services. It is true there is greater increase than that, the increase in the price that we pay for labor, and for the nurses, and so on. In that way I do think, I must say, that many of our nurses have been underpaid, there is no question about it, for the training that they have. They haven't received what they should have.

Thank you, Mr. Chairman.

Mr. VAN DEERLIN. Thank you, Dr. Carter. Mr. Brown, do you have very, very brief questions for the witness?

Mr. BROWN. Doctor, necessarily, as a junior member of this committee my questions must be brief because time always catches up with us and I think you are kind of in that same position as a late arrival witness.

This is the procedure that we have been following in this particular legislation. I have only two areas that I would like to pursue with you very briefly.

One is your opposition to the repeal of section 624 of the Public Health Service Act. Do I understand your feeling to be that this may give the Secretary of Health, Education, and Welfare too free a hand in the assignment of funds?

Dr. CASELEY. No. I think, sir, that the concern which we have had is that if there is one field which has been woefully underresearched and underinvestigated it has been the nature of the program design of the structures in which health care is given. This has been from a lack of the people competent to do the job and a collateral lack of funding for it.

We would prefer to see the emphasis on this identified and emphasized by retaining it as a part of the Hill-Burton Act, not in any sense decry the need for the other, but to hold it out as an identifiable area of its own.

Mr. BROWN. In your testimony on clinical laboratories and improvement of them you make a statement that:

> We believe that there is limited need for this provision as it applies to hospitals, in that most hospital laboratories do not engage in interstate commerce and that the great majority of such laboratories are fully competent.

Could you provide this committee with any statistical information or any study that would verify that comment?

Dr. CASELEY. It would require a reinventory of the quality control mechanisms which these laboratories have. I think our question here lay more in this area. The Joint Commission on Accreditation of Hospitals continually refines and upgrades the instruments by which they apply their standards.

The clinical laboratory is one of the elements which comes under scrutiny and, by their surveyors, gets special attention. They are continuing to upgrade that. Quality control is a very important item, but we note that there is an exclusion here of the laboratories which are operated by physicians and we believe that they likewise should be included in this act because it is in the smaller laboratories where there is a paucity of quality control, which is an expensive process in itself. It requires a large laboratory to justify a good quality control instrument.

We mean in smaller laboratories there is probably greater chance for wide variations.

Mr. BROWN. I am not suggesting that I necessarily doubt your comment in this regard, but if it is possible to provide some verifying data I for one would appreciate it and would like to see it.

Dr. CASELEY. We will endeavor to do so.

(Information requested follows:)

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS,
Chicago, Ill., May 29, 1967.

VANE M. HOGE, M.D.,
Assistant Director, Washington Service Bureau,
American Hospital Association, Washington, D.C.

DEAR DOCTOR HOGE: This is in response to your request concerning the standards of the JCAH as they relate to hospital laboratories. The clinical laboratory, being one of the principal services of the hospital, is the subject of careful review by the members of our survey team. All laboratories in accredited hospitals must meet the standards of the JCAH with regard to facilities, services, and the qualifications of personnel. In addition, the JCAH requires that all such laboratories be supervised by a physician who is a member of the medical staff of the hospital. Further, certain key policies required by the JCAH assure the maximum in protection for the patient. Such policies include the mandatory examination of all tissue removed in surgery, the routine checking of the calibration of special laboratory instruments, the role of the laboratory in infection control, etc.

Since the time of its creation in 1952, the JCAH has provided incentive and leadership in elevating the quality of care in hospitals and the service they provide. Consistent with this, its traditional purpose, the JCAH is presently undertaking a comprehensive review of its standards for hospital accreditation and it is expected that a revision will be published before the end of this year that will be even more stringent than those currently promulgated.

Sincerely,

JOHN D. PORTERFIELD, M.D., *Director.*

Mr. BROWN. I am glad that you comment on subsection (a)(2) of section 2. My own concern is with the problem of overcentralization of decisionmaking powers with reference to individual institutions and with reference to the States and it is interesting to me to note that you are concerned about the State having too great a power to determine what individual institutions should do.

Of course, I am concerned about the possibility of writing in an open-ended bit of business in this legislation which will allow the Federal Government to overwhelm the States with what their plan should be by having criteria which could be applied differently to different States, so I would hope we will have the opportunity to correct that in this legislation.

Mr. VAN DEERLIN. Thank you, Mr. Brown. Thank you, Dr. Caseley. The House has granted permission to resume the hearings at 2 o'clock this afternoon.

If an appearance late in the day is inconvenient to any of the three remaining witnesses, any of them would be welcome to leave a prepared statement for the record. Otherwise, the first witness at 2 o'clock will be on behalf of the National Association of Counties.

(Whereupon, at 12:05 p.m., the committee recessed to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Horace R. Kornegay presiding.)

Mr. KORNEGAY. The hearing will now come to order.

The first witness I would like to call to testify will be Mr. Robert P. Janes who is the chairman of the Board of County Commissioners, Hennepin County, Minn.

He is going to make a statement on behalf of the National Association of Counties.

Mr. Janes, I would like to take this opportunity to welcome you to the committee. We are grateful to you and your very fine national organization for the interest that you manifest for the hearings.

Thank you very much.

STATEMENT OF COMMISSIONER ROBERT P. JANES, CHAIRMAN OF THE BOARD OF COUNTY COMMISSIONERS, HENNEPIN COUNTY, MINN., APPEARING FOR THE NATIONAL ASSOCIATION OF COUNTIES; ACCOMPANIED BY C. D. WARD, GENERAL COUNSEL

Mr. JANES. I am real pleased to have the opportunity to participate in the hearings before this committee.

Before I begin I would like to just briefly mention that I have along with me sitting on my right, your left, Mr. C. D. Ward, who is general counsel for the National Association of Counties which you know is the voice of the counties in Washington and he will be assisting me today.

In addition to being chairman of the Hennepin County Board of Commissioners of Hennepin County, Minn., I am chairman of the National Association of Counties' Committee on Health and Education on whose behalf I am appearing here today.

The Comprehensive Health Planning and Public Service Amendments of 1966 and the proposed Partnership for Health Amendments of 1967 address themselves to one of the critical needs of our grant-in-aid programs; that is, an attempt to restructure them so as to simplify their administration and to maximize the utilization of the resources they make available.

The basic principle of combining related categorical problems is endorsed by the National Association of Counties and we urge its extension and expansion as a method of alleviating the torturous problem confronting local officials of being aware of approximately 400 different Federal grant-in-aid programs, their application procedures, their complex requirements, the confusion which exists up and down the line in their administration and the additionally complicating factor of there being nowhere near enough money to go around.

COMPREHENSIVE PLANNING

As of this date, there are something in excess of 40 Federal programs having to do with comprehensive planning of some sort or the other. Oftentimes separate "comprehensive planning programs" are carried out in the same locality with little, if any, coordination.

Unquestionably, the situation should and can be improved. It is our hope that the legislation you are considering today can be instrumental in doing so. As was pointed out in the Senate committee report accompanying S. 3008 last year, the act intends that the State health planning agency be the mechanism through which individual specialized planning efforts can be coordinated and related to each other.

The agency is also to serve as a focal point with the State for relating comprehensive health planning in areas outside the field of health such as urban development, public housing, et cetera. It is our view that

having the State health agency undertake this coordinating function is an essential element of the legislation. It is important to note that the law provides that the agency to do the State planning and coordination is an instrumentality of the State itself and is not a private nonprofit organization.

However, on the local level the legislation provides a serious dichotomy by providing that the comprehensive areawide planning may be done by an agency other than a public body, that is, a private, nonprofit planning agency.

We feel that this is a mistake, in that, rather than encouraging a coordinated approach, it facilitates the further fragmentation of our local efforts. No nonprofit planning agency has the capability to coordinate health planning with those other related functions outside the health field in that they will have neither the responsibility nor authority for them.

In the American county platform, the official policy statement of the National Association of Counties, we have long recognized the need and the desirability of relating the health programs with our other related activities of our local governments.

The preamble to our health and education section reads as follows:

> The National Association of Counties recognizes a broad definition of health and stresses the interdependency of the generally accepted health services with the other services rendered by the counties. It urges that the county health departments be involved in the planning and development of the health aspects of related services and programs. A list of some areas of concern, which should not be considered as all inclusive, is as follows: welfare, education, water resources, county planning, air pollution, water pollution, public works, jails, recreation, hospitals, economic opportunity, civil defense, mental health, sanitation and refuse disposal.

It is our recommendation that the Partnership for Health Amendments for 1967 add the following amendment to the project grants for areawide health planning:

> In the absence of substantial reasons to the contrary, all project grants are to be made to public agencies composed of officials appointed by and responsible to the elected officials of the local governments participating in such health programs.

In order to obtain the maximum benefit, health programs should be coordinated with one another as well as with many other programs being carried out by our general purpose units of local government. This can best be done by having the areawide planning carried out under the auspices of the local governments. This would in no way preclude the inclusion of representation from sources other than governmental on the planning body. We appreciate the fact that there are many factions, groups, interests, et cetera concerned with and responsible for health other than the local governments.

However, I think it is obvious that local government does bear the primary health responsibility as well as the responsibility of the other related programs previously mentioned. We are confident that in organizing any local planning agency, the local elected officials will obviously be concerned with and sensitive to representation from the appropriate consumer groups.

The law presently provides that on the State level, the State health planning council shall include representatives from a variety of in-

terest groups, notwithstanding the ultimate authority for their appointment being invested in an elected official, that is, the Governor. A similar type of advisory council could be provided for our public areawide planning agencies with the membership appointed by the appropriate elected official.

We are pleased to note the amendment now under consideration which would require 70 percent of the grants for comprehensive public health service to be spent for health services in local communities. We do urge, however, that this committee consider how this provision will, in effect, be implemented. Will the State plan of services provide merely that 70 percent of the funds be used within communities, with no regard to established local plans, including those developed through project grants for areawide health planning? Will it be possible to superimpose a State plan of services over a local plan?

The National Association of Counties strongly feels that an acceptable areawide, metropolitan, or local plan, particularly when carried out under planning funds authorized by this legislation, should be made a part of the State plan, thereby assuring the funds spent by the State for service in local communities will aid in implementing the plans developed by the local governments. We urge that the legislation make explicity clear that local plans approved by the State agency be incorporated into the State plan.

With respect to section 2(a)(2), we are in agreement with the objective of avoiding duplication of facilities and services. However, it would be our opinion that where an areawide health planning program exists, it would be more appropriate for it to develop a program for capital expenditure for replacement, modernization and expansion rather than having the State directly assist in such a program as is presently provided. The State would still retain a review of the local plan if they are included as an integral part of the overall State plan as we have suggested above.

In essence, if we are to have an effective coordinated comprehensive health program at the local level, the locally elected officials must have not only the responsibility, but the authority as well.

That concludes my formal remarks, Mr. Chairman. I would like to take this opportunity to thank you for the courtesies extended to me and I appreciate again the opportunity to appear before you with this statement.

Mr. KORNEGAY. Thank you very much, Mr. Janes. We appreciate your appearance here.

I would first like to call on another great Minnesotan, Congressman Nelsen.

Mr. NELSEN. Thank you.

I wish to thank the gentleman for his statement. I noted with a great amount of interest the recommendations that you make. Having formerly served on local levels of government in the State legislature, I am sure that you, as I, are encouraged by the trend apparently developing at the national level to recognize the merit in block grants to States with comprehensive planning under which the States assume a greater amount of responsibility and more freedom of action.

Under the suggested language that you propose here you again will harness still farther down the line more of the State personnel to do a better job to meet the needs of the people at all levels of government.

I compliment you for your statement and I think it has some very, very constructive objectives and would serve a very useful purpose.

Mr. JANES. Thank you, Congressman.

Mr. KORNEGAY. Mr. Blanton.

Mr. BLANTON. I have no questions.

Mr. KORNEGAY. Mr. Carter.

Mr. CARTER. I want to compliment the gentleman on his statement; I think it is very good. I liked particularly his use of local machinery to carry out this policy. I think it is much more effective and will be more effective than if we send people from Washington down there to see that the program was carried out.

I want to state that you have an outstanding representative, Mr. Nelsen. He is a member of this committee, a wonderful man. I just trust that you people in Minnesota appreciate him as we here do.

Mr. KORNEGAY. Thank you.

Mr. Kuykendall.

Mr. KUYKENDALL. I want to compliment you on your position paper and to repeat what my colleague Mr. Nelsen said about, I think, the healthy trend of our recognition as part of the Federal Establishment of the fact that not only you have a function and ability but I see an increasingly recognition that you may have a greater ability in these fields than any other.

This morning the distinguished Governor of West Virginia testified before this committee about something that bothers me in the future. I see this as a coming trend and I welcome it, but in my concern about the necessity of reciprocal action on your side it was mentioned that the matching funds obligation on your side is becoming an increasingly great burden.

Mr. JANES. That is correct.

Mr. KUYKENDALL. Do you see enough of an awareness on the part of the State legislatures as well as—well, in my county in Tennessee it would be called the county court; I don't know what you call it in your county—to be willing to face the taxpayers, to face the political ramifications of having to raise this money on the local level.

My question to you is, are you aware and do you see an increasing awareness of the fulfillment of this responsibility on your side?

Mr. JANES. Congressman, I can only speak for Minnesota because this is where I am familiar. Yes, I do see this in Minnesota. It is a tremendous problem facing all levels of government very frankly.

If I could just take a moment to perhaps comment again on the statement that you just made earlier, and that is that there is an increasing awareness of local governmental units, I think, to realize that they have responsibilities must have some of the tools to work with and that we are extremely interested in being able to work with all agencies, be they at the Federal or State level.

I think this is part of the purpose of this bill.

Mr. KUYKENDALL. That is all, Mr. Chairman.

Mr. KORNEGAY. Thank you very much, Mr. Janes.

Of course, it is always a pleasure to see you and the National Association of Counties. We appreciate very much your fine contribution to these hearings.

Mr. JANES. Thank you very much.

80-641—67——12

Mr. KORNEGAY. The next witness will be Dr. Thomas B. Turner, Association of American Medical Colleges.

Doctor, it is a real pleasure to welcome you to the Interstate and Foreign Commerce Committee. Dr. Berson, I believe, has testified.

Dr. TURNER. Yes. We are having him with us.

Mr. KORNEGAY. We are pleased to see you on this occasion.

You may proceed.

STATEMENT OF DR. THOMAS B. TURNER, DEAN, SCHOOL OF MEDICINE OF THE JOHNS HOPKINS UNIVERSITY, PAST PRESIDENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY DR. ROBERT C. BERSON, EXECUTIVE DIRECTOR

Dr. TURNER. Mr. Chairman, I am Dr. Thomas B. Turner, dean of the School of Medicine of the Johns Hopkins University.

As the chairman has noted, with me is Dr. Robert C. Berson, Executive Director of the Association of American Medical Colleges.

Our association represents all the accredited medical schools and a majority of the major teaching hospitals in the United States. I have been asked to express our appreciation for this opportunity to tell you our thoughts with respect to both the bill, H.R. 6418, and the "Partnership for Health Act" of 1966, which it extends and expands.

We have two things to say, gentlemen. We want to express our thoroughgoing and complete approval of the objectives and of almost all the content of the act and the bill.

Having done that, we will point out one serious flaw in the original act and in the present bill before us which could do serious damage to our schools of medicine and to our teaching hospitals, to their relations with the Government and to their ability to provide the doctors we need, a flaw which we believe reflects a confusion of terminology with potential results never intended by this committee or the Congress.

First, we are delighted to support legislation that aims at creating a much more effective partnership between the Federal and State and local units of government in the field of public health.

We agree that with few exceptions, State departments of public health have been woefully understaffed and underfinanced. The provisions of this legislation designed to enhance competence in those departments seem well planned to meet a longstanding need.

We agree, too, that comprehensive planning to meet public health needs on a statewide and local area basis is badly needed and that the fragmentation and imbalances created by a host of categorical grants-in-aid to State departments of public health can best be corrected through lump-sum grants with each State permitted to set its own priorities as regards its own public health problems.

We support State planned training of home-health aids and the establishment of home-health services.

We believe the provisions making possible an interchange of public health personnel between the States and the Federal Government to be imaginative and of great potential value.

All of those provisions were in the legislation enacted last year which this would extend and expand.

In addition to extending the life of Public Law 89–749, this bill contains three new provisions which our association also regards as very well worthwhile.

Certainly the quality of the services rendered by clinical laboratories is of vital importance to all our people. Currently, in many instances, it is far below—indeed dangerously below—what it should be. We support the provisions of H.R. 6418 designed to improve the performance of clinical laboratories.

Last year we strongly endorsed legislation passed by the Congress which made possible cooperation between veterans hospitals and community facilities and cooperative use of expensive equipment and talented manpower. This bill would make it possible for Public Health Service hospitals to similarly cooperate with other institutions, and that provision, too, has our strong support.

The section providing for research and demonstrations relating to health facilities and services seems to us highly constructive and important and has our strong support. There is urgent need for improvements in the effectiveness with which health services are delivered to people who need them and the efficiency with which facilities are designed and used.

But these are complicated matters and research, demonstration and evaluation of methods must be conducted with thoroughness and care. Universities, medical schools, and teaching hospitals, as well as other institutions and organizations can make important contributions if the resources are made available.

We assume that it is intended that these programs would be supported on their merits and potential national contribution, and would not be subject to the control of State planning agencies and we would urge that Congress make its intentions quite clear on this point.

With all these proposals, we are in hearty agreement and, in addition, we thoroughly approve of the provision authorizing grants to schools of public health. Like our own schools, these schools of public health—few in number—are undertaking to meet a vast national need. Graduates of each such school fan out to meet the needs not of any one State but of all the States and of the Nation itself.

As we interpret section 4 of the act, the Surgeon General will make these grants directly to such schools of public health as are undertaking to meet this national need. There will be no agency of any one State intervening to say "No." To say, "We have a more immediate and pressing need in our locality that takes precedence over the needs of our neighboring States or of the Nation." Such intervention would frustrate the will of the Congress, and we assume that it is not contemplated by your committee.

Yet the possibility of such intervention remains. And that, gentlemen, brings me to the one point where we must take serious issue with this legislation. Where we must urge you to amend both the act and the bill. Where we must ask for a very clearcut statement of Congressional intent in your committee's report.

The Senate acted first on what became Public Law 89–749. In reporting the bill, the Senate committee said, and I quote, "The bill would extend to public health programs the concept of comprehensive planning that has been effectively used in the Hill-Burton program, strengthen and improve the existing programs of grants-in-aid for

public health services, and provide Federal assistance to the mentally retarded and other handicapped children."

Having stipulated that these were the purposes of the bill and having stressed "public health services," the report went on to list some 13 activities carried out by State and local public health authorities which would be materially strengthened by the passage of the legislation.

The stress throughout the report was on public health activities. Traditionally public health activities primarily involved such things as control of contagious diseases; the sanitation of milk and water supplies; sewage disposal; the cleanliness of restaurants and food handlers; control of disease carriers; statistical reporting in births and deaths.

All such matters involve the invocation of the police powers of the State and local Governmental units. They come quite properly within the jurisdiction of State governments and certainly an agency of State government could make and enforce plans for the efficient discharge of such functions.

The same is true of controls over air and water pollution which similarly involve the police powers of both State and Federal Governments. Planning for these and for such newly developed public health functions as the operation of clinics, the administration of categorical health programs, and the distribution and nonduplication of quasi-public health facilities can quite properly be carried out by a single State agency.

But whereas the Senate report stressed public health needs and your House committee report referred to—I quote—"comprehensive health planning that would identify public health needs," unquote, the language in the act and in this proposed legislation goes far beyond what has been considered the realm of public health activities.

Specifically, the act authorizes one State agency to draw up comprehensive plans covering all health facilities and including all health manpower. And it contemplates having that one State agency set priorities which would determine which health promoting activities would be undertaken at a given time and which of a host of differing types of health facilities could be funded at a given time. Many States have designated the Department of Public Health as that agency. We repeat, gentlemen, that we consider this quite proper and obviously desirable as regards a State's public health activities and its public or quasi-public health facilities. It would not be at all proper, in our opinion it would be self-defeating, and would represent a great leap backward if State planning agencies were given the power to force their plans on institutions educating health personnel.

This is the point we would urge on you with all the power at our command.

We believe what we have to say applies to the education of all health personnel at the university level. However, our particular sphere of competence has to do with the education of physicians and the operation of teaching hospitals and we will restrict our testimony to that area.

It is most important that this committee understand the roles and the functioning of our schools of medicine and teaching hospitals, and indeed it is scarcely necessary to point out that the past history of

this committee and its actions amply demonstrates that you do understand this very thoroughly.

Most medical schools and many teaching hospitals are integral parts of universities. Those which are not have long histories of distinguished contributions to education in the health professions. We do not believe the State health planning councils could be expanded enough to include representatives of these institutions without becoming so large as to be ineffective.

Most importantly, each medical school and major teaching hospital, whether State supported or not, exists, at least in part, to serve our entire Nation. Each is located within a State but no one exists to serve only the needs of that State. Medical schools accept students and teaching hospitals accept interns, residents, and patients from throughout the Nation. After completing their training, young physicians serve in the Armed Forces, the Public Health Service, and settle in various parts of the Nation to serve the civilian population. And many members of the allied health professions are similarly mobile.

The idea that such institutions should be completely subject to control by a planning agency in the State in which they happen to be located simply would not work—that is, save to the great detriment of the United States

Ohio, for instance, is the home of some three medical schools with another being developed. Their graduates serve in countless States. Surely it is not the intent of the Congress to make it possible for a State planning agency to say that if perhaps two of those institutions would turn out enough physicians for Ohio, no Federal funds would go to expand the others until all of Ohio's needs for venereal disease clinics, drug addiction centers, for example, sewage plants, and other public health facilities of high priority for that one State had been met.

Surely that is not what this committee meant. Yet that is what this legislation seems to make possible.

Similarly, what of schools like those at the University of Colorado or the University of Minnesota, whose graduates provide many of the doctors for Idaho, Montana, North and South Dakota and other States without medical schools? What State agency in which of these many States shall determine the fate of these schools?

What of George Washington University here in Washington? Or Georgetown? Or Howard? Their graduates serve as doctors in dozens of States. Shall their futures be determined by the Department of Health of the District of Columbia? Surely you do not wish it so.

We could talk of many such cases of Harvard and Boston University and Tufts in Massachusetts which serve all of New England. Of my own Johns Hopkins, proud of its years of service to the entire Nation. Does anyone want or think our future should be subject to a temporarily appointed director of public health for the single State of Maryland, no matter how competent the incumbent might be at any particular time?

This, gentlemen, is the situation in which we now find ourselves.

It is a situation which we found somewhat alarming last year but concerning which we were unable to take proper counsel or make proper representations to you because of the unexpectedness with which, as you will recall, hearings were held, and their brevity. The Congress acted before we could react.

We were not too alarmed, because it had been our understanding that the proposed comprehensive plans to be drawn by the State agencies were to be of an advisory nature only.

Now we are alarmed. Now, we find that these State health planning agencies may have power to enforce their plans on all health serving institutions and to control the construction of all health facilities including apparently those essential to the functioning of medical schools and teaching hospitals.

Testifying before the House Ways and Means Committee on March 1 of this year, Secretary Gardner said, and I quote:

> We are recommending that where institutions participating in the Medicare program make capital expenditures that are not in accordance with statewide health plans, we would have authority to reduce reimbursements to the institutions or to terminate the participation agreement with them. This requirement can do much to strengthen state health planning.

I would only add that it would certainly strengthen it; it could make acceptance of the State plan compulsory!

Even more alarming to us are certain recommendations made in the recent report on medical care prices which we are advised are now administration policy.

One recommendation says:

> The Federal Government shall require that grants to State and local Governments for health purposes shall be spent in accordance with these plans and should deny funds for construction or expansion of health institutions which refuse to comply with the directions of the state or area-wide planning agency.

To us that language means that the funds this committee authorized under the Health Professions Educational Act and similar legislation to be granted to medical schools if those schools agreed to increase the number of their students could now be withheld even if the school were carrying out its contract with the Congress and the Federal Government.

They would be withheld if the school's plans to expand its educational facilities, its research facilities, its teaching hospital, or its animal care facilities did not happen to coincide in detail with a master plan made with only one State in mind and with the immediate public health needs of that State obviously taking priority over the long-range educational needs of other States and of the Nation.

Mr. Chairman and gentlemen, I am sure in my own mind that neither Secretary Gardner nor those who wrote the recommendations in the report had our university schools of medicine or their essential hospitals in mind when they made those statements.

I am certain that when this committee and the Congress passed the Health Professions Educational Assistance Act and urged us to plan to increase the supply of doctors by 50,000 just as quickly as possible, they did not intend that our plans for expansion would be subjected to control or interdiction by any single State agency or local community planning body.

Yet, unless you amend both the act and this bill, unless you clearly spell out your intent that State health planning agencies not have the power to enforce their plans on or withhold Federal funds from institutions engaged in the education of health personnel and the facilities essential to such educational pursuits, that is the position in which we will find ourselves.

We are not experts in legislative draftsmanship. It would appear to us that section 315(a)(2) of the act which sets forth the items to be included in a comprehensive State plan could have a provision added stating that "the education and training of college or graduate level health personnel and the provision or utilization of facilities used in connection with the training of such personnel shall not be considered as coming within the purview of the State planning agency."

A somewhat similar provision would seem needed in section 2(a)(2) of H.R. 6418.

Other amendments may well be needed. Certainly we would hope for a strong statement in the committee's report making it crystal clear that our medical schools and teaching hospitals are not to be affected by the operation of this legislation.

In conclusion, gentlemen, let me repeat that we strongly favor the enactment of all parts of this legislation, so long as the powers of enforcement of the State health planning agency are limited to grants for comprehensive public health services and project grants for health services development [sec. 314 (d) and (e)], for which a State agency may properly plan.

We believe in planning to meet health needs. We believe in the planning of health facilities. And we believe in planning for the education of the medical manpower this Nation needs—a subject now under consideration by the President's Commission on Health Manpower.

Should this committee believe that the planning of such education should at this time be made the subject of legislation, we ask that it take the form of a separate title or a separate bill; that the planning agency designated by national or regional; that the schools and hospitals we represent be consulted in its drafting.

Thank you very much, Mr. Chairman.

Mr. KORNEGAY. Thank you very much, Dr. Turner.

I would like to call on Mr. Nelsen for any questions he might have.

Mr. NELSEN. I think the point that you make is well taken and certainly something that needs to be cleared up. I have never given that a thought before but it is my guess that some of these programs that you cite here as being in jeopardy, in my opinion were not intended to be interfered with.

I may be wrong but I think this needs to be cleared up. Certainly we all recognize the tremendous need in the field of training of personnel in almost every area of public health—doctors, nurses, and particularly in the field of mental retardation where we have the title III provision for training of personnel to teach those who are retarded.

No matter how concerned we are about the problem, if we don't have the personnel to proceed with programs, the entire program breaks down.

I appreciate your statement and I am sure this will be thoroughly gone into with a resulting clarification of language that will be satisfactory.

Thank you.

Dr. TURNER. Thank you very much.

Mr. KORNEGAY. Mr. Blanton.

Mr. BLANTON. Thank you, Mr. Chairman.

Doctor, first of all I think your point is well taken and I admire your great university. I want to ask you a couple of questions.

This program has to be under the directorship of some agency or organization, but is it your opinion that it could better be administered from here in Washington than on the State level as far as the medical universities are concerned?

Dr. TURNER. If we are talking about the medical schools and not the comprehensive planning bill, the medical schools are great national resources and certainly they contribute to the States, obviously.

But they have meaning and a responsibility far beyond State borders and I think, therefore, that the planning has to be at the national level or at the most a regional level and not a State level.

Mr. BLANTON. Well, what you would anticipate from the State level would be discrimination from the State public health authority?

Dr. TURNER. I don't think it is a question of discrimination, I think it is a question of a point of view. Obviously a State agency would have its primary responsibility to the State. A medical school by legislation of this Congress and in all the thinking of the people of this country I think have a responsibility way beyond the borders of the State.

These two responsibilities at times may not be altogether in harmony and, therefore, I think it is in the national interest not to give a State planning agency a veto power over what an educational institution such as a medical school may do, may want to do in research or teaching or developing manpower.

Mr. BLANTON. You don't feel then that the State agency would have the time to spare to appraise the different programs of the university within their borders and work toward securing grants or funds for these progams?

Dr. TURNER. I think in many instances there would be a great community of interest and I can't imagine the planning agency in which the medical schools and universities would not have some input.

On the other hand, I don't believe a State planning agency could really be asked, each 50 of them, to see the national picture as I think it has to be seen because the medical schools are really the focal point in the manpower problem; for example, it is only going to be solved through these great university medical centers for the Nation.

Mr. BLANTON. Of course, you know that the national picture is made up of the bits and pieces that you speak of.

Dr. TURNER. That is right.

Mr. BLANTON. Is your fear the anticipation largely on the fund idea or on the direction of your programs?

Dr. TURNER. I would say on both. After all, a State has certain priorities and properly so. They have to and should be considering the immediate needs of the individuals in those States.

Now the medical schools have to take a broader view because they have to think in national terms researchwise and manpowerwise.

Mr. BLANTON. Again I want to thank you for your time.

I have no further questions, Mr. Chairman.

Mr. KORNEGAY. Mr. Ottinger.

Mr. OTTINGER. I have no questions, Mr. Chairman.

Mr. KORNEGAY. Dr. Turner, thank you for coming here to give us the benefit of your knowledge on the bill and raising this for us.

Let me ask you this. In the medical schools and hospitals have you run into any particular problems in the so-called hardship plan in which it is a regional plan proposition? Do you run into any problems? Some of these that have been suggested under this bill arise at the State and local level?

Dr. TURNER. I don't know of any problems that we run into on that legislation which after all is a regional concept in this legislation and it does not have the implied veto powers that this legislation seems to have in it at the present time. The regional medical program is a positive program and I am very optimistic about it.

As a matter of fact, I am retiring as dean on June 30 and they persuaded me to head up the heart disease, cancer, and stroke program in Maryland. I am very optimistic indeed that this can be a powerful and useful program that will reach down to the people of the State and region but there is an element of conflict here as I think you can see.

This is on a regional basis, the heart disease, cancer, and stroke, and this is on a State planning basis.

Mr. KORNEGAY. Well, the acts of someone insofar as planning is concerned, of course, you cannot fail to participate in the heart disease, cancer, and stroke program as a medical student; but you refrain from participating in that for which your funds from the Federal Government would be used in promoting the program.

I am not quarreling with you or disagreeing with you. I think you have raised a very interesting point. I am trying to analyze the two acts to proceed, where we are and whether or not you may not have some trouble down the road somewhere under the heart disease, cancer, and stroke raised in connection with this.

Dr. BERSON. May I make a point on this, Mr. Kornegay.

Mr. KORNEGAY. Yes, sir.

Dr. BERSON. I think there are two differences between these programs, the heart disease, cancer, and stroke, and the comprehensive planning bill that are significant to medical schools. One is that in the regional programs the mechanism for the very active participation of the medical school and of the hospital in the planning process along with a lot of other people has been written into the law and is being worked out and the relationship of that planning body is to a national advisory council.

There is not built into that system an official State agency that has authority and responsibility to enforce its plans. The active participation then is one of the very significant things.

We think it is going to be very difficult to set up a State planning agency for comprehensive health planning that can get the full participation of the institutions that are a part of our education without the advisory board getting so big that it could not amount to anything.

If there is not active participation, then you would not expect the plans to be very appropriate for the educational purpose.

Mr. KORNEGAY. Thank you.

Thank you, gentlemen, for coming and giving us the benefit of your testimony.

Dr. TURNER. Thank you for your courtesy.

Mr. KORNEGAY. The next witness is Dr. Alden N. Haffner.

STATEMENT OF DR. ALDEN N. HAFFNER, CHAIRMAN, COMMITTEE ON PUBLIC HEALTH AND OPTOMETRIC CARE, AMERICAN OPTOMETRIC ASSOCIATION; ACCOMPANIED BY WILLIAM P. McCRACKEN, COUNSEL

Dr. HAFFNER. Mr. Chairman and members, with me is the Washington counsel of the American Optometric Association, Mr. William P. McCracken, Jr.

Mr. KORNEGAY. Glad to have you, Mr. McCracken.

Mr. MCCRACKEN. Thank you, Mr. Chairman.

Dr. HAFFNER. I am Dr. Alden N. Haffner, executive director of the Optometric Center of New York, and chairman of the American Optometric Association's Committee on Public Health and Optometric Care.

Although most members of the committee are well informed about our association, some may wish to know more about its services to our Nation and to the profession of optometry. The information sheet titled "Facts About AOA" outlines the association's purposes.

Last October, Dr. Henry B. Peters, assistant dean and director of clinic, School of Optometry, University of California, testified before this committee when it considered the original "Partnership for Health" legislation, the Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89-749). The thrust of his statement was to assure that the "partnership" would appropriately include the profession of optometry and its institutions in the comprehensive statewide health planning proposed. At the time, the committee indicated that optometry would be represented in this type of planning, as the profession was not specifically excluded from the legislation.

Based on experience to date, it appears that statewide planning provided for in the "Partnership for Health" legislation has not as yet been undertaken anywhere in the Nation. There has been no sign of intent that optometrists will be invited to participate in planning. It is our bitter experience that unless Congress specifically names optometry in its legislation or in its legislative reports, members of our profession are rarely invited or permitted to participate in public health care activities.

The legislative history of the act now being extended is contained in House Report No. 2271 of the 89th Congress. Among other things, the committee said:

> It is recognized, however, that the ultimate responsibility for determining the type and character of health services to be provided is the responsibility of the individual states, so that the states may provide services in healing arts *in addition to medicine and dentistry.* (Italic supplied.)

Therefore, whether the State provides services in the healing arts or provides something else—it's something in addition to medicine and dentistry. Certainly optometry is something in addition to medicine and dentistry, but we do not believe the catchall phrase is sufficient to attract the States' attention. We therefore recommend that the legislative history on H.R. 6418 include the word "optometry" in the phrase "in addition to medicine and dentistry."

H.R. 6418 not only extends and improves Public Law 89-749 for comprehensive health planning, and provides grants to States and

regions for health needs identified through such planning, it also includes new subjects in which optometrists have considerable interest such as those sections that provide: cooperative planning between Public Health Service medical facilities and community health facilities to cope with health problems resulting from disasters; volunteer services in the operation of health care facilities and provision of health care; cooperative sharing and use of facilities, resources and services between the Public Health Service and other facilities in the health care community; and health care for Federal employees at remote stations of the Public Health Service.

It is our intention today to provide you with some information about optometry's role as an independent coordinate health discipline in relation to each of these provisions. A personal illustration from my experience may assist you to better understand how optometry can participate as a "partner" in community health.

The Optometric Center of New York is a unique institutional resource in the New York City health care community. There are similar, although newer and less-developed, optometric centers in the District of Columbia, Georgia, New Jersey, Michigan, Pennsylvania, Missouri, Colorado, and California. The Optometric Center of New York, a tax-exempt and non-profit institution, is a community facility providing the most modern care available in the visual sciences.

Our institution cares for four basic categories of patients: those referred to the Center by more than one hundred social service and social welfare agencies and institutions in the community; those referred by private practitioners; those referred by other patients; and of course children referred from the lower West Side Health District.

The Center's patients are from all social, educational, and financial backgrounds. Patients pay fees when and where possible. Prior to the introduction of the title XIX program in New York State, needy patients referred to the Center by social welfare and social service agencies received all care at no charge to either the patient or the referring agency. The Optometric Center of New York was among the first institutions in the community to endorse and participate in the title XIX Medicaid program, which through our institution, provides care of exceptional quality to thousands of disadvantaged persons.

The Center's staff is composed of more than 70 people of diverse disciplines, half of whom have skills in highly specialized areas. Because the Center has attracted to its professional staff the most talented and dedicated men and women, it has become a nationally known and widely used post graduate educational center in the visual sciences. It offers to various professions a regular series of clinical courses, symposia, seminars and conferences, designed to provide eye care practitioners from around the world with information concerning research findings and clinical activities related to their health disciplines. In addition, the institution offers residency programs to a selected number of graduate optometrists in specified clinical specialities.

Because of its strong academic background, the Center was chartered by the board of regents of the University of the State of New York, the provisional charter having been granted in January 1959, followed by an absolute charter in January 1964.

Through a grant from the Cuban refugee affairs program of the U.S. Welfare Administration and the U.S. Office of Manpower De-

velopment, the Center provided the additional academic training required by Cuban refugee optometrists so they could be eligible for optometric license examinations in the State of New York. This is an example of the educational potential of such an institution in our community.

The Center serves as a research resource. It draws upon the finest scientific minds to carry forth its program of visual science research, supported by both private and governmental agencies. A brochure titled "Visual Science Research—Optometric Center of New York," which describes many of the Center's grants for research, is submitted for your information.

The Center also serves as an information source on visual science. It maintains a very extensive collection of texts and journals in optometry, ophthalmology, perceptual psychology, and optical science. Its 8,000 texts and 18,000 periodicals are used for researching specific subjects by all health professions, social and welfare agencies, and by representatives of industry, news media—radio, television, and newspaper, scientists, and so on.

The broad level of professional care the Center offers provides a resource facility for the community, industry and various health professions. Major clinical departments at the Center include: General Optometric Care, Visual Training Clinic, Contact Lens Clinic, Sub-Normal Vision Clinic, Developmental Vision Clinic, Ophthalmology Clinc, Tonometry Clinic, Geriatric Vision Clinic, Pediatric Vision Clinic and so on. There are specialized units including Eikonometry, Visual Fields and Ocular Prosthetics.

As a result of its broad base in service, education and research together with its involvement with the Community, the Optometric Center of New York staffs and supervises the professional standards of vision care at the optometric clinics of the Gouverneur Ambulatory Care Unit of Beth Israel Medical Center in Lower Manhattan and the Medical Center of the National Maritime Union also in Manhattan.

The board of trustees and directors of the Center constitute a judicious mixture of lay and professional community leaders whose civic-mindedness has led them to service with the Center. As a result, the Center maintains an active interest in the health of the community and is frequently called upon to advise and otherwise aid on problems of groups concerned with various areas of community, industry, and health care activity.

I have taken time to describe the Optometry Center in New York, its activities and is relationships with other organizations in the community for a very special reason. I want you to understand that such a vision care center is highly specialized and its activities are limited strictly to the vision needs of the population. Because of its highly specialized nature, it is improbable that a State-level comprehensive health planning council would consider a vision care center to be a community resource in the same context as that of a hospital.

In view of the developing role of the vision care center and its services, we feel it is essential that optometry be specifically mentioned in legislative reports concerning H.R. 6418. Only in this manner can you be assured that a knowledgeable representative of optometry will be included on each State planning council, to explain the function

of a vision care center and to assist in integrating the optometric profession and its institutions into the overall health program of the State.

Members of this committee have already done much to bring optometry into the mainstream of federally directed or sponsored health programs and are probably more conscious than most leaders of the importance of vision to functional capabilities. There is a tendency at the State agency level, however, to ignore or remain uninformed about the importance of good vision in such vital areas as accident prevention, achievement in school, vocational productivity, and care of the aging, and so forth. I believe it will be necessary for Congress through its legislative reports, if not in the legislation directly, to stress the need for involvement of optometry in health programs, lest vision programs be lost in the battle for priority attention to other areas of health.

You are familiar with the Neighborhood Health Center programs now being developed through the Office of Economic Opportunity. A number of these centers are already in operation. Several more are in the process of being funded. Under this program, there is a family medical team composed of three persons, for every 1,500 family units. The captain of the team is to be a "basic adult health physician." His speciality will be either general practice or internal medicine. There will also be a pediatrician and a specialist in obstetrics and gynecology. If the population is large enough—say 30,000 to 50,000 persons—there will be several such family health management teams. They will refer cases requiring the services of dermatologists, orthopedists, and so forth, to such specialists in the community. Or, if the need for such speciality service is great enough, appropriate specialists will be retained on the Center's staff. In most instances, however, it is believed unlikely that such medical speciality needs will be large enough to warrant speciality staff positions.

It is known, however, that the optometric and dental needs of the population are so great that the health specialities of optometry and dentistry will have to be employed in these centers. At least 60 percent of the neighborhood population will require the regular periodic attention of optometrists employed as staff professionals.

In order to project the necessary total health services required by a community, please contrast the professional needs of neighborhood health centers with your knowledge of the involvement of optometry in planning for health facilities, resources, services and training required by a State and you will understand our association's concern that Congress call to the attention of the several States the need for participation by optometrists and optometric institutions in the planning process.

There is one area of Federal Public Health Service planning activity which our association wishes to compliment particularly and bring to your attention. I refer now to the Division of Health Mobilization.

I quote from the "Introduction" to the U.S. Government Printing Office brochure "The Role of the Optometrist in National Disaster":

> In 1963 the American Optometric Association established a Subcommittee on Civil Defense to study the potential visual needs of the population surviving a nuclear attack on this country and to develop plans to meet these within the framework of national survival programs. The Subcommittee, among other things, concerned itself with the provision of emergency priority optometric

services for individuals who are visually handicapped because of the destruction or loss of their corrective spectacles.

Two years of research followed and a disaster plan was developed, coordinated with the Federal agencies most concerned with emergency health services; the Division of Health Mobilization, Public Health Service, and the Office of Emergency Planning. Optical manufacturers were consulted regarding the assembly of an emergency visitation care kit equipped to provide corrective lenses for 500 people in a disaster situation.

Because of the involvement of the optometric profession in the planning by Federal agencies working to cope with health problems resulting from disasters, we are alert to the need and commend to this committee's attention provision for cooperation with States in emergencies as contained in H.R. 6418 on page 8, beginning with line 19.

It also appears to us reasonable and a proposition of commonsense that the Secretary of the Department of Health, Education, and Welfare should be empowered to accept volunteer and uncompensated services for use in the operation of a health care facility as well as in provision of health care as requested in the section of H.R. 6418, found on page 16, beginning with line 2.

It is as yet impossible for us to provide sufficient tax and philanthropic dollars to pay for all the health facilities and care required by the disadvantaged of our Nation. The spirit of voluntary effort among health professionals is a dominant drive to be protected and stimulated.

In a number of instances, however, there is a need to wed the tax expenditure with voluntary effort so as to provide a viable instrument for service. As an example, consider the East Bay Children's Vision Center of Oakland, Calif.

The East Bay Children's Vision Center developed from a demand by the local board of education for vision care of children who were unable to secure such care from any community, State, or Federal program known at the time.

A local landlord provided space for a center gratuitiously. The center was made a legal entity through the gratuitous service sof a local attorney. East Bay unions donated necessary partitioning, flooring, painting, and carpentry services. Optical equipment and ophthalmic supplies were furnished at no charge by local optical laboratories. Professional services were volunteered by members of the local optometric society.

The need was known; the community was responsive; yet—the project could have floundered for lack of funds to pay for such items as utilities, maintenance of building space, clerical help, and administrative supervision. Thanks to a grant from the Office of Economic Opportunity, funds were made available for these items and the Easy Bay Vision Center is today an important and necessary health resource for Oakland and neighboring communities and it is growing. The Center represents a good balance of voluntary effort, philanthropic endeavor, and wise investment of tax dollars.

It is with a sense of partnership and a desire for cooperation that members and units of the optometric organizational structure approach the proposals now pending before this committee in H.R. 6418.

We note especially that section on page 16 of the bill providing for a sharing between the Public Health Service and health schools, agencies, or institutions of facilities and services on a reciprocal or reim-

bursement basis. We protest the title "Medical Care Facilities and Resources."

We believe the term limits the "sharing" to those areas which are clearly medical—meaning solely within the field of medicine—as compared with "health" areas—meaning within the province of all recognized professions and persons concerned with total human health and well-being.

We respectfully suggest that lines 12 and 13 on page 16 should be changed to read "Cooperation as to Health Care Facilities and Resources" and line 17 be changed to read "Sharing of Health Care Facilities and Resources."

And, in the same vein—a desire to cooperate and be of service—we are concerned that the section found on page 19, beginning with line 11 titled, "Medical Care for Federal Employees at Remote Stations of the Service" is misnamed and should be corrected to read "Health Care for Federal Employees at Remote Stations of Service."

We also respectfully suggest that line 22 of page 19 be amended as follows: Insert a comma and the words "and optometric care" following the word "hospitalization."

Federal employees need and should be entitled to optometric care on the same basis as medical, surgical, dental, and hospital care.

In summary, we wish to state that the optometric profession is in agreement with the need for comprehensive health planning at each level of our social and political structure in order to provide more efficient, higher quality health care at reasonable cost and in a spirit of partnership among all elements of health resources and facilities.

From our prior experience we know that vision care and the optometric providers of service will be discounted or ignored unless Congress clearly indicates its intent that they be appropriately included.

Most of our actions each day are triggered or stimulated by God's priceless gift to us—the gift of vision. Our emotional and physical well-being are dependent upon the degree to which our visual capabilities are protected and enhanced.

Your consideration of the recommendations and amendments proposed in this statement will be appreciated and implementation of them will be a major step in assuring total health care, which we believe to be the intent of the Congress in passing this legislation.

Thank you for the kind attention you have given to my statement. If you have any questions, I will be happy to answer them.

Mr. OTTINGER (presiding). Thank you very much for your fine statement, Dr. Haffner. I am particularly pleased to welcome you to the committee as a representative from the State of New York.

It is very interesting to hear about your center for vision and your desire to see to it that the contributions in the profession of optometry are adequately included in this legislation.

I think some of your suggestions certainly can be met without any problem.

I have no questions.

Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

I have no questions but I certainly want to add my commendation to the gentleman for his fine statement and his efforts in this very

important field. Obviously as we consider the legislation that is needed it is necessary that certain things be clarified.

This always happens and I am sure there will be a more clear indication as to what the legislative intent and administrative intent are along the lines that you have suggested.

Dr. HAFFNER. Thank you, Congressman.

Mr. OTTINGER. Mr. Blanton?

Mr. BLANTON. I have no questions.

Mr. OTTINGER. Mr. Brotzman?

Mr. BROTZMAN. I have no questions.

Thank you very much for your testimony.

Dr. HAFFNER. Thank you.

Mr. OTTINGER. We appreciate your taking the time and trouble to come before us. We will give your suggestions very serious consideration.

This concludes the hearings scheduled for today on this legislation. The Chair regrets to announce that the hearings on this bill scheduled for next week will have to be postponed. The full committee will start hearings next Tuesday on House Joint Resolution 559 introduced today by Chairman Staggers which was requested by the President, dealing with the current threatened railroad strike.

The committee stands adjourned.

(Whereupon, at 3:10 p.m. the committee adjourned, to reconvene at the call of the Chair.)

PARTNERSHIP FOR HEALTH AMENDMENTS OF 1967

TUESDAY, JUNE 20, 1967

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

The committee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Harley O. Staggers (chairman) presiding.

The CHAIRMAN. The committee will come to order.

Today we are resuming hearings on H.R. 6418, which is the Partnership for Health Amendments of 1967.

Unfortunately, it became necessary for the committee to suspend these hearings on this legislation in order to consider proposals by the President to deal with the threatened nationwide railroad strike. I am sorry we had to inconvenience some of the witnesses who had planned to be able to testify before the committee over a month ago when we had to suspend these hearings so abruptly.

I hope this has not given hardship to any of the witnesses.

Our first witnesses this morning will be Mr. Donald Elliott, chairman of the New York City Planning Commission, and Dr. Howard Brown, health services administrator of New York City.

Would you gentlemen come forward to the table.

I want to welcome both of you and say we appreciate the fact that you are here to give us the benefit of your views on this very important legislation.

You may proceed as you see fit.

STATEMENTS OF DONALD ELLIOTT, CHAIRMAN, NEW YORK CITY PLANNING COMMISSION; AND DR. HOWARD BROWN, ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION OF NEW YORK CITY

Mr. ELLIOTT. Mr. Chairman, we thank you very much.

If it is acceptable, Dr. Brown will lead off and I will follow.

Dr. BROWN. I am Dr. Howard J. Brown. I am health services administrator for the city of New York. In this capacity I am responsible for coordinating the programs of all the official health agencies of the city of New York including the health department, department of hospitals, the mental health board, and the office of the chief medical examiner.

We are here to support H.R. 6418, which would amend Public Law 89–749, probably the most significant health legislation in our view recently enacted by Congress.

The city of New York wholeheartedly is in favor of this legislation, filed by you, Congressman Staggers.

80–641—67——13

Our only objection is that it does not go far enough in terms of appropriation for regional comprehensive health planning. We believe the authorized appropriations should be increased even more than this measure would do.

The need for more funds is obvious when one examines the commitment implicit and explicit in the Social Security Amendments of 1965, generally referred to as medicare and medicaid.

These social security amendments provide considerable financing for an improved level of health services, but they have also placed an increased burden on local health resources. It is now quite apparent to us that unless we plan the use of public moneys and health resources, we will not only fail to attain the desired effects of these programs, but may even lose ground because of inflation and wasted resources.

In fact, we are already seeing in New York evidence of excessive increases in costs without an appropriate increase in quantity or quality of health services for those who need them most.

You have seen figures showing the substantial increases in health care costs in the past year nationally. In New York City we feel these increases may continue unless adequate planning is undertaken.

One of the roots of the problem, of course, is that the manpower needed for health services is in short supply, and this shortage is most acute in the low-income areas of our city. I might say also in other large cities. We definitely feel that government has a great responsibility for the planning of health services.

In recognition of our sense of responsibility in this area we are proposing for New York City a health planning agency. This planning agency would be headed by the health services administrator and would include representatives of our human resources administration, the city planning commission, and Mr. Elliott is here with me, and other agencies involved with health services.

Under the reorganization which has been proposed by Mayor Lindsay and is being enacted, the health services administrator would be responsible for coordinating the city's health services under the administrative reorganization.

This agency, if the city council approves appropriate legislation, would subsume the various city agencies dealing with health services.

I would like to give two examples of the kind of planning we are doing which we feel needs to be expanded and strengthened. For example, in our borough of Brooklyn in the last 5 years we have had a great shift in the ethnic population with marked increases in the low-income children.

Our central city hospital in Brooklyn is Kings County Hospital which has become increasingly crowded. In the past year and one-half we surveyed the unmet needs for children's services in Brooklyn. It has become quite clear that we cannot meet them unless we use the combined facilities of our city hospitals, our department of health health centers, and our voluntary clinics and, indeed, in addition, open some group practice units to meet the need.

Without this kind of planning we cannot meet the need. We are moving to do this by converting our health centers which formerly gave only preventive services into treatment centers. We feel confident of some Office of Economic Opportunity grants which will enable us to extend some additional new programs and the city from its own

funds has written an expanded contract at Kings County, the large city hospital, to expand greatly the full-time staff carried for children.

This is one example of planning a mixture of resources to meet the needs.

Another example is in the area of mental health. We have developed for the city through the mental health board a service of community mental health centers. We have found under our new planning that if we combine these with our hospitals we will save greatly on the cost because we won't have to duplicate laundries, heating plants, kitchens, and that kind of thing.

In addition, we will give, we feel, better service. The whole experience of municipal government in the past number of years has been that health services cannot be maintained in a vacuum but must be related with other functions of the government and Mr. Elliott, who is the chairman of our city planning commission, wants to discuss this point with you.

In the plan we are proposing for our planning agency in New York City, we contemplate the appointment by the mayor of an advisory council to the health planning agency which would include representatives of major groups concerned with health, most significantly the consumer of health services.

We feel that the provision of your law is a most wise provision calling for consumer representation.

Our proposed health planning agency will need adequate staff to measure the community's health needs and to develop programs to meet these needs. It will also have to measure carefully the public and private resources—physical and human—available to tackle the problem.

Finally, one of its most important functions will be to evaluate programs to see if we are meeting our goals and using our money and resources wisely.

The magnitude of this job dictates a larger increase in funding than proposed by H.R. 6418. The funds which H.R. 6418 would authorize are not adequate.

We also strongly favor certain special provisions of the proposed amendment, particularly those assisting health care facilities to develop new plans and new kinds of facilities and those authorizing grants for research, demonstrations, and construction of hospitals and other facilities.

In health we have only begun to use automation and manpower innovatively. We need the opportunity to experiment with this. We also understand that Representative Ottinger will propose amendments called the Hospital Emergency Assistance Act of 1967 which will provide grants and loans to hospitals in need.

I can tell you that in New York City, and from my experience this is true in large urban areas, there is a major problem of hospital obsolescence.

Emergency rooms are generally overcrowded and inadequate. Many hospitals lack intensive care units. There is an urgent need to modernize X-ray facilities and laboratories.

We strongly support these amendments.

In conclusion, we feel that these provisions for comprehensive health planning are at present at highest priority for health funds.

The CHAIRMAN. I would like to say that we certainly want to thank you, Dr. Brown, for your testimony and coming from the largest city in the land we certainly will give a great deal of consideration to the fact that both of you represent the city of New York.

We will not have any questions until after Mr. Elliott has given his testimony.

You may proceed, sir.

Mr. ELLIOTT. Thank you very much.

My name is Donald Elliott. I am chairman of the City Planning Commission and Director of the Planning Department of the city of New York and I am here to join with Dr. Brown on this testimony because of the interrelationship in the overall planning of the city which health planning has and to impress upon your committee how strongly the city of New York feels about this matter.

I will not repeat what Dr. Brown has said but simply say that I agree with his testimony and endorse it.

We are not coming to say to you that we want Federal funds so that we can begin to plan our health services from a comprehensive point of view.

New York City has long been a leader in comprehensive health planning. About a decade ago the city administration recognized the need for an overview of health problems and an interdepartmental health council was established.

This interdepartmental health council, consisting of city agencies dealing with health problems, was in a sense the spiritual father of the health services administration which Mayor Lindsay hopes to establish.

Dr. Paul M. Densen has headed the program planning, research, and evaluation division of our health department. That whole division is another proof of our conviction that planning is an extremely important part of the overall work in the city.

New York State has also set up an interdepartment health planning agency. With proper financing, then, we in New York City should be in an ideal position to improve our health services.

At the city planning commission, we are producing the first comprehensive plan in the city's history. This proposed plan, which we expect to have ready early next year, will place strong emphasis on health services.

As part of our overall comprehensive planning process, and in working with the Health Services Administration, we have established certain major developmental goals for the city, and we have found that health services will be a major element in programs to achieve these goals.

I think examples of how this relationship of this planning works out is easy to see. Let me suggest that when we plan 6,000 new housing units that changes the whole balance of the need for ambulatory care facilities, for hospital beds as well as for other kinds of community facilities.

We are trying not to move any part of our program in one area of the city so rapidly that it throws out of balance the production of other parts of the city's work.

Our experience at the planning commission leads me to underscore what Dr. Brown said about government's role in comprehensive health

planning. It is inconceivable that this vital function could be fulfilled by an agency outside of the government.

Funds which H.R. 6418 will provide are essential if we are to achieve the desired health service goals. Without appropriate funding we cannot do an adequate job of comprehensive health planning.

Without comprehensive health planning the services we deliver will unquestionably suffer. Without improved health services we cannot talk realistically in terms of a great society.

In fact, we will not even be able to promise many of our low-income citizens a decent existence.

We thank you very much for giving us the opportunity to appear before this committee and we are hopeful that these amendments will pass.

Mr. Moss (presiding). Thank you, Mr. Elliott.

Mr. Kuykendall?

Mr. KUYKENDALL. Thank you, Mr. Elliott. I don't know whether this falls in line with the scope of your health-planning function on this proposed legislation, but first let me ask you this question.

I happen to feel that it is somewhat out of date that the rather bound-in conditions under which a locality may receive Hill-Burton funds. Hill-Burton is so lacking in specialization that it is not serving the function that they should.

In your planning, do you see any suggestion or any proposals that the Hill-Burton concept be modernized so as to be able to put money, in the more specialized type hospital?

Dr. BROWN. Certainly we feel that Hill-Burton grants need to be greatly expanded for New York City. Let me give you some measure of our problem.

The cost of replacing or renovating hospitals that are now obsolete has been estimated in New York City alone as $705 million and this does not include construction of psychiatric nursing home facilities.

We receive in the city only $2 or $3 million a year which, of course, is not adequate. The amendment that Mr. Ottinger proposes, as I understand it, which includes a combination of grants plus low-interest loans for those hospitals that are unable to raise the matching funds, would be most significant particularly for updating the hospitals in our low-income areas.

Mr. KUYKENDALL. I was going to ask you a question in this area but let me get back in just a moment. I haven't made myself clear.

I represent the city of Memphis, Tenn., which is by its geographical location a multistate city and we have had a recent request for a Hill-Burton grant for the enlargement of a children's hospital which specializes in open-heart surgery and related fields.

After the public solicitation raised $2½ million they were turned down flat because they didn't happen to fall under the old formula of just beds. This is what I meant when I asked, did you feel that the concept should be updated and modernized as far as getting more into the area of specialized needs and not just beds.

Dr. BROWN. If we use the question of specialized needs in a wide sense and include a wide variety of facilities. I am familiar with the fact, incidentally, that in Memphis you draw specialized cases from a considerable amount of the northern part of the delta area, Mississippi, particularly.

Mr. KUYKENDALL. We also have Missouri, Arkansas, and Kentucky.

Dr. BROWN. Yes. Because of the first-rate services you have there. I think certainly, if this is combined with the kind of planning we are talking about in this legislation. In some large cities we have had the problem that we have built too many open-heart surgery facilities and this has been a problem in New York City.

On the other hand, we have not built enough extended-care psychiatric and neighborhood health clinics. I think what we have to allow each area to do is to develop a plan which would involve the most balanced use of facilities and in that sense I would agree with your comments.

Mr. KUYKENDALL. Now, I am very sorry, Mr. Chairman, that we don't have copies of Mr. Ottinger's amendments in front of us. I am impressed by what Mr. Ottinger seems to have proposed. Would you tell me whether or not there is ratio or how the determination between loans and grants is arrived at?

Dr. BROWN. As I understand it, two-thirds can be a direct grant. If a voluntary hospital cannot raise the remainder, they can have loans up to 90 percent of the remainder at 2½ percent interest.

Mr. KUYKENDALL. What is the determining factor as to how much of the need is a grant?

Dr. BROWN. I am sorry. I am not familiar with that. Let me say that in New York City we see an increasing problem with voluntary hospitals and many good ones that we wish to strengthen, particularly those that have been left behind in the low-income areas being able to raise funds for expansion which is leading to an increasing necessity for the government to step in and build hospitals.

This kind of grant-plus loans proposed by Mr. Ottinger would, I think, be a great way to capitalize on the voluntary resources.

Mr. KUYKENDALL. You stated my question. Yet I am still not quite clear.

Dr. BROWN. I am to get a copy of the amendment this morning. I don't have it with me.

Mr. KUYKENDALL. I do not want to discourage the private participation of private capital. However, I realize that you might need practically a 100-percent grant in one neighborhood and in another area the people might be fully capable of raising the 75 percent of the money.

I am hoping that this legislation does have a flexibility that would not discourage private participation.

Dr. BROWN. I have just received the amendments. From a quick look it would seem, as I look at it, it does give that flexibility. For example, in New York City, in our low-income areas and some of our particularly sectarian hospitals, they would have a great difficulty in raising more than 10 to 30 percent of the cost, although, of course, they operate with great efficiency and effectiveness.

On the other hand, we have hospitals that are more richly endowed that could certainly raise a higher percentage. It seems roughly looking at it it would allow that.

Mr. KUYKENDALL. I would hope that it did.

Thank you, Mr. Chairman.

Mr. MOSS. Dr. Brown, do you see any conflict between your planning for the needs of the city of New York and the State planning, which was authorized under Public Law 749 in the last Congress?

Dr. BROWN. We feel that the State plan and the agency plan announced by Governor Rockefeller will complement our planning. We obviously have to have a very close relationship with the State planning.

Considerable funding flows through the State. Many of the standards for both facilities and care given are promulgated by the State. I see a natural relationship between the plan which they have promulgated under the provisions of the legislation and the plan we are proposing for New York City. They do complement each other.

Mr. MOSS. In other words, there is a close liaison and coordination between your planning and the planning for the State of New York?

Dr. BROWN. Yes. To be specific, we have had with the official State agencies meetings virtually every 2 weeks, and indeed tomorrow we are having lunch with the State health commissioner and his top staff on this very issue, and our planning has been closely coordinated.

Mr. MOSS. If the amendment which will be proposed by Congressman Ottinger of your State should be adopted, do you have any estimate of the immediate urgent needs of the city of New York?

Dr. BROWN. I am pondering a bit over the words "urgent" and "immediate."

Mr. MOSS. I believe that the Ottinger amendment would be aimed at taking care of the construction of emergency facilities in the areas. The gentleman is present now. I defer to him for a general outline of what he has in mind in the amendment.

I understand that you are apparently working on an amendment for inclusion in H.R. 6418. In the amendment are you talking only of the emergency needs or the need for emergency facilities?

Mr. OTTINGER. Mr. Chairman, I am delighted to welcome these witnesses. Mr. Chairman, the objective of the amendment is to try to supply funds immediately and directly to meet the emergency needs of hospitals that are in critical condition. It is undertaken with the realization that in this time of financial stress in the country we cannot undertake a large building program to try and meet the overall needs of the entire country for increased hospital facilities, facilities including buildings and equipment and all of the complex paraphernalia that goes with hospital service, but that we would not be doing justice in terms of a comprehensive planning endeavor if we were not to recognize that there are immediate critical needs in the hospital field. If we fail to meet those needs, the planning exercise really would become meaningless.

This is the intent of the amendment, to provide an immediate input to meet the critical needs of the hospitals that are so short that they have to place patients with really serious problems on long waiting lists, or keep them waiting in corridors for very serious lengths of time before they can receive treatment. These things are happening in many hospitals today.

We have hospitals in my county where they actually have to have beds in the halls because there are not sufficient facilities at the present time to be able to accommodate the patients with emergency problems.

The amendment is designed to overcome those critical needs.

The Public Health Service did a survey last year of hospitals throughout the United States and found that some 143 hospitals were in critical condition. It was geared to this Public Health Survey that we set our own demand to meet this emergency need.

Mr. Moss. Will the gentleman yield?

I asked for the estimate of cost under the conditions stipulated by Congressman Ottinger because the study which the Hospital Review and Planning Council made 2 years ago showed a need then for modernization of hospitals in New York City of three-quarters of a million dollars.

Dr. BROWN. Yes.

Mr. Moss. Now, would you characterize that as the urgent need or is the urgent need a lesser figure, recognizing that there have been changing conditions in the intervening 2 years?

Dr. BROWN. I am, I suppose, faltering over the word "urgent." Certainly, if you were in New York and I were to take you on a tour of our hospitals, including our crowded and inadequate X-ray rooms, our psychiatric facility which has at Bellevue beds wall to wall, and our emergency rooms which are uniformly crowded beyond any level of human acceptability, I think you would agree certainly that $100 million is "urgent."

Now, at what point between the $100 million and the three-quarters of a million dollars that the Hospital Review and Planning Council has decreed necessary to replace and renovate, I think, would be a matter of definition.

Certainly, there are some critical areas in which we should be able to move fast. I would pick our emergency rooms as an example. Increasingly our low-income areas are being abandoned by physicians and these emergency rooms become the family doctor for 300,000 to 1 million people.

Mr. Moss. If we were to hold this record open at this point, how long would it take you to give us a more carefully considered figure?

Dr. BROWN. We could give you that within a matter of days.

Mr. Moss. I ask unanimous consent that the record be held open at this point to receive that figure.

(The information requested was not available at time of printing.)

Mr. Moss. Now, I am happy to yield back to the gentleman from Tennessee, Mr. Kuykendall.

Mr. KUYKENDALL. Mr. Ottinger, we were discussing the amendment before your arrival. I am sorry that I have not had a chance to see your amendment. I am sure everyone thinks that his problem is an emergency compared to everyone else's.

Have you attempted in the amendment to set up any sort of criteria or have you selected an agency to determine "emergency situations" and secondly, the degree of emergency?

Mr. OTTINGER. Yes. The Secretary of Health, Education, and Welfare is to make the determination according to very clear and specific standards spelled out in the legislation.

We have been working with the Public Health Service to define those standards as accurately as possible and practicable. Obviously, you can draw these standards with the current state of hospital facility shortages in the country in a great many different lines.

You can end up with a multibillion-dollar program or a more modest program. In view of the widespread and urgent need it is hard to draw hard lines, but in view of the financial pressures upon the Government at the present time we just had to come up with standards that would enable us to meet only those truly critical conditions that presently exist.

There is the long-range planning effort. The Surgeon General, when he came up here, expressed some reservations about investing substantial amounts of money in further hospital facilities before the completion of planning.

I don't think we can allow the present critical condition that we see in many parts of the country to slide while the long-term planning effort is completed.

I think the health, welfare, and safety of the Nation demands that there be a compromise at some point. I think we are going to have to meet the truly emergency conditions of the hospital facilities where they exist at the crisis level in many parts of the country while we work to see that the planning effort catches up, as the less critical backlog. This way we will be able to make a long-term investment in hospital facilities in cooperation, of course, with the States.

The problem of exactly where you draw that line is a difficult one. We did circulate to each member of the committee a copy of the original bill and a section-by-section analysis and since that time we have been working out with the Public Health Service more precise standards of precisely the field that you have been talking about.

I hope to have that before the committee in the next day or two.

Mr. BROTZMAN. Will the gentleman yield?

Mr. KUYKENDALL. Yes.

Mr. BROTZMAN. I would like to ask the gentleman a question.

Do I understand that your amendment is an amendment to the measure under consideration or is it to the Hill-Burton Act?

Mr. OTTINGER. It is an amendment to the bill that we are presently considering.

Mr. BROTZMAN. H.R. 6418?

Mr. OTTINGER. That is correct.

Mr. BROTZMAN. I thank the gentleman.

Mr. Moss. Mr. Rogers, would you like to withhold for the moment?

Mr. ROGERS. Yes.

Mr. Moss. Mr. Kornegay?

Mr. KORNEGAY. Mr. Chairman, I have no questions for the gentleman at this time.

Mr. Moss. Mr. Harvey?

Mr. HARVEY. No questions at this time.

Mr. Moss. Mr. Van Deerlin?

Mr. VAN DEERLIN. No questions.

Mr. Moss. Mr. Stuckey?

Mr. STUCKEY. No questions?

Mr. Moss. Mr. Brown?

Mr. BROWN. No questions.

Mr. Moss. Mr. Ottinger?

Mr. OTTINGER. Mr. Chairman, I apologize for being late. I was delayed on a plane coming from New York. I would like to again welcome Dr. Brown and Mr. Elliott and thank them for the support they gave my amendment in my absence.

I wonder whether you have any advice for us, since your experience is certainly vast and important and in a very big context. In terms of meeting the Nation's health needs, where do you think that the line might be drawn to tackle the most critical problems that you face?

Would you draw the line in terms of occupancy as the Public Health Service did in its survey last year, or can you think of other standards that might be applied to get at your most critical needs?

Dr. BROWN. I think you should allow for variation from community to community. Bed occupancy certainly can be a factor. Our voluntary and proprietary hospitals in New York City have been running this last year at 95 percent net occupancy. This represents in part a shift from our city hospitals largely under the choice possible under the social security legislation.

We are concerned about next winter in terms of bed occupancy in our voluntary proprietary system. We do have an outlet in our city hospital beds many of which are, however, in obsolete and unacceptable facilities so that expansion of some of our voluntary facilities would be of critical importance in terms of beds.

For the large urban areas one of the highest priorities based on my experience across the country and this is true in New York City, is the expansion of clinics and emergency rooms.

In New York City, for example, each year for the last decade we have had a steady expansion in visits to these facilities so that they are now serving many times the number of people that they were designed for and these for low-income people are the family doctors at night, weekends, for their sick children and their sick grandparents.

They are presently indecently crowded. If these are not expanded rapidly, we could well see an undue expansion of fee for service practice which I think would be inflationary.

For both prudent physical management and high quality of care, I think in New York City this kind of thing would be of great urgency.

Mr. OTTINGER. Thank you very much.

Do you have anything to add, Mr. Elliott?

Mr. ELLIOTT. No, except to emphasize the question of flexibility. I think the amount of money which will be available on whatever terms is decided is not going to be adequate to the task.

We are pouring our own resources in in as great a quantity as we can and I think it is important that if the amendment is passed that it be administered in such a way that the needs of the localities can be sensitively approached and that we don't run into a series of arbitrary standards which might have national significance but would simply not be apropos in any particular community.

Mr. OTTINGER. Thank you, Mr. Chairman.

Mr. Moss. Mr. Rogers?

Mr. ROGERS. I have read your statement, Dr. Brown, and Mr. Elliott, and I see that you do endorse that the bill has a very serious part to play in the delivery of health services, particularly in the urban areas.

Now, what relationship would your planning council anticipate having with the State planning group?

Dr. BROWN. We have been working very closely with the planning agency which the Governor of the State has created by executive order. It is an official agency including the health department and the mental health services and similar State agencies.

We have been in weekly contact with them as we are developing our proposed plan for New York City. I would think they must have a

very close relationship because considerable funding under title 19, for example, flows through the State.

In our own State, hospital standards are regulated by the State. These are examples. We, for example, will propose that the regional health commissioner for the State be on our planning agency to assure the coordination.

Mr. ROGERS. Everyone talks about the increase in cost of delivering health services. I know you say that the manpower is the main cost. Did you say that in your statement?

Dr. BROWN. I think there are several factors that are causing the rapid increase in costs this year and the projected increase for next year.

One is, of course, the shortage of all levels of health manpower. This is particularly acute in low-income areas throughout the country, urban and rural, where the shortage is greater.

There is an interesting fact about this that I might relate about New York City. In New York City we have enough doctors by any standards one might use. We have one doctor for 450 people.

However, we still have a shortage in our low-income areas unless we go in and organize hospital-connected plans because the doctors don't want to practice there privately, illustrating the need for planning.

One way that we could combat inflation in my judgment would be to modernize our hospital plant. For example, I know of no industry that would use high-priced talent like doctors to write out everything they do rather than dictate it.

We have only begun to use automation and efficiency in our hospitals. I think that essentially doing this, modernizing our plant, would be noninflationary. In addition, with the rapidly rising costs of hospital care, and you are familiar with the rapid escalation this year and that proposed for next year, alternative facilities need to be developed such as nursing homes, extended care, and we think more diagnostic facilities which will reduce the number of hospital days and in that sense keep the total bill down.

Mr. ROGERS. Then you would anticipate that your planning council would make these recommendations? Of course, we have programs now to build nursing homes and so forth. We also tried to encourage programs for increasing health personnel.

Have you seen any effect that this legislation has had?

Dr. BROWN. Certainly we are using the legislation for manpower training to develop personnel. We have a number of grants in New York City.

Let me respond to the earlier part of this. One of the most expensive parts of health care is general-care beds and these are very popular with people who want to give money. So you need a planning effort to construct the alternatives such as nursing homes or to plan and see that they are constructed rather than leaving it to the free forces in the community.

Simply financial incentives alone without planning won't do it in my judgment.

Mr. ROGERS. Now, it is your thinking that nursing homes should be built in conjunction with hospitals?

Dr. BROWN. Oh, I strongly feel they should.

Mr. ROGERS. And be a part of them, except they would be a cheaper way of delivering the care?

Dr. BROWN. Absolutely; they should be related to the hospital for several reasons: First of all, it favors the rapid transfer; it favors efficiency in the sense that you can use common X-ray laboratory and other facilities and also a common staff.

Mr. ROGERS. I think this has been one of our problems in many areas of the country. The nursing homes have been so far divorced from the medical centers that they had to duplicate so much of the equipment and manpower.

Dr. BROWN. Yes.

Mr. ROGERS. What is your greatest shortage in manpower in New York? You say you have enough doctors? It is simply a question of the placement of them?

Dr. BROWN. We have a great shortage of nurses and our shortage of nurses in New York City is greater than in the country as a whole.

Mr. ROGERS. Could you give us a statement of what this shortage might be?

Dr. BROWN. In our city hospitals, and we have 21 city hospitals in New York, less than 25 percent of our nursing positions are filled.

Mr. ROGERS. Less than 25 percent are filled?

Dr. BROWN. In the voluntary system in New York City about 70 percent are filled. In our public health nursing services of the health department, slightly less than half are filled.

Mr. KORNEGAY. Would the gentleman yield at that point?

Mr. ROGERS. Yes.

Mr. KORNEGAY. Doctor, what sort of recruitment program, if any, do you have in New York for nurses at this time?

Dr. BROWN. We have had a national program for our city hospitals. We certainly do all we can to recruit locally. We are expanding in conjunction with the city university in nurse training programs in the city system in both the associate and baccalaureate degrees.

We are also setting up with the city university a health career institute to train other levels. Interestingly, one of our problems in nurse recruitment in our city hospitals is that some of our plants are so obsolete that nurses are not happy working there and far prefer the far better facilities in the voluntary system which is one reason that we are very eager for Mr. Ottinger's amendment to pass.

Mr. KORNEGAY. If the gentleman will permit one other question.

Although the committee recognizes the great national shortage of nurses, can you assign any reason to the fact that your doctor-patient ratio is very favorable when compared with the national and yet your nurse ratio is way down?

Is there any reason to which you can ascribe that imbalance?

Dr. BROWN. I can only guess. We have had a substantial influx of foreign-trained physicians into New York City. Well over one-third of all of our doctors were trained outside of New York City.

Mr. KORNEGAY. England, Germany, and those places?

Dr. BROWN. Yes. We had a large influx in and around the thirties of Jewish physicians. New York State has traditionally been more liberal in licensing foreign-trained physicians than other States. This is one thing.

Secondly, we have seven medical schools in the city. A substantial number of physicians stay. I can't quite explain why our nursing ratio

per 100,000 population is one-half that of upstate New York. I can only guess at the reasons for that.

Mr. KORNEGAY. Thank you very much.

Mr. ROGERS. Do you have any diploma schools of nursing?

Dr. BROWN. Yes, we have a substantial number. I can't recall the exact number but we certainly do.

Mr. ROGERS. Are any of those contemplated to be phased out or do you plan to increase these schools?

Dr. BROWN. We in the system, the city system, have a plan of converting our diploma schools to associate degrees, the 2-year programs and 4-year programs.

We feel that this will improve recruitment in nursing and our previous experience would indicate that this is the case. Also, we look forward in the city system, because of the great shortage to nurses actually being supervisors with practical nurses and specially trained aides providing most of the direct patient care; hence, some emphasis on baccalaureate programs.

Mr. ROGERS. What would you estimate in your survey of the situation would be the moneys necessary to bring your hospitals to a proper condition?

Dr. BROWN. In New York City we have studies that show three-quarters of a billion dollars for the voluntary and city hospitals both.

Mr. ROGERS. What budget do you have in the city to improve your hospitals?

Dr. BROWN. We have a capital budget from city funds over the next 5 years of slightly over $500 million and I might point out that this is almost virtually entirely city funds.

Mr. ROGERS. Do you get any money from the State?

Dr. BROWN. No direct State funds except there are mental health construction funds both from State and Federal governments.

Mr. ROGERS. What do you anticipate from the Federal Government? Are there plans to ask for any specific amount?

Dr. BROWN. We, of course, get some Hill-Burton funds for the city but these are not significant and are largely used in the voluntary sector.

I indicated earlier and was requested to prepare a specific request should Mr. Ottinger's amendment pass. I would suggest that we could legitimately, however, in both the voluntary and city hospitals request all of the amount that I have heard.

Mr. ROGERS. Thank you very much.

Mr. MOSS. Mr. Keith?

Mr. KEITH. No questions, Mr. Chairman.

Mr. MOSS. Mr. Brown?

Mr. BROWN. I would like to ask a question, if I may.

Doctor, you commented on the fact that you have more physicians in New York City than in most other places in the country on a per capita basis but you still have difficulty getting them to practice in the low-income areas. Do you have any positive suggestion on how this might be accomplished?

Dr. BROWN. Yes. You think we have attributed this shortages of physicians in low-income areas either to shortage of doctors or low income. I don't think either is the basic reason.

It seems to me that if we intend to deliver health services to all in-

come levels local government is going to have to take an active role in setting up group practice centers in these low-income areas.

This might take the form of a prepatient plan such as you have in Cleveland or it might take the form of the neighborhood health centers that we are building in our low-income areas in New York City.

I do not think that simply paid fees will attract doctors to low-income areas.

Mr. BROWN. Since Cleveland is not in my district, would you explain the prepaid plan?

Dr. BROWN. There has been in Cleveland, and I am not as familiar as I should be with the details, a comprehensive plan by which through payment capitation, so much per person per year, complete services are provided by a group practice unit.

Mr. BROWN. This is paid by whom?

Dr. BROWN. This, at the moment, is paid by employers under union agreements. I have spent most of my recent life in low-income areas and planned the neighborhood health centers for the Office of Economic Opportunity across the country.

In my judgment, the reason that doctors do not want to practice in solo practice in low-income areas is that the completion of complicated medical plus social problems cannot be handled well by a solo doctor in his office.

On the other hand, if you set up a group practice unit or health center, which is connected with hospitals, this provides the scientific resources and with the social workers, public health nurses, or trained nonprofessionals, you can provide the necessary help for social problems that are almost invariably connected with health problems.

Mr. BROWN. When you refer to company paid plans in union areas you are not referring to the lowest income areas, I gather, are you?

Dr. BROWN. No. I think what we are going to have to do in our lowest income areas, particularly in the large cities, is to take the initiative in setting up these connected with hospitals and this will be particularly important so that the title XVIII and XIX fund will be used both to secure high quality of care but also with a sense of physical responsibility.

Mr. BROWN. Are you suggesting that this is a combination problem then, in fact, in the lowest income areas wherein public funds are going to have to be used to guarantee the doctors an adequate or comparable remuneration for a more complex practice.

Dr. BROWN. Let me say it is only partially a matter of guarantee of an equivalent income. A low-income practice can be quite lucrative because very often low-income doctors see large numbers of patients for short visits.

The more important thing is providing a setting in which they can practice good medicine.

Mr. BROWN. When you describe the situation you just mentioned, are you talking about single practice?

Dr. BROWN. In low-income areas I do not think we will attract physicians unless we set up these new neighborhood health centers.

One example is in Watts where the University of Southern California has set up such a program and has indeed attracted very good doctors.

In our South Bronx which is a low-income area we are able to attract well-trained young physicians who work on salary in our hospitals

and medical schools in neighborhood centers but we cannot attract these same doctors to open even a solo office even though their income might be larger in solo practice.

Mr. BROWN. Is it your suggestion, then, that it is a combination of professional problems and economic problems?

Dr. BROWN. Yes.

Mr. BROWN. And where you have the group practice the economic problem is met in what way again?

Dr. BROWN. By collecting the fees under title XVII and XIX or by adopting capitation arrangements; that is, paying so much per person per year you can provide——

Mr. BROWN. Who pays this?

Dr. BROWN. We can use title XIX funds to pay capitation and indeed one of our hospitals in Brooklyn has set up a plan in which under capitation arrangements so much per person per year they guarantee to provide complete care.

In this instance, title XIX funds are being used. On the other hand, we have——

Mr. BROWN. These are totally Federal?

Dr. BROWN. Title XVII, as you know, is a mixture of Federal, State, and local. There is a very important point and it bears on this whole amendment. Really to attract care to the areas that do not have it such as the low-income areas of the country—and I observed this in other large cities besides New York—we are going to have to plan programs. They simply will not be attracted by fees alone.

Mr. BROWN. And the anguish we have before us deals with this to the extent that it provides funds for the local government?

Dr. BROWN. It provides money for plant and a very important provision is that it also provides money for demonstrations and innovations which will certainly be needed to change the character of practice in the areas that you were concerned with in the Social Security Amendments of 1965.

Mr. BROWN. Thank you.

Mr. Moss. Mr. Keith?

Mr. KEITH. I have no questions.

Mr. Moss. Dr. Carter?

Mr. CARTER. I am interested in the shortage of nurses in your area, doctor. What is the average monthly salary of a registered nurse in New York City?

Dr. BROWN. In the city system our nurses start on the day shift at $6,200 and on the 4-to-12 shift and night shift it is $7,300. The voluntary hospitals start at about $6,400 and go to $6,600 on the day shift and tend on the other shifts to range around $7,500 to $8,000.

Mr. CARTER. Do you have any complaints from nurses concerning their wages? Do they think they are adequately paid?

Dr. BROWN. Well, I don't think any one ever thinks that his wages are adequate. However, the bigger complaint of our nurses in New York City is the obsolete plant in which they must work. That is one of the biggest complaints which is why I lay such great emphasis on rennovating and updating the hospital plant.

Mr. CARTER. They complain more about where they work than for what salary they work? Is that right?

Dr. BROWN. Yes, clearly.

Also, a frequent complaint which we are trying to remedy which I should emphasize is being asked to do nonnursing duties. Historically, as you know, in hospitals nurses have filled in every chain. If a floor needed mopping or the diet trays were not delivered, nurses have been disciplined and pitched in.

Now, we have to stop this and our plans for next year in the city hospitals include greatly strengthened numbers of nonprofessional personnel.

Mr. CARTER. Nurses have been doing such things as mopping the floors?

Dr. BROWN. I said historically. In the most recent years to my knowledge nurses have not been doing that in our city hospitals.

Mr. CARTER. Certainly, I think it would be a waste of talent if they did and certainly a great misdirection. It is my opinion that something must be done and if this takes renovating the hospitals, of course, that should take place because we must have more nurses.

The problem is not just unique to New York City but occurs all over the country.

I am wondering how much of this dissatisfaction with practice in some of your impoverished areas is due to just the undesirable condition which exist there.

Dr. BROWN. I think there are several factors. We have inherited some quite obsolete plants in our city hospitals. I might say it is comparable to the city hospital problem across the country.

I have been through all the large cities. Secondly, I think there is another factor: Nursing low-income patients is much more demanding than high-income patients and the reason is that they tend to have such complex social and other problems.

One factor in urban areas which I think will help the distributions mixing up much more the income levels so that a nurse would have a mixture rather than solely the low-income patients and, of course, it will be possible for us to do that in New York as we develop the title XVIII amendment.

Mr. CARTER. Thank you very kindly.

Mr. BROWN. Mr. Chairman?

Mr. MOSS. Mr. Brown?

Mr. BROWN. May I ask one more question?

Mr. MOSS. Yes. I think Dr. Carter would be pleased to yield to you for that purpose.

Mr. BROWN. I will be glad to ask it when the questioning of the other members is finished.

Mr. MOSS. I think Dr. Carter has yielded.

Mr. CARTER. I yield.

Mr. BROWN. Dr. Brown, this is a difficult question to ask but maybe a more difficult question to answer. I think it cuts right to the heart of this matter.

I come from an area which has a relative under supply of doctors, perhaps because of the population but I think also perhaps because the medical practice needed is more lucrative elsewhere as it may well be in New York because there is a higher per capita income in New York than there is in my area.

The thing that becomes very difficult for me to try to explain to my constituency is why New York City with its vast resources should

be financed in this effort by the rest of the country and I want to find out first whether that is, in fact, true.

In other words, will New York City be receiving more than it pays, if you know and can answer that question, in such a program as this comprehensive health planning program first, and then the next question is:

Can you give me the rationale for why this should be done with Federal funds and not local funds?

Dr. BROWN. What is your district in Ohio?

Mr. BROWN. The seventh district.

Dr. BROWN. Which area is that?

Mr. BROWN. Well, it is a seven-county area in west central Ohio.

Dr. BROWN. What city?

Mr. BROWN. Springfield is the largest city.

Dr. BROWN. I am from Ohio and I was trying to think of the area. I haven't looked at it recently.

Certainly, our health problems in the low-income areas of New York City are every bit as great or worse than those in that area.

Mr. BROWN. Sure they are in the low-income areas of your city. My question is: The city taken all in all, with the ratios of doctors to citizens of 1 to 450 is a vast improvement over my area.

Dr. BROWN. Now, perhaps Mr. Elliott can respond to the question on whether we pay more taxes than we receive in New York City. I think the importance of the planning legislation is that it focuses on the official designation of an agency for planning which to date we did not have and in that sense, strengthening the idea of planning.

Funds are always important to finance or expand an existing activity. The official designation of such an agency is the most important one in my judgment.

Mr. BROWN. Let me tell you what is bothering me and then I will let you worry with the problem from there.

I don't think any one of us on this committee, or you either, object to the problem of medical costs and planning to try to see if those medical costs are reduced and that the average American citizen has the highest possible medical services. And I don't think any one of us feels that you can do this without a certain cost.

The question that I am asking is that, and this is a problem we face in every aspect of the Federal Government now, we are facing in this country a $29 billion deficit. This program as it develops is going to cost not millions of dollars but billions of dollars as I understand it.

This is a wonderful program and a very needed work in our country. It is a very beneficial program for the average American citizen and one I think, therefore, that could be extremely popular.

It is like motherhood, the flag, the Marine Corps and good health and everything else rolled into one. The guts of the problem is financing.

Now, how much can the Federal Government put into this is the question we are ultimately going to have to answer. Nobody objects, I am sure, to the program as it is laid out.

Mr. OTTINGER. Would the gentleman yield for just a comment on the relative position of New York in Federal financing?

I think I can be helpful on that. I believe in every distribution program in which the Federal Government is involved, New York pays more than it receives.

Within New York State, New York City has, in every program within the State, contributed more than it has received.

Therefore, in New York City the Federal program as a whole is way behind the eight ball. Indeed, because of its relative affluence within the Nation and within the State, New York City's position as compared to the other States is that it has always contributed a great deal more than it has received in any program.

Mr. BROWN. It is also true of the State of Ohio and probably also true of my district which is, I think, the thing that prompted my question.

Mr. ELLIOTT. Let me just deal with a couple of those problems. In the first place, what Congressman Ottinger said is completely accurate. No matter how you measure this the city of New York pays way out of proportion with the money it has received.

I may also say that the city of New York has not in the past and certainly is not now carrying out its own responsibility. We are what can only be described as a high tax island.

I suggested to you that we have a 5 percent State tax, a State, city, and Federal income tax and that we support a school system in excess of $1,000 per pupil per year.

As Dr. Brown suggested to you, over the next 5 years we will spend half a billion dollars in our own moneys for hospital construction.

The city of New York faces national problems. This is true for the major cities across the country. They are not simply assaulting the problems of the local areas. As you know, there is a very subtantial migration into the major cities from rural areas, particularly in the South, and has historically been for a period from Puerto Rico, so that the cities are in effect national centers for taking impoverished peoples and training them, bringing them into the economic mainstream of the country, and this often takes a generation to do, at which point they spread across the rest of the country.

I think that the kind of question you are really asking is one of the priorities of national resources and I think that I am perfectly convinced that the kind of standards which we are trying to achieve in health as we are in education and in housing and some of the other areas are minimal standards for a nation of the kind of ability and affluence of this one.

I just don't believe that we have begun to reach the point where our national resources are inadequate to the job and I think if you take any one of a realistic cost benefit and see what not over 2 or 3 years but over a generation or so you could accomplish in terms of making available manpower for the needs of the country that the kind of programs that we have been talking about today and that we are trying to do in the city of New York easily prove themselves out.

It is true that the particular dollars sound like a lot or money but I can assure you that on behalf of the citizens of the city of New York they recognize and have shouldered, I think, far more than their share of the responsibility.

In fact, the cities—and New York is high on the list—have been carrying national problems on their own resources to an extent which is unrealistic.

Mr. BROWN. The question is not one of whether or not New York City has the ability to pay for these things, but rather, whether they will undertake to finance this problem.

Mr. ELLIOTT. No; the question is that the city of New York is bearing more than its share of the cost now. There comes a point beyond which a locality cannot and should not be asked to solve what I think are essentially national problems.

Mr. BROWN. These problems are going to be solved, are they not, at the community level? That is what I am perhaps confused about. Isn't this the objective of this plan?

Mr. ELLIOTT. They are going to be solved at the community level but they are problems that affect the entire Nation and are national problems.

Mr. BROWN. I have no question about that. I agree thoroughly on that. But, if the ambition is to solve them at the community level and if the ability of the community to resolve them financially is high, I am a little bit lost on why we are running it through the Federal process here related to the apparent ability of the Federal Government to fund these programs.

We are into a great many programs which we can't fund now because of the $29 billion deficit that we are talking about.

Mr. ELLIOTT. The way to solve the deficit is to raise additional revenue.

Mr. BROWN. Which would add to that tax level in New York City, I gather.

Mr. ELLIOTT. That is correct, but if it became a question of Federal policy to return to the city of New York a greater share of its tax moneys these problems could be handled locally, but I think since that is not the present procedure then we are forced to seek Federal grants in order to achieve those results.

On the particular question of one doctor for 450 people, this is not a statistic which is applicable. We are not asking in these programs that Federal moneys be used to support those people who can afford to pay the private doctors. What we are talking about and what Dr. Brown has been putting all of his stress on today is the provision of medical services in those areas where the ratio of doctors is nothing like that and where the individuals are not able to afford it.

Mr. BROWN. Thank you.

Mr. MOSS. The Chair would like to say there are other members who haven't had the opportunity for questions.

Mr. BROWN. If I may make just one comment, Mr. Chairman——

Mr. MOSS. Very brief.

Mr. BROWN (continuing). The ratio between rich and poor or the balance between rich and poor in my district is not as wide as it is in a city like New York.

On the other hand, my feeling is that the allocation of local resources is basically the problem of New York if you have one doctor to every 450 residents. I think we have a national problem more evident in my area since we don't have any way near that ratio of physicians to residents and we also have similar problems, although we apparently don't have the nurse shortage you do.

It just strikes me that there is a very interesting total problem here because of the question of whether or not the Federal Government

can, in fact, fund the programs such as this that we are undertaking. They are worthwhile in nature, but where is the money coming from.

Mr. Moss. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman. I have no questions.

Mr. Moss. Mr. Stuckey.

Mr STUCKEY. No questions, Mr. Chairman.

Mr. Moss. Mr. Pickle.

Mr. PICKLE. I have no questions now, Mr. Chairman.

Mr. Moss. Mr. Adams.

Mr. ADAMS. I have no questions, Mr. Chairman.

Mr. Moss. Mr. Blanton.

Mr. BLANTON. No questions, Mr. Chairman.

Mr. Moss. Are there additional questions?

If not, I want to express the committee's appreciation to Dr. Brown and Mr. Elliott for their appearance here this morning. Your testimony has been valuable to the committee.

Mr. ELLIOTT. Thank you.

Dr. BROWN. Thank you very much.

Mr. Moss. The Chair would now like to recognize Dr. John B. Wilson, chairman of the Council on Legislation, the American Dental Association. Dr. Wilson, I note you are accompanied by an associate. Would you introduce him for the record and does he also have a statement?

STATEMENT OF DR. JOHN B. WILSON, CHAIRMAN OF COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION; ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER

Dr. WILSON. Thank you. Mr. Chairman and members of the committee I am John B. Wilson a dentist of San Marino, Calif. In addition to maintaining a private practice, I am chairman of the Council on Legislation of the American Dental Association. With me is Mr. Bernard J. Conway of Chicago, chief legal officer of the association.

The American Dental Association recognizes and endorses the major goals of H.R. 6418. As we understand it, these goals are to encourage States and communities to make comprehensive plans in order to meet efficiently the health problems in their own areas and to give them as much flexibility as possible in implementing these plans.

The concern we have with H.R. 6418 arises from the vagueness of the bill's language. It is difficult to speak with precision to a proposal that so largely lacks precision itself. The testimony of administration witnesses and the proposed regulations that have been offered do little, in our opinion, to offset this vagueness.

Our major concern is that the bill makes no attempt to define what is meant by "comprehensive health services." Without such a definition, there is no way to forecast how adequate this measure is. Will the programs, in fact, be as comprehensive as those under the superseded categorical grant-in-aid programs, which included a dental health component? Our fear is that unless some minimal guidelines are set, the programs may well be less comprehensive.

This is not a mere academic point of interest to the American Dental Association. A study of the long history of Federal, State, and local public health programs, prior to the 1965 initiation by Congress of a

dental health category, revealed a consistent and nearly universal neglect of dental public health.

Yet dental disease is one of the Nation's most serious, large-scale problems. It is certainly the most prevelant of all the chronic diseases that afflict mankind, being experienced almost literally by everyone. This is especially true with regard to the incidence of tooth decay and periodontal disease. While such other manifestations as cleft lip and palate or oral cancer are not so common, they cripple or kill thousands of people each year.

This evaluation of the serious nature of dental disease is not held by dentists alone. Others involved in and concerned with the Nation's health also endorse it. The Honorable Wilbur J. Cohen, now Under Secretary of the Department of Health, Education, and Welfare, for example, has underscored the problem in testimony before congressional committees.

And Mr. Cohen, like the association, has gone on to point out that dental public health has been grossly neglected on the Federal, State, and local levels. Among other things, he has said:

> 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 one percent—went to dental health.
>
> This pattern of allocation of public funds is in sharp contrast with that of private funds, when $15 out of every $100 spent for health care goes for the purchase of dental services.

I might add that this picture basically is the same today as it was in 1961.

Continuing the quote:

> So great a disparity cannot be ignored, for the current allocation allows less than four cents per person per year for all state and community activities in dental health. And four cents per person a year simply is not enough. It does not permit programs which even begin to meet the existing national need.

Given these facts, then, about dental disease, there can be no question but that it should be included in any reasonable definition of "comprehensive health services." This documented neglect on the Federal, State, and local levels, however, leads us to conclude that Congress should require such a definition.

The association was gratified last year when this committee, in its report on the Comprehensive Health Planning and Public Health Services Amendments of 1966 (H. Rept. No. 2271, 89th Cong., second sess.), indicated strongly that it too was anxious to clarify this point. On page 7 of the report, the following statement appears:

> The Committee expects, however, that the regulations pertaining to planning will provide for the comprehensive concept that is intended to insure adequate recognition of dentistry and services for the mentally retarded and other institutionalized persons.

The association does not believe that the draft regulations we have seen fulfill this expectation of the committee.

While the lack of a definition of "comprehensive health services" is the chief reason for our concern, other illustrations can be cited.

There is, for example, the question of whether the program under consideration here is intended to confer authority to State health planning councils that would supersede or conflict with the provisions of

previously enacted laws such as the Health Professions Educational Assistance Act or the Allied Health Professions Training Act.

While the association assumes that this is not the intent of Congress, the present language is susceptible to various interpretations. It would seem appropriate for this committee to add clarifying language to the bill.

At the same time, the committee may also wish to examine more closely the membership of the State health planning councils. It is the association's conviction that no council could be considered "comprehensive" unless its membership includes representatives from all the major health professions, including dentistry.

In closing, the association would like to make it clear that none of the suggestions we have offered would, in our opinion, detract from the planning aspects or flexibility that are the desired objects of H.R. 6418.

Nor would the association wish to detract from them. We are heartily in accord with these objectives. We believe firmly that these qualities will prove to be of considerable assistance in forwarding our national objectives in public health.

Certainly, within dental public health, there are a number of activities that could be improved in this way. Many States and communities, for example, are in need of assistance in inaugurating programs of fluoridation, the most effective, most inexpensive and safest public health method known for reducing the incidence of dental decay. For those communities that do not have communal water supplies, the direct application of fluoride to children's teeth is an effective alternative.

States are also in need of help in promulgating wider use of oral cytology techniques, the best method we now have for detecting oral cancer sufficiently early to have real hope of preventing disfigurement or death.

Mr. Chairman, this concludes our testimony. On behalf of the American Dental Association, may I express our appreciation for this opportunity to present our views. Mr. Conway and I would now be glad to attempt to answer any questions you or members of the committee may have. Thank you.

Mr. ROGERS (presiding). Thank you very much, Dr. Wilson. Mr. Kornegay?

Mr. KORNEGAY. No questions, Mr. Chairman.

Mr. ROGERS. Mr. Keith.

Mr. KEITH. No questions, Mr. Chairman.

Mr. ROGERS. Mr. Van Deerlin.

Mr. VAN DEERLIN. Dr. Wilson, you excited my interest in a paragraph near the end. How is the campaign for fluoridation going now?

Dr. WILSON. Well, it is not going quite as successfully as we would like to have it, but we are making headway. Most of our largest cities, as you know, in America today, have fluoridation, of which we are very proud.

The American Dental Association has carried a great campaign and I think we are gradually accomplishing our aims.

Mr. VAN DEERLIN. You still have difficulty in many local elections though, don't you?

Dr. WILSON. Yes, we do. We need help in many areas.

Mr. VAN DEERLIN. This legislation, you think, might assist in that direction? I ask this question at the risk of bringing people out from under rocks.

Dr. WILSON. I think all of our official agencies recognize the good that fluoridation does. It is on the local level where for some reason or other a few people come out from behind the rocks, as you say, and do fight the program.

Mr. VAN DEERLIN. I said under rocks.

Dr. WILSON. Under rocks. Excuse me.

Mr. VAN DEERLIN. It describes a different form of life. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Carter.

Mr. CARTER. The main tenor of your presentation seems to be that dental health, dental public health, is not receiving adequate attention in this bill. Is that true?

Dr. WILSON. That is correct.

Mr. CARTER. I think that something should be done, some guidelines should be set down, so that any State receives ample funds to retain the program. I certainly think you have a good point here. Thank you, sir. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Pickle.

Mr. PICKLE. I have no questions, Mr. Chairman.

Mr. ROGERS. Mr. Brown?

Mr. BROWN. I have no questions, Mr. Chairman. I just want to congratulate the gentleman on his statement.

Mr. ROGERS. Mr. Adams?

Mr. ADAMS. I have no questions, Mr. Chairman.

Mr. ROGERS. Mr. Kuykendall.

Mr. KUYKENDALL. This fluoride thing is something that I happen to be personally very interested in, and you ask for help. What do you have in mind? I happen to agree with the gentleman from California that it brings them out.

Dr. WILSON. This is right. Perhaps Mr. Conway would like to augment what I have already said.

Mr. CONWAY. It is mainly a need for funds in the area of health education. The dental division of the U.S. Public Health Service has for some years been administering some very modest amounts of money in this direction. We believe that because fluoridation is such an important program that, let's say, something like $3 to $5 million a year might be wisely spent, particularly in the smaller communities where the problem of education is a great one.

Mr. KUYKENDALL. May I suggest that one of your problems may be that the work that I have seen done in this education is, let's say, a little too educational. It is a little too high plane, because the political fight that is fought against you is not on a very high plane.

Dr. WILSON. That is right.

Mr. KUYKENDALL. And I was just wondering here if a little more Madison Avenue might not be the partial answer.

Mr. CONWAY. I believe that is true and I think this indicates the element of cost again. Assistance of that kind is quite costly. In addition, with the limited funds that the Division of Dental Health has had, they have granted money to persons in the psychological area to make determinations which agree with the expression that you just made that much of the educational material is way above the heads of the people who have to be swayed. But, I believe again that the answer to the question mainly is more money to be used mainly in

health education. Some of the smaller communities also need financial help in getting the first capital acquisition, the facilities for fluoridation.

Many of the communities really could install fluoridation if they were assisted perhaps by Federal grants in that area.

Dr. WILSON. Just to follow through just a bit more on that and comment, as you know, the U.S. Public Health has done a great job for us in researching this and they do send their personnel to testify before local government authorities, but, as you said, perhaps this material is too scientific for the average layman to understand.

I think this is part of our problem. I know this happened, or I feel certain it happened, in our own city of Los Angeles.

Mr. KUYKENDALL. The experience that I have had from meeting with these groups is they bring more politics than they do science, at least at antifluoridation meetings, as you well know. This has been very disturbing to me. I have always been able to meet them on a pretty even plane. I grew up in one of these Texas areas where they have no cavities because these areas, very close to Mr. Pickle's district over there, have many times as much fluoride in the water as prescribed in fluoridation and it doesn't hurt anybody.

I have been as a former salesman a little bit disturbed about the lack of real salesmanship. I said near Mr. Pickle. I don't know what his cavity situation is. I have been a little bit disturbed that there wasn't this real salesmanship and too much science was being used in the selling of this very important program.

Dr. WILSON. I agree.

Mr. PICKLE. Will the gentleman yield? I am afraid if I were to smile and open my mouth I would defeat the gentleman's argument.

Mr. KEITH. Mr. Chairman.

Mr. PICKLE. The gentleman has reference to Hereford, Tex. I grew up a little bit south of there.

Mr. ROGERS. I think Mr. Keith was trying to get you to yield there.

Mr. PICKLE. Be glad to yield.

Mr. KEITH. Having been chairman of a commission that studied fluoridation of water and aware of these forces that are sometimes involved, we had a scientist from Austria who testified that if you had fluoride in water and at the same time perhaps were having a diet that had some compounding ill effects the fluoride would cause such things as athlete's foot and falling hair, and I really think that we want to look very carefully before we contribute to these diseases.

I might add this is all in humor on my part, but this man was very serious and it was very difficult to combat and even the sophisticated town of Wellesley kicked it out after they had it for a while.

Mr. BROWN. Would the gentleman yield? I won't argue about the sophistication of Wellesley, but certainly in this group we have more danger of falling hair than we do of athlete's foot.

Mr. ROGERS. Mr. Ottinger.

Mr. OTTINGER. No questions, Mr. Chairman.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman. No questions.

Mr. ROGERS. Mr. Devine.

Mr. DEVINE. No questions.

Mr. ROGERS. Any other questions? Thank you very much, Dr. Wilson and Mr. Conway. The committee is grateful for your being here and for your testimony.

May I ask just one question before you leave. Would you submit to the committee language that you might like to see the committee consider? I realize, of course, that in trying to get away from categorical grants we are trying not to specify more than is necessary.

Mr. CONWAY. We shall do that.

(The following material was received by the committee:)

AMERICAN DENTAL ASSOCIATION PROPOSED AMENDMENTS TO H.R. 6418

As indicated in its formal statement, the American Dental Association recognizes the desirability of giving the states wide flexibility and broad discretion in meeting state and community health problems. At the same time, based upon long experience with general public health grants, the association believes that minimal standards should be set by the Surgeon General to assure that the "comprehensiveness" intended by the statute is in fact achieved. The association does not believe, for example, that a state plan can be comprehensive if dental public health is omitted.

Accordingly, the association suggests that language be inserted in Section 314(d) requiring that in order to be approved, a state plan must "either include adequate provision for each category of public health services supported by grants in fiscal 1967 under sections 314 and 316 of the Public Health Service Act (or under appropriation acts then effective), or contain evidence satisfactory to the Surgeon General justifying the exclusion from the state plan of any such category."

In order to assure that the state health planning councils include representatives of the major health professions, the association recommends that language be inserted in Section 314(a)(2)(B) requiring that a state planning council shall include "representatives of organizations concerned with the provision of health services and shall include practicing physicians and dentists."

The association also believes that language should be inserted in the bill making it clear that H.R. 6418 is not intended to confer authority on any state agency that would supercede or impinge upon the administration or implementation of already enacted laws designed to alleviate the national health manpower problem such as the Health Professions Educational Assistance Act. Accordingly, it is suggested that H.R. 6418 be amended to provide that "Nothing in this Act shall be deemed to supercede the provisions of P.L. 88-129, the Health Professions Educational Assistance Act and its amendments or any other law heretofore enacted relating to the training of health personnel."

Mr. ROGERS. Thank you.

Dr. WILSON. Thank you very much.

Mr. ROGERS. The committee is pleased to have as its next witness Miss Julia Thompson, director of the Washington office of the American Nurses' Association here. Miss Thompson, it is a pleasure to have you and we will be delighted to have your testimony.

STATEMENT OF JULIA THOMPSON, DIRECTOR, WASHINGTON OFFICE, AMERICAN NURSES' ASSOCIATION, INC.

Miss THOMPSON. Mr. Chairman and members of the committee, I am Julia Thompson and I am director of the Washington office of the American Nurses' Association, which is the professional organization of registered nurses in this country. We are pleased to support H.R. 6418, the Partnership for Health Amendments for 1967.

Last year the American Nurses' Association endorsed the principles inherent in the Comprehensive Health Planning Act which was signed

into law as Public Law 89–749, November 3, 1966. We see H.R. 6418 as a continuing effort to assist health agencies strengthen and expand their services to the public in a forwardlooking and efficient manner.

We would like to speak particularly to some of the provisions which we believe play an important part in making H.R. 6418 a most significant bill in the health field. We have not included data in our statement to justify the need for the legislation. This has adequately been done previously.

The first item to which we would like to speak is that which provides for extension and expansion of the authorizations for grants for comprehensive health planning and services. The passage of medicare has pinpointed problems in the delivery of quality health services. There has been a growing awareness of these problems but as yet, only minimum fruitful action.

One of the major identifiable problems has been the lack of coordination between the various agencies at the different administrative levels.

The provision for comprehensive planning grants should reduce the possibility for duplication and for fragmentation of services by providing the means for the various health disciplines and agencies to plan and implement the programs together.

Comprehensive health care means that the needed health care and service is always and readily available to the consumer. The present status quo operation, based on the outmoded premise that all States or local areas need the same kind of services and method of delivery, requires change.

The block grant rather than categorical funding, will be beneficial because financing will be based on problems peculiar to the area, rather than on disease categories. The plans should be sufficiently flexible so that they can be readily adapted to the changing health needs of a given locality.

The establishment of a State health planning council with a broad service and consumer representation will provide the consumers with the opportunity to participate and identify priorities for their own communities. The patterns can be established to utilize manpower resources wisely, and facilities effectively. Coordination of new projects with existing health programs is necessary. If all of the health disciplines share the responsibility of working and planning with and for the American public, safe and economically attainable health care can be provided for all of our citizens.

The next item to which we would like to speak is that which relates to broadening and improving the authorization for research and demonstrations relating to the delivery of health services.

Funds for demonstration projects, as proposed in this section of the bill, should stimulate activity in State and local areas to experiment with new ways to provide comprehensive health care.

However, there must be available personnel with planning skills, to work with the health personnel and the consumers to assist in the development of community plans. Provision in the bill for training planners, we believe, is most significant.

The next item is in support of the performance of the clinical laboratories, and we believe that standards for clinical laboratories must be established and maintained. Quality in all services is essential if health care to the public is safe and effective.

The next amendment would be the accreditation of nurses' education program. The American Nurses' Association supports the amendment of section 843(f) of the Public Health Service Act which would delete the authority of the Commissioner of Education to accredit programs of nursing education programs.

And then we would like to speak to the authorization for cooperative activities between the Public Health Service hospital and community facilities.

Inherent in the partnership for health concept is the cooperative relationships of all agencies and services in a locality. This relationship should include Federal facilities as well as those in private or local governmental structure.

Such interaction should generate better care on a more economical basis. It should also foster better working conditions for all health personnel and act as a recruitment stimulant.

Comprehensive planning can point the way to a more economical health service by avoiding duplication and fragmentation of health services; by providing for more skilled health personnel; and more efficient utilization of manpower resources.

We thank the committee for this opportunity to present the views of the American Nurses' Association on H.R. 6418. We urge that you report favorably on this legislation.

Mr. ROGERS. Thank you, Miss Thompson. Mr. Van Deerlin.

Mr. VAN DEERLIN. No thank you, Mr. Chairman.

Mr. ROGERS. Mr. Devine.

Mr. DEVINE. No questions, Mr. Chairman.

Mr. ROGERS. Mr. Pickle.

Mr. PICKLE. Miss Thompson, I notice you comment on the improvements in the performance of clinical laboratories. You represent the Nurses' Association and this question may be a little broader than your group, but I am concerned about clinical laboratories privately operated by such institutions as life insurance companies. I have had objection that they feel that this act is not intended for life insurance groups, that is, clinical laboratories operating for underwriting purposes where there is merely a need of establishing their desirability to take a certain insurance risk and it really has nothing to do with a clinical laboratory in the broad sense of the word.

Would you feel that those companies would be exempt or should be exempt?

Miss THOMPSON. I would choose not to comment on that. Our statement related to the fact that we believe that any laboratory test should be of a quality that would provide the physician with accurate information for a diagnosis rather than in terms of which laboratories should be included in the standards set.

We feel that all of them should have the same standards so that all tests would be safe.

Mr. PICKLE. I recognize, Miss Thompson, that your position and views would probably be limited in this general field. I wanted the record to show that I have had this correspondence from two or three companies in my State and they think it is unnecessary they be included, and I am simply stating that viewpoint.

I am also concerned about the statement you made that you would like to see the deletion of the authority of the Commissioner of Educa-

tion to approve the general programs in the field of nurse training. If we take this away from the Commissioner of Education, who is going to have this authority?

Miss THOMPSON. The Commissioner of Education now has the authority to name an accrediting agency. It is my understanding that it is the recommendation of the Department that this language be removed because the Commissioner did not wish to have the responsibility of accrediting institutions.

Mr. PICKLE. Why would you want this removed from the Commissioner of Education?

Miss THOMPSON. We are merely supporting the language that was in the original Nurse Training Act.

Mr. PICKLE. Let me pursue that further. Why do you support the original language? What is your reason?

Miss THOMPSON. We believe that any institution that is to secure Federal money should meet some kind of criteria prior to the money being allocated. The Commissioner of Education now has the privilege of naming any accrediting body to establish the criteria to be met.

Mr. PICKLE. I don't know that this is the time and place to pursue this except I do feel that the Nurses' Association, accredited schools, associated schools, the Office of Education, and the HEW in general have come coordination to work out before we can feel secure, at least in my opinion, to pursue this particular section. Thank you, Mr. Chairman.

Miss THOMPSON. I might add that conferences to resolve the problem that arose several years ago are still being carried on and the National Commission on Accreditation has submitted a proposal for consideration by all of the people that are concerned with the problem. This month the groups involved are meeting with the Regional Accrediting Association to see whether some reasonable compromise can be attained in relation to the accreditation statement.

Mr. ROGERS. Mr. Brown.

Mr. BROWN. Miss Thompson, I would like to hit two or three different scattered points in the testimony we had previously about the level of nurses' salaries in New York City. Do you have any judgment as to whether that makes those salaries high or low nationally?

Miss THOMPSON. I would say that they are in competition with the urban areas of the country. Many of the less populated areas have much lower salaries.

Mr. BROWN. $6,200 and $7,400 is a pretty high salary for the Nation on the total average, urban and rural?

Miss THOMPSON. That is right. I believe that the latest average figure is about $90 a week.

Mr. BROWN. It occurs to me that if those figures get out in general circumstances in my part of the country we might lose a lot of nurses on their way to New York until they find out how much it costs to live in New York and that would send them back home, but maybe there is a basic problem here that the Congress ought to give some attention to, as to why it costs that much to maintain one's self in New York.

The suggestion has been made that we ought to go to more automation in hospitals. Do you have any feeling about this? This would reduce the nurse contact with the patient. Has the nursing association given any thought to this or have you given any thought to the desirability of this as a means of solving the nurse shortage?

Miss THOMPSON. There are many activities in a hospital that could be automated without reducing the nurse contact with the patient. There could be recordkeeping done automatically, electronic methods of dispensing of the drugs, and there are a variety of things that could be done without reducing the contact.

Mr. BROWN. Is it your thought that this work should be done by nurses, or that it should be done by administrative personnel who are not necessarily trained as registered nurses?

Miss THOMPSON. I would think it should be done by persons trained in this particular kind of activity rather than by nurses who do not have this training.

Mr. BROWN. And this would be one of the objectives of this comprehensive health planning program, it would seem to me, because I would concur with your view that the training of nurses either is going to have to change to include some EDP courses or else the nurses are going to have to be left with the patient contact area and somebody else is going to have to be trained in the areas of reading of remote instruments and data processing kinds of information.

Miss THOMPSON. We believe that some of the problem related to the shortage has to do with utilization, and that was referred to by Dr. Brown earlier this morning in his statement. The nurse was the first person who was constant in the hospital and she assumed many, many tasks that weren't necessarily the kinds of things that nurses were prepared to do.

Many of the personnel in hospitals are daytime personnel, such as pharmacists and physiotherapists, and others whose duties very often are taken over by the nurse after the day shift is over.

We believe if we had better utilization of those that we have, that we could give better nursing care to the persons in institutions. Also when you have an occupation that is primarily female you have to oversupply all the time because of the other activities that women engage in.

Mr. BROWN. I don't trust myself to speak to that. But I gather that your feeling, Miss Thompson, is that the nurses ought to be administering to patients rather than manning the mops.

Miss THOMPSON. Yes.

Mr. BROWN. Thank you.

Mr. ROGERS. Mr. Ottinger.

Mr. OTTINGER. No, thank you, Mr. Chairman.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Mr. Chairman, I just want to thank Miss Thompson of the American Nurses' Association for her clear and concise testimony. No questions, sir.

Mr. ROGERS. Dr. Carter? Excuse me.

Mr. CARTER. Thank you, Mr. Chairman. It happened I was out during your presentation. However, I had already read it. I am interested here—the chairman may have mentioned this—in your support of the amendment of section 843(f) of the Public Health Service Act which would delete the authority of the Commissioner of Education to accredit programs of nursing education.

Would you explain that please?

Miss THOMPSON. We have agreed that the language that gave the Commissioner the responsibility for approving institutions for the

purposes of Federal funding should be dropped because the Commissioner himself believes that this should not be a function of his Office and we concur in this decision.

Mr. CARTER. You really think that that should be left up to the American Nurses' Association itself?

Miss THOMPSON. No, the Commissioner, according to the language of the law, has the privilege of naming any national body that he chooses to be the accrediting body and at this particular time he has designated the National League for Nursing.

Mr. CARTER. National League.

Miss THOMPSON. National League for Nursing.

Mr. CARTER. Yes, I see. Thank you very kindly.

Mr. ROGERS. Miss Thompson, of course we all know of the fine job you are doing for the nurses here in Washington.

Miss THOMPSON. Thank you.

Mr. ROGERS. Now, I am very much concerned about the position that is taken in the bill by the Department and, of course, by the association on the accreditation, because I don't think there has yet been realized evidently by the Department nor by the nurses association, the National League of Nursing, the urgency for us to do something on the training of nurses.

We have just had additional testimony today, which perhaps you heard, that in New York City in the city hospitals only 25 percent of the positions are filled and this is shocking, and instead of accelerating that program we seem to be still in limbo, not deciding what to do and not really having an accelerated program of training of nurses as we should, partly, I think, because of a reluctance to settle this accreditation program. Some junior colleges don't know whether they they can proceed with nurse programs because they can't get Federal aid that others can, so it just seems to me that there must be some recognition.

I understand this amendment was put in because they thought they had reached an agreement to settle this problem, but then they agreed and evidently fell apart, or it never was agreed to although they thought they were close to an agreement, according to Under Secretary Wilbur Cohen. It is my own personal opinion, and probably a number of others, that this should not be taken out or, if anything, we should take it away completely and put it in the Surgeon General and just go ahead. I am not sure that the Nation can afford to wait in getting schools accredited where they can receive funds to build these programs and turn out adequate nurses on some technicality of how we are going to accredit these.

We all want the standards high, but certainly it can be seen to by the Surgeon General that established standards be high enough if necessary. I would suggest that you explain the urgency of this matter to those involved and ask that they do get together because I certainly would be opposed to striking out this language at all until there has been a definite solution to the problem.

And further, I would be inclined to suggest an amendment to the committee to turn over the entire matter to the Surgeon General to allow Federal funds to go into institutions that wanted them in order to turn out adequate nursing facilities and to train nurses for this Nation, because our need is increasing and the supply is evidently dropping.

Miss THOMPSON. I might add here that out of the 218 associate degree schools 103 of them have reasonable assurance and 32 are fully accredited, which give us a total of 135. Twenty-two out of 218 are not eligible yet for reasonable assurance because the school itself is not accredited by the regional association.

Mr. ROGERS. I wonder though if you get them into a problem of philosophy of whether the school that needs the help that is not yet accredited should be the one to have the funds to build it up where it can turn out proper people.

Miss THOMPSON. The reasonable assurance does provide for schools to have money even though they are not ready for full accreditation. They would have to submit data that would mean that they were setting up an adequate program. If at the time the school graduates the first class they haven't carried out the reasonable assurance promises, then they would not be fully accredited. During the time in which they were developing a program they could have money with having met criteria for reasonable assurance.

Mr. ROGERS. I am not sure but what the Surgeon General should have this authority if this can't be worked out very quickly, and I would urge that the problem be met with urgency to try to get a solution before this committee reports out this legislation.

Miss THOMPSON. I think that there needs to be a solution to the problem. I agree with you.

Mr. ROGERS. Thank you so much. Your testimony has been most helpful. Any other questions?

Miss THOMPSON. Thank you.

Mr. ROGERS. The next witness is Dr. Robert W. Coon, chairman of the National Committee for Careers in Medical Technology. Dr. Coon, we are pleased to have you. I might say that the House is now in session, that if you would like to submit your statement and just give us a quick statement it would be helpful to the committee. We will put your full statement in the record at this point without objection.

If you could just give us a quick statement of your point of view here it would be most helpful.

STATEMENT OF DR. ROBERT W. COON, CHAIRMAN, NATIONAL COMMITTEE FOR CAREERS IN MEDICAL TECHNOLOGY

Dr. COON. Thank you very much, Mr. Chairman. In view of the shortage of time and the meeting of the House I would request that you submit this statement into the record.

(The statement referred to follows:)

STATEMENT OF DR. ROBERT W. COON, CHAIRMAN, NATIONAL COMMITTEE FOR CAREERS IN MEDICAL TECHNOLOGY

I am Robert W. Coon, a pathologist. I am Chairman of the Department of Pathology at the University of Vermont College of Medicine and am Director of Laboratories at the Medical Center Hospital of Vermont in Burlington, Vermont. I am Chairman of the National Committee for Careers in Medical Technology, an organization sponsored by the American Society of Medical Technologists, the College of American Pathologists, and the American Society of Clinical Pathologists. Our Committee was formed some years ago in an attempt to improve the recruitment into the field of medical technology.

I welcome the privilege of presenting my views on H.R. 6418 "Partnership for Health Amendments for 1967" particularly to Section 5 entitled "Clinical Laboratories Improvement."

In earlier statements you have already heard of the definite correlation that exists between errors in tests and lack of training on the part of the medical technologist. I am here to present to you further information on the need for developing and maintaining standards for training and certification, and to report on some of the problems that seem to stand in the way of getting and maintaining them.

The first of these problems is, of course, the current manpower shortage. When there aren't enough qualified medical laboratory personnel to do the tests, even the most highly motivated of laboratory directors are sometimes forced to drop their standards in order to get the the job done. In cooperation with the Public Health Service and other governmental agencies, we at the National Committee for Careers in Medical Technology are making a nation-wide effort to alleviate this shortage through intensified recruiting efforts to attract young people for professional training and also by the retraining and bringing back to work of retired medical technologists. Another way of stretching laboratory manpower is to develop echelons of workers at lower professional levels to handle less critical tasks under supervision. This is what the American Society of Clinical Pathologists has done in the past three and one-half years by creating a secondary echelon of technicians trained at the post high school level and called Certified Laboratory Assistants.

As a laboratory director I have two major responsibilities, the first to provide high quality laboratory service and the second to provide these services at all times when they may be needed for the care of the patient. This second responsibility frequently becomes an overriding problem when one considers the nature of the demands. The usual Monday through Friday work week provides services for only 45 of the total of 168 hours in the week. However, the demands for laboratory services in general hospitals are present throughout the week, both day and night. About 73% of the hours during which services may be requested are what we call "after hours and weekends." Looking at this from another viewpoint, of the 5800 short-term nonfederal hospitals listed in the last Hospital Guide Issue approximately 80% are smaller than 200-bed capacity, yet these hospitals care for approximately 46% of all admissions to such hospitals. Providing competent, adequately trained personnel to meet these around-the-clock demands is one of the major problems facing all hospital laboratory directors.

I have stressed this problem because of my concern that if federal standards are developed they will become the minimum standards for the several states and may be so rigid as to create major difficulties until we have an adequate pool of trained manpower.

Standards for Medical Technology were established nearly forty years ago by the American Society of Clinical Pathologists through its Boards of Registry and Schools of Medical Technology. Since then educational requirements have been increased until now the essentials for training are three years of college with a heavy emphasis on biology and chemistry, followed by a twelve-month specialized program in an approved hospital clinical laboratory. The Board of Registry of the American Society of Clinical Pathologists administers a national examination following completion of the educational program. In addition, most of the 45,000 currently registered Medical Technologists have a baccalaureate degree in science and a good many have advanced degrees in such clinically related areas as biochemistry, microbiology, etc.

These professionally developed standards for Medical Technologists have been approved by the Council of Medical Education of the American Medical Association and accepted by the National Commission on Accrediting and the U.S. Office of Education. You will hear more about them tomorrow from Dr. W. B. Stewart, who is Chairman of the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists. The Board of Certified Laboratory Assistants was established in 1963 to set standards for the training of high school graduates. Some of these programs are in high school vocational schools and junior colleges, but all have the important feature of the related clinical training being in approved hospital laboratories. Suffice it to say, that the number of hospital schools for Certified Laboratory Assistants has already grown to 150 with a combined capacity for 1300 students a year. But you will hear more about this level of training later from Leslie Lee of Orlando, Florida, who will speak for the Board of Certified Laboratory Assistants of which he is a member.

In addition to the manpower shortage another roadblock is the built-in resistance of human beings to change. It is not only a question of delineating personnel and procedures, so that the time of the professional medical technologist is not wasted on tests and procedures that can be safely and well done by trained Laboratory Assistants, but it is also a matter of re-educating hospital and laboratory administrators as well as the laboratory personnel giving up some jobs and taking on others. It is difficult enough to change the habit patterns of individuals; it is even harder when the status quo is perpetuated and even encouraged by federal and state legislation. Let me give you some examples.

California has long had the highest standards for certifying Medical Technologists of any state in the union. Just a year or so ago, in fact, the requirements were raised again, so that now students must have their baccalaureate degree even before they take their twelve months of clinical training. In my opinion this is not too much to expect of a Medical Technologists in her role as supervisor, teacher, and specialist performing critical and sophisticated tests.

But the California law goes further. It states that *all* quantitative biochemical and bacteriological tests done in a clinical laboratory *must* be done by such Medical Technologists, which means that *legally* not even routine tests can be handled by lesser trained personnel. This is why all "medical technology" courses so-listed in California junior college catalogues are "transfer" courses, which means that the student must go on to the University for another two years before taking clinical training and the state licensure examination.

The misuse of highly trained and skilled personnel for that part of the laboratory work that can be done by persons with intermediate training I believe to be almost as reprehensible as giving inadequately trained personnel responsibilities for tests that might appear to be easy but that require an understanding of the scientific principles involved in order to recognize the variables that can lead a diagnosis astray. Even though this is a waste in this time of critical manpower shortage, too high standards are better than standards that are too low where human lives are at stake.

More recently states establishing standards for laboratory personnel have shown a tendency to error in the other direction. Because of political pressures brought by disreputable laboratory owners and members of self-authorized accrediting agencies for clinical laboratory personnel, some states are considering legislation with grandfather clauses that would let just about anybody in, and others would give the authority to set up and police standards to state health departments most of which are without the clinical experience to qualify for this highly complicated task. In addition, state legislatures attempting to find some rhyme or reason to all of this are getting different and conflicting advice from what on the surface appears to be the same organization, but are actually different groups with similar but not identical names. The American Society of Medical Technologists, which will be represented at these hearings by Miss Ruth Heinemann, stands for professional certification of medical technologists at the collegiate level, whereas a second self-authorized certification agency, The American Medical Technologists, certifies graduates of twelve month commercial school courses. It is no wonder that state legislators are having a difficult time. For example, in its last session the Illinois State Legislature almost passed a bill with standards that were both too high and too low if that is possible! It provided on the one hand that anyone now working in a laboratory could be licensed upon paying a fee, but after 1971 only persons holding baccalaureate degrees with a major in chemical or biological science who had also completed one year of internship in an approved laboratory would be eligible. Thus, until 1971, the citizens of Illinois would have no protection whatsoever, but after that, if the law were enforced there would be insufficient utilization of all levels of medical laboratory personnel.

A third roadblock has to do with terminology. The last time I appeared before you gentlemen was to give support to the Allied Health Professions Personnel Training Act, which as you know was originally designed to bolster health occupations training at the baccalaureate level. In fact, "Medical Technology" was written into the Act as one of the professional careers to be supported. As was fitting, your committee was concerned with the part junior colleges could play in training for the health occupations, and certain amendments were added to the bill to make this possible.

Unfortunately, and this I am convinced was an honest mistake, in rewriting of the bill, the professional title "Medical Technologist," which stands for one trained at the baccalaureate level with background in college chemistry and

biology, became automatically applicable to the junior college AA or AS graduate. In fact, *only* by designating their two-year terminal courses as "*Medical Technology*" can junior colleges qualify for basic improvements grants under the Act. Yet it is patently impossible to squeeze 32 units of chemistry and biology plus the other sciences and mathematics, and twelve months of hospital clinical laboratory training into two college years.

Don't misunderstand me, I am not against terminal training of medical laboratory personnel in junior colleges. In fact, right now in Vermont, we are developing such a two-year program in our own university. However, what the students are trained to do must correspond to what their responsibilities will be in the laboratory. At Vermont, we do not intend that our two-year graduates be called "Medical Technologists."

But you can see the possible effect this wording in the legislation will have on hospitals throughout the country. How is the hospital personnel officer to evaluate the qualifications of a "medical technologist" replete with an AA or AS degree who has just graduated from his local community or junior college, and who applies for one of the many empty positions in the hospital laboratory for Medical Technologists? If it is in the province of this Committee to clarify this situation and to take the term "Medical Technology" out of the junior college portion of Public Law 89–751—Section 795(1)(A)(2ii)—and substitute a more generic term such as technician or laboratory assistant, I would ask it.

In requesting this I want to make it clear that we do not want to bar junior college courses for medical laboratory personnel from the benefits of the Act. On the contrary such a change would make it much easier for us to work with them to provide the clinical training that is required. As it is now we can't provide such training in hospitals that are giving clinical training to Medical Technologists at the baccalaureate level, since the junior college students do not have sufficient academic background. However, at the present time we are working on a joint committee with the American Association of Junior Colleges to develop guidelines for two-year programs, and very recently The American Society of Clinical Pathologists appointed a committee to identify such training by an appropriate name and establish a mechanism for establishing standards and certifying graduates.

Probably the biggest challenge of all is the need to assess laboratory personnel requirements in view of the changing demands for laboratory services, and the changing patterns of laboratory organization, performance and methodology. To freeze medical laboratory personnel requirements at their present stage would be tantamount to restricting the fullest application of developing medical research and automation. The complications of the present are considerable, but they are nothing compared to the changes that are going to take place in the foreseeable future. Our National Committee for Careers in Medical Technology is so concerned with this, that we are bending all our efforts toward a national conference this Fall that will take a new hard look at clinical laboratory education for the future. We plan to bring together leaders from academic as medical education, clinical sciences and biomedical engineering, public health, and manpower to discuss and develop recommendations for future action.

We will attempt to reassess the education of various levels of laboratory personnel in the light of newer findings of medical research, expanding technology including automation and expanding demands occasioned by regionalization, Medicare and Regional Medical Programs. We will also be concerned with mobility of personnel, i.e., the "job ladder" concept—and equivalency testing. We will be particularly concerned with examining laboratory education and training so as to be able to recruit the needed students for clinical training at levels that academic institutions including junior colleges can provide.

In conclusion I would submit for your consideration that legal standards for medical laboratory personnel do not make licensure the badge of respectability for poorly trained and qualified persons nor should they require that highly trained professionals perform the routine tasks that can be competently done by others. Nor is this the time to discourage the development of new categories and kinds of specialists and technicians.

I would suggest in fact that this problem is of sufficient importance to merit the appointment of a specially qualified Commission composed of people experienced in the field to study the needs and to advise the Secretary of Health, Education, and Welfare on standards for training and certification commensurate with present and future developments.

I thank you for the opportunity of appearing before you today.

Dr. COON. I would like to emphasize one or two points, though you will hear additional testimony during the coming days that is somewhat related in many ways.

First of all, of the various problems that we have faced, one is the manpower shortage and we have heard discussions of this this morning. There are many efforts going forward at the present time. I think one of the major efforts that must be made is in relation to junior college programs, and you are well aware of that fact.

I think one of the problems that we have to face in the licensure of clinical laboratories is to be sure and look at the total picture, and one of the problems that early emerges I see in my own situation as a director of a hospital laboratory is the difficulties in providing high quality services at all times. This is not difficult on weekdays during the daytime, but recognizing that this is only 25 percent of the hours during the week and the person who appears with an automobile accident late at night has the same rights to high quality services as does the person who comes in during the more conventional working hours. This is a real major problem in terms of our present manpower shortages.

We have standards for training of medical technologists in this country, but we have many areas of confusion because of confusing names of various organizations, and I think that must be given careful consideration as one tries to match standards to the groups purporting to maintain them, et cetera.

I think the experience of California is particularly illuminating in terms of problems of licensure where, as I understand it, standards are so high that it is really quite difficult for some of the more routine tests to be done legally by less than full trained medical technologists even though it may be under supervision.

One of the problems that I would like to call your attention to has to do with terminology. In terms of the Allied Health Professions Training Act, which you know was originally designed to bolster the health occupations training at the baccalaureate level, the term "medical technology" was written into the act as one of the professional careers to be supported.

As was fitting, the committee was concerned with training for health occupations and made certain amendments in this bill so it could go for junior colleges.

However, the inclusion of the term "medical technologist" for the junior college programs has led to confusion because this is a baccalaureate level course with commensurate responsibilities, for which training cannot be given in the limited time available at the junior college level. So if it is in your province, I suggest amending this so that it is possible for the junior colleges to develop appropriate training programs that would be eligible for grants under this act.

As I understand it, in Florida, which is very active in supporting and developing programs for training of laboratory personnel in junior colleges, they cannot be called medical technology courses because of a State licensure law, and consequently are not eligible for any support under the Allied Health Professions Training Act.

Possibly just a simple changing of the name to the generic term of laboratory assistant or something of this nature would accomplish it.

Mr. ROGERS. Would you submit your suggested language to the committee?

Dr. COON. Yes, sir; I would be pleased to do it. We have a number of groups who are studying these problems but if we do go into a licensing program, I am concerned that whatever standards are developed at the national level will become the minimum for the States, and I think that the problems are so complex and with so many ramifications with different groups and what not that it would be most desirable that a specially qualified commission be appointed to advise the Secretary of Health, Education, and Welfare in terms of developing these standards for training and certification.

Mr. ROGERS. I presume that the Secretary could establish one himself without legislation as long as the committee put that in a report.

Dr. COON. Yes.

Mr. ROGERS. I am sure the committee will receive your suggestions on that and would be glad to have your suggested language.

Dr. COON. I appreciate the opportunity to present our views.

(The following material was received by the committee:)

NATIONAL COMMITTEE FOR CAREERS IN MEDICAL TECHNOLOGY,
Washington, D.C., June 27, 1967.

HON. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: At the request of Congressman Rogers, who was acting Chairman of the Interstate and Foreign Commerce Committee at the time I appeared before that group June 20 to provide information relating to the Clinical Laboratories Improvement section of H.R. 6418, I am substituting a proposal to amend Public Law 89-751, Section 795(1)(A)(ii), the Allied Health Professions Personnel Training Act.

In my discussion of standards for medical laboratory personnel on June 20, I noted a serious terminology problem created by the inclusion of the term "Medical Technology" in the junior college portion of Public Law 89-751 and suggested that—"If it is in the province of (your) Committee to clarify this situation and to take the term "Medical Technology" out of the junior college portion of Section 795(1)(A)(ii) of the Public Law 89-751 * * * that I would ask it."

We suggest that it read: Section 795(1)(A)(ii) of education in optometric technology, dental hygiene, or any of such other of the allied health technical or professional curriculum as are specified by regulation."

The use of the term Medical Technology in that part of the Act forces junior colleges to call the graduates of their two-year clinical laboratory courses "Medical Technologists" in order to qualify for basic improvement grants under the act, although historically and currently the trend has been toward "Technician" or "Laboratory Assistant."

Forcing the use of the term "Medical Technology" on the junior college terminal course places the entire structure of standards for medical laboratory personnel in jeopardy, since professional standards of education place Medical Technologists at the baccalaureate level, standing for supervisory positions, Instructors, and those responsible for the performance of critical or difficult tests and procedures. In other words, a Medical Technologist must have a fundamental and basic understanding of scientific principles as related to laboratory medicine in order to recognize variables and make differential judgment on the work performed.

As I noted on June 20, when I ad libbed from my prepared text, at the present time in Florida the state educational system and pathologist directors of hospital laboratories are working together to inaugurate 2-year courses in the junior college system to train Laboratory Assistants. However, these won't be eligible for Allied Health Professions Training Act grants unless they change their names to Medical Technology.

It would rectify this situation, as well as serve the national interests, if the term "Medical Technology" were simply eleminated from the junior college section of Public Law 89-751 which is 795(1)(A)(ii), leaving it up to the Secretary of Health, Education, and Welfare to include in regulations the appropriate terminology for the programs of education in the clinical laboratory field leading to an AA or AS degree. This, in fact, is what he is doing for all the paramedical

professions, with the exception of medical technology and dental hygiene, both of which are by name in the act. There is no problem with dental hygiene, since it is already accredited professionally as a 2-year course of study.

May I repeat and make it clear that it is not our intent to bar junior college courses for medical laboratory personnel from the benefits of the act. On the contrary, such a change in Public Law 89–751 will make it a great deal easier for National Committee for Careers in Medical Technology's National Council on Medical Technology Education which has established a joint committee with the American Association of Junior Colleges to develop suitable guidelines and terminologies for 2-year courses for medical laboratory personnel to accomplish their purpose. In fact, it is anticipated by September that the American Society of Clinical Pathologists with the concurrence of the American Association of Junior Colleges will be in a position to recommend suitable terminology for junior courses as well as to provide mechanisms to enable them to make suitable arrangements for clinical training.

We very much appreciate the opportunity to recommend the above-suggested changes in section 795(1)(A)(ii), Public Law 89–751.

Sincerely yours,

ROBERT W. COON, M.D.,
Chairman.

Mr. ROGERS. Thank you, Dr. Coon. It has been most helpful to the committee. Mr. Ottinger.

Mr. OTTINGER. No questions, Mr. Chairman.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. No questions.

Mr. ROGERS. Thank you. We certainly appreciate it.

The next witness is Mr. Bernard I. Diamond who is chairman of the Government and Professional Relations Council of the American Association of Bioanalysts.

Mr. Diamond, the committee is pleased to hear you. We will be glad to make your statement a part of the record. If you would like to just comment for us it would be helpful to the committee since the Congress is now in session. We are liable to be called to the floor at any time.

STATEMENT OF BERNARD I. DIAMOND, CHAIRMAN, COMMITTEE ON GOVERNMENTAL AND PROFESSIONAL RELATIONS, AMERICAN ASSOCIATION OF BIOANALYSTS, AND ROBERT S. BOURBON, COUNSEL

Mr. DIAMOND. Thank you very much, Mr. Chairman. I would like to introduce our counsel, Mr. Bourbon, sitting to my right, of Silver Spring, Md.

Mr. ROGERS. We are glad to have him before the committee too.

Mr. DIAMOND. We do understand the problem here and although we had planned to present this committee statement in toto if you will permit me the opportunity to make a summary for a few minutes I think perhaps we can highlight the important points here.

Mr. ROGERS. Thank you.

Mr. DIAMOND. I would just like to say that I do represent the American Association of Bioanalysts, an association comprising independent clinical laboratory directors from throughout the United States.

These are people who have devoted their talents to the direction and application of the life sciences to clinical laboratory analyses, those who teach such curriculums and those who hold similar commissions in the armed services or governmental laboratories.

We have since the advent of medicare supported the programs of public health and improvement of clinical laboratories and we think that the public does have a right to expect protection in the area of clinical laboratory services, and we have testified on a number of occasions before the Senate and also before the House regarding some of the issues.

However, our basic concern with H.R. 6418 in the light of our experiences under the Medicare Act is that perhaps the Secretary will receive a very broad authority in terms of licensure in interstate commerce and it is our concern that perhaps the Congress may not want to delegate that much authority in establishing regulations for laboratories in interstate commerce.

One of the important issues involves the payment of fees for issuance and renewal of licenses which is in subsection (d) (3). We are concerned here that this provision will turn what purports to be licensure into pure intimidation through selective taxation, without upper limits. Such fee should be limited as to amount absolutely and not calculated upon some arbitrary, flexible, and now unknown basis.

We think too that there should be some consideration by your committee to laboratories who perhaps do 95 percent of their work in intrastate commerce, only 5 percent in interstate commerce. Certainly provision should be made for this.

Another important consideration refers to the fact that subsections (f) and (g) provide that the license of any laboratory may be temporarily suspended without a hearing for a period of not to exceed 60 days if the Secretary determines that the public safety or welfare would be in imminent danger. We certainly have no quarrel with the concept of the public not being placed in imminent danger, but I think that you will realize that in this type of operation the closure for 60 days could really mean the ending of the operation.

We think perhaps a stay pending appeal or provision for a 2- or 3-day show cause procedure might not only protect the public interest, but at the same time protect the laboratory until adjudication is made of the case.

We also want to criticize to some extent, as it appears in the bill, that the Secretary's decision as to the facts, if supported by substantial evidence, shall be conclusive. We see no reason why the findings of the Secretary should be elevated to such status, contrary to what we believe is normal administrative procedure under Federal practice.

And perhaps a summarizing statement. The bill reads that there will be excluded from the interstate licensing bill licensed physicians, ostepaths, dentists, or podiatrists, even when acting on their own patients. We submit that if the absolute standard is one of interstate service through quality control no person should be exempt.

Another question regards the Secretary's utilization of local agencies in the setting up and enforcing of the law. We ask what type of local nonprofit private agency or institution will be called upon to assist the Secretary? We think that such assistance ought to be limited to entities other than those which are comprised of individuals having an adverse economic interest to the independent laboratory; that is, professional associations or hospitals conducting laboratory tests in direct competition with independent laboratories.

I would just like to conclude. We earnestly submit that the Secretary of Health, Education, and Welfare cannot satisfactorily fulfill the intent of Congress in improvement of clinical laboratories in interstate commerce unless Congress gives him direction.

The Secretary cannot be held within reasonable bounds where the basic law provides standards which are vague or it lacks them all together. Rulemaking by Department heads should always implement legislative intent and purpose.

We therefore recommend and request your consideration of the foregoing remarks. I trust you will enter those into the hearings and very much appreciate this opportunity.

(The full statement of Mr. Diamond follows:)

STATEMENT OF BERNARD I. DIAMOND, CHAIRMAN, COMMITTEE ON GOVERNMENTAL AND PROFESSIONAL RELATIONS, AMERICAN ASSOCIATION OF BIOANALYSTS, AND ROBERT S. BOURBON, COUNSEL

Mr. Chairman and gentlemen of this committee, we are appreciative of this opportunity to express our views here today in connection with H.R. 6418.

I am Bernard I. Diamond, Director of the Diamond Laboratories, an independent bioanalytical laboratory in Philadelphia, Pennsylvania.

The American Association of Bioanalysts, of which I am Chairman of the Committee on Governmental and Professional Relations, is affiliated with the American Institute of Biological Sciences and the American Association for the Advancement of Science. I am accompanied here today by counsel, Robert S. Bourbon, Esquire, of Silver Spring, Maryland, Bernard S. Kaplan, of Morristown, New Jersey and John J. Egan, of Hartford, Connecticut, at the request of and representing State associations of bioanalysts, clinical laboratories and clinical laboratory directors in the following States:

Maryland	Massachusetts
New York	Illinois
New Jersey	Ohio
Oklahoma	Michigan
Pennsylvania	Connecticut
California	Texas
Rhode Island	Florida

The membership of the American Association of Bioanalysts, comprising 700 independent clinical laboratory directors, is composed of individuals who have devoted their talents to the direction and application of the life sciences to clinical laboratory analyses, those who teach such curricula and those who hold similar commissions in the armed services or governmental laboratories.

THE PUBLIC INTEREST

Without question, the public has every right to expect and receive protection in the area of laboratory services in the vital scope of interstate commerce. A great deal of information, much of it incorrect, has been brought before the Congress and carried in the press, concerning alleged deficiencies in laboratory testing. Recently, there has been substantial national publicity, on the basis of the statement of Dr. David Sencer before the Special Senate Sub-Committee, that in excess of 25% of all clinical laboratory tests in the United States are unsatisfactory. This assertion is erroneous. The basis for this data was the communicable disease center survey of 67 laboratories in federal institutions. The number of tests was not given and what was proved was the unsatisfactory performance of a certain group of federal medical laboratories. To conclude from this restricted "study" that "all laboratories in the United States" are includable within its statistics is both unwarranted and grossly unfair.

To attempt here to explain the role of competent, qualified operation of the independent clinical laboratory is at the least, a sizeable assignment in the limited time we have available. Suffice it to say, we believe the 3,000 or more independent clinical laboratories (that is, independent of a physician's office or hospital) are a valuable and irreplaceable segment of the integrated health team.

PRIOR TESTIMONY

We have testified previously, in 1965, before the Senate Finance Committee and earlier this year, on March 10, 1967, before the House Ways and Means Committee, in connection with the Social Security Amendments of 1965 and 1967. It has consistently been our position that the Medicare Program, for example, merited our support, and that reasonable regulation of the independent laboratory thereunder would be in the public interest. We have found, however, that the division of Government charged with such regulation, namely, the Department of Health, Education and Welfare, through its, "Conditions For Coverage of Services Of Independent Laboratories", has fabricated a bureaucratic crisscross of regulations which is discriminatory, ambiguous, restrictive and unrealistic.

CONCERN FOR BROADENED AUTHORITY

We are deeply concerned that the authority given to the Secretary of Health, Education and Welfare, under the laboratory licensure provisions of H.R. 6418, in light of our experiences under the Medicare Act, is far too broad and will effectively work to strangle the independent laboratory director, at a time when demand for health services is increasing, not diminishing and the availability of trained laboratory personnel diminishing, not increasing.

COMMENTS REGARDING H.R. 6418

We should like to enter the following comments regarding the Bill under discussion:

(1) Subsection (d)(1) of Section 5 of the Bill provides that a license shall not be issued for a clinical laboratory unless application therefor contain or be accompanied by such information and assurances as the Secretary finds necessary and unless the applicant agrees and the Secretary determines that such laboratory will be operated in accordance with standards found necessary by the Secretary to carry out the purposes of this Section.

EXPERIENCE UNDER MEDICARE

Our experience as laboratories regulated under Medicare is that the Secretary, even where given no authority to do so under the authorizing legislation (Title XVIII, Subparagraph 10 & 11, Section 1861 (s), Public Law 89–97) has attempted to require assurances of compliance with mandates in unrelated matters in areas where he clearly had no authority to operate. We would hope that the Congress, under this Bill, would not turn over the rule making authority completely to the Secretary, without any guidelines. Not only has the Secretary, under Medicare, adopted regulations which are grossly unbalanced in favor of hospital, pathologist and physician-directed laboratories, but these regulations are backed up by a growing body of informal rulings, of which the laboratory director learns only indirectly and whose application, we find, is being brought to bear unevenly and unfairly in the various states.

(2) Subsection (d)(3) provides for the payment of fees for issuance and renewal of licenses, subject to regulation by the Secretary. We are concerned here that this provision will turn what purports to be licensure into pure intimidation through selective taxation, without upper limits. Such fees should be limited as to amount, absolutely, and not calculated upon some arbitrary, flexible and now unknown basis. They should not be open-ended, to support what will be, we predict, a growing body of administrators.

INTRASTATE AND INTERSTATE COMMERCE

(3) Subsection (e)(2) provides for revocation, suspension or limitation of a license where an owner or operator "has engaged or attempted to engage or represented himself as entitled to perform any laboratory procedure or category of procedures not authorized in the license," notwithstanding as much as 95% of such laboratory activity apparently may be in intrastate, as opposed to interstate commerce. Subsection (e)(4) permits additional regulation by the Secretary, wherein, without guidelines or standards, he is authorized to call, at will, upon the laboratory for "any information or materials, or work on materials." Such provision should specify for what purpose these requests for information shall be made, in order to preclude harassment, invasion of privacy and abrogation of other constitutional guarantees.

"TEMPORARY SUSPENSION" AND ITS EFFECT

(4) Subsections (f) and (g) provide that the license of any laboratory may be temporarily suspended without a hearing for a period of not to exceed 60 days if the Secretary determines that the public safety or welfare would be in imminent danger. While no one can quarrel with the concept of the public not being placed in imminent danger, a temporary closure of a laboratory for 60 days or less will, by virtue of the nature of its operation, result in its being put out of business.

A stay pending appeal, or provision for a 2 or 3-day show-cause procedure, would be more equitable, protecting the public and the director from the arbitrary action of the Secretary, acting through some functionary in an area far removed, perhaps, from this seat of government, but whose action can be just as final as if the Secretary himself had nailed the door closed.

CONCLUSIVENESS OF SECRETARY'S DECISION

(5) Subsection (g)(3) provides that, in the case of an appeal to the Circuit Court of Appeals from the Secretary's decision, his findings, "as to the facts, if supported by substantial evidence, shall be conclusive."

We see no reason why the findings of the Secretary should be elevated to such status, contrary to what we believe is normal administrative procedure under federal practice.

SELECTIVE EXCLUSION

(6) Subsection (g)(1) excludes from the application of the Act the licensed physician, osteopath, dentist or podiatrist, even when acting through his employees. We respectfully submit that if the absolute standard is one of interstate service through quality control, no person should be exempt. It is doubtful whether a professional, performing infrequent testing procedures, is invariably or even regularly, capable of rendering more accurate services than an independent laboratory director who is devoted full time to such testing procedures and who may have been in the field 20 years or more competently serving his community.

It is to be noted that the language authorizing in this Subsection the performance of laboratory tests "solely as an adjunct to the treatment of his own patients," may still permit interstate testing activity on other than the professional's own patients.

UTILIZATION OF LOCAL AGENCIES

(7) Under Subsection (j), we ask what type of local "non-profit private agency or organization" will be called upon to assist the Secretary in carrying out his functions under the Act? Such assistance ought to be limited to entities other than those which are comprised of individuals having an adverse economic interest to the independent laboratory, e.g. professional associations or hospitals, conducting laboratory tests in direct competition with such independent laboratories.

UNRESTRICTED REGULATION

We view the laboratory control section of H.R. 6418 as an open invitation to the Secretary of Health, Education and Welfare, without limitation, to regulate the independent laboratory out of business, a new type of uncontrolled regulation to be superimposed over and above the over-inclusive regulations already promulgated under Medicare.

This type of federal licensure also fails to take into account those states which have regulated, or are in the process of doing so, the field of independent laboratory procedures. Pursuant to the current laboratory regulations under Medicare, the Secretary has already guaranteed the development of standardized regulation in the states. As a practical matter, the states, being local certifying agencies, must now coordinate with the Secretary.

INTENT OF CONGRESS

We earnestly submit that the Secretary of Health, Education and Welfare cannot satisfactorily fulfill the intent of Congress in improvement of clinical laboratories in interstate commerce, unless Congress gives him direction. The Secretary cannot be held within reasonable bounds, where the basic law provides

standards which are vague or it lacks them altogether. Rule-making by Department heads should always implement legislative intent and purpose.

CONCLUSION

We therefore recommend and request your consideration of the foregoing remarks and suggested amendatory changes, as they pertain to regulation of independent laboratory services in interstate commerce.

Thank you.

Mr. ROGERS. Thank you very much, Mr. Diamond, and Mr. Bourbon. We appreciate your being here.

Any questions, Mr. Ottinger?

Mr. OTTINGER. I am not really sure that I understand what your objection to the regulation of laboratories is. Is it you want standards set up in the legislation that are more precise than those presently within the bill?

Mr. DIAMOND. Yes, we do. I think that they should be specific. We think that, as we indicated, our experience under medicare has left a great deal to the interpretation of the State agencies. We have run into problems of varying interpretations by State agencies.

Mr. OTTINGER. My recollection is—I don't know if I can put my fingers on it—there are presently standards now in legislation. Do you have language that you would like to see adopted?

Mr. DIAMOND. We felt that we would be presumptuous to come here at least today with a completely rewritten bill, but we certainly do have many approaches to the kind of bill that you are considering and given a little time we would come up with some suggestions if that would be suitable.

Mr. OTTINGER. What kind of limitations do you have in mind, without having to be specific at this point?

Mr. DIAMOND. We would consider limitations perhaps in the area of proficiency testing. This is an area which clinical laboratories have been developing over the many years and I think the Public Health Service is just now beginning to develop an adequate proficiency testing program; and I think that it is possible if the laboratory can perform the test, do it accurately, and report it promptly, this would be the best guarantee of adequate performance of the laboratory.

We have under medicare one set of qualifications and regulations and here we would consider superimposing a second set of regulations. There sort of seems to be no end to writing of qualifications in this area. I think somewhere we need to draw the line.

Mr. OTTINGER. I just get the feeling that in order to be able to act on your general discomfiture we are going to have to have more specific ideas of what it is that is concerning you and how you suggest we get out of it. There is guidance within the present statute.

Mr. ROGERS. Would the gentleman yield?

Mr. OTTINGER. Surely.

Mr. ROGERS. Perhaps, as Mr. Ottinger suggests, you can submit for the committee's consideration your specific suggestions as to the language that you believe should be included in the bill. Then the committee could go over your suggestions in their specific form, if this would meet with the gentleman's approval?

Mr. OTTINGER. That will be fine. On page 11 there are really quite specific standards that are set up, opportunities for hearings and so forth. I would certainly like anything you present to see that you

address yourself with specificity, why the standards that are provided are inadequate and what additional standards might be provided.

Mr. DIAMOND. We will certainly do that.

On page 11 it does say: "In accordance with standards found necessary." We know from experience that there is a whole broad area of directoral level technologists.

Mr. OTTINGER (reading):

> A laboratory license may be revoked, suspended, or limited if the Secretary finds, after reasonable notice and opportunity for hearing to the owner or operator of the laboratory, that such owner or operator or any employee of the laboratory—

And lists six offenses.

Mr. DIAMOND. Yes.

Mr. ROGERS. Any other questions?

Mr. OTTINGER. No more questions. Thank you.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. No question.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. I have one question, Mr. Chairman. Mr. Diamond, I don't understand your objection to the section for administrative finality in terms of the findings of the Secretary as to the facts under (g)(3), if supported by substantial evidence, shall be conclusive. That certainly permits you to take an appeal on the phrase, "If supported by substantial evidence," and I think that is in keeping with attempting to make the administrative agencies decisions final.

So what is the complaint? I don't understand it, the complaint here on page 6.

Mr. DIAMOND. I guess the only word that we are concerned about is "conclusive" here and substantial evidence you know in this type of situation can sometimes be a problem.

Do you want to comment on the legal implication of that statement:

Mr. BOURBON. It had been our feeling, Mr. Kyros, that the conclusiveness which is assigned to the findings perhaps went further than ought to be the case, that there ought to be some opportunity to review the procedure, not have a court absolutely bound by the findings of fact, that the court could look into the findings of fact and see whether it is fact squared with the facts as they came before the hearing.

Mr. KYROS. But won't it be able to be in keeping with our decisions in administrative agencies because it must be supported by substantial evidence?

Mr. BOURBON. It must be supported by substantial evidence, but the question is what is the effect of the substantial evidence. In this case a court would be bound, it seems to us, by the earlier findings and we think that there ought to be some adaptability allowing the court to look behind and at least examine into these facts.

Mr. KYROS. Thank you. No more questions, Mr. Chairman.

Mr. ROGERS. Mr. Brown.

Mr. BROWN. I have one question which goes, I suppose, to a technical matter. Where laboratory samples are provided either directly in the hospital or, where they are sent in by mail for analysis, is it possible that there could be deterioration of the sample in such a way that one couldn't tell whether the improper reading was done by a laboratory or, as a result of improper facilities or study or capacity of the

laboratory to handle the material or that it could be an improper conclusion by the deterioration of the biological sample.

Mr. DIAMOND. There are sort of two parts to the question. The first part is the mailing of samples. I think that any competent laboratory director throughout the country knows which samples are stable and which are unstable.

As an indication, Dr. Sencer's laboratory in Atlanta, Ga., handles by now about 100,000 samples a year, but these are samples which have been proven to be stable over a period of time and they present no problem.

Now, as to the receipt of the sample in the laboratory a properly run laboratory running quality control, which means that they run known sample values daily with every run of their unknowns and if the values are not in accordance with what they should expect to find they can put their finger on the particular sample that is in question, there is or should be an adequate quality control system which will obviate any problem. Does that answer your question?

Mr. BROWN. In other words, the state of the art is such that you can pin down inadequate laboratory procedure from a medical and legal standpoint. Is that what you are saying?

Mr. DIAMOND. I say to a great extent we can. A laboratory receiving a specimen, say, for blood sugar traveling through the mail for 5 days, let's say, and not adequately preserved against deterioration will produce a very low value. The laboratory director could pick this up immediately as being an incorrect value and request a further sample.

Mr. BROWN. Thank you.

Mr. DIAMOND. Does that answer your question?

Mr. BROWN. I think so. I want to just try once more to rephrase it. It seems to me that if the state of the art is such that can pin down failure of the laboratory medically and legally then you have one problem. If you cannot pin down the laboratory medically and legally because the state of the art hasn't reached that degree of sophistication, then you have another problem completely, but you feel that you can pin down the laboratory to failure within the laboratory to perform the function which it is required.

Mr. DIAMOND. To a considerable extent, yes.

Mr. BROWN. When you say that then that begins to back away from the emphasis which I would put on it initially in my question. Can somebody assessing this and hoping to reach a finality of judgment judge without a reasonable doubt that the laboratory has failed to meet its requirements?

Mr. DIAMOND. Well, I am answering the question from the point of view of the technical person in the laboratory. When you say medically and legally, I am not an attorney. I am not qualified to answer on that basis. I don't know what would represent such evidence, say, in a court of law. Perhaps Mr. Bourbon might comment.

Mr. BROWN. Is the counsel in a position to answer that question?

Mr. BOURBON. This seems more of a medical judgment to make than anything else. It occurs to me, however, that if any examination procedure were set up under the Secretary there might be established by expert testimony a fixed standard, subject reasonably to some variations beyond which certain acceptance might not extend. That is

about as much as I can say. I am not skilled in the laboratory field.

Mr. BROWN. I am sure the chairman sees what I am trying to get at. If you are concerned about an arbitrary judgment by the Secretary, how much room is there for arbitrary judgment and how much of the judgment is really legal, medical, and technical judgment? How much room is there for judgment, period?

Mr. DIAMOND. I think that this is right now in the process of being worked out. Evaluation programs have been in effect in many States and the Public Health Service has been evaluating State laboratories throughout the country and the limits on the performance are being established at the present time.

I think there is some agreement on a particular value, how much higher or lower it can be than the true value. These limits have been established.

Mr. BROWN. You feel these standards can be written?

Mr. DIAMOND. Yes.

Mr. BROWN. Thank you.

Mr. ROGERS. Then you might submit your viewpoint on that for the committee.

Mr. DIAMOND. We can do that; yes, sir.

Mr. ROGERS. As I understand it, you would prefer to have fees omitted entirely in this program or not?

Mr. DIAMOND. We would prefer that.

Mr. ROGERS. And you want the Secretary only to suspend, have this authority, and also to provide for an accelerated hearing?

Mr. DIAMOND. Yes.

Mr. ROGERS. Would this be your position?

Mr. DIAMOND. Yes, sir.

Mr. ROGERS. Thank you so much. Your testimony has been most helpful to the committee and the committee will be pleased also to receive the specific language that you might like to send us.

Mr. DIAMOND. We shall send this to you. Thank you very much, Mr. Rogers.

(The following material was subsequently submitted to the committee:)

SILVER SPRING, MD., *June 27, 1967.*

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
U.S. House of Representatives,
Rayburn Building,
Washington, D.C.

DEAR SIR: This will have reference to testimony given by Bernard I. Diamond before your Committee on Tuesday, June 20, 1967, in connection with H.R. 6418. At the request of the Committee Chairman, I am setting forth below our suggestions as to possible amendment of the Bill, consistent with our testimony. We propose the following:

Amendment No. 1

In line 25 of Subsection (c) on page 10 of the Bill, strike out the word "may" and insert in lieu thereof the word "will" and strike out the words "or only" and insert in lieu thereof ".".

Amendment No. 2

On page 11 of the Bill, strike out lines 1 and 2 of Subsection (c).

Amendment No. 3

On page 11 of the Bill, strike out Subsection (d) (1) and insert in lieu thereof the following new Subsection (d) (1):

"A license shall be issued in the case of any clinical laboratory which is participating or may be able successfully to participate in a proficiency testing program approved by the Secretary."

Amendment No. 4

In lines 13, 14 and 15 of Subsection (d)(2) on page 11 of the Bill, strike out the following: "or any class or classes thereof; and may be renewed in such manner as the Secretary may prescribe" and insert in lieu thereof the following: "in the case of a temporary license only".

Amendment No. 5

In lines 18 through 23 of Subsection (d)(3) on page 11 of the Bill strike out the following: "such sum (which in no event may be more than the sum determined by him to be necessary on the average to provide, maintain, and equip an adequate service for the purpose) as the Secretary may by regulation prescribe from time to time" and insert in lieu thereof the following: "in any case the sum of $25.00 per annum".

Amendment No. 6

In line 10 of Subsection (e)(3) on page 12 of the Bill, strike out the following: "standards" and insert in lieu thereof the following: "requirements of the Secretary".

Amendment No. 7

In lines 11 and 12 of Subsection (e)(3) on page 12 of the Bill, strike out the following: "laboratories and laboratory personnel prescribed" and insert in lieu thereof the following: "successful participation in a proficiency testing program approved".

Amendment No. 8

In line 15 and lines 17 and 18 of Subsection (e)(4) on page 12 of the Bill, strike out the following: "he deems" and "or continued compliance with the Secretary's standards hereunder," respectively.

Amendment No. 9

In line 19 of Subsection (e)(5) on page 12 of the Bill, following the word "refused" insert the following: "without just cause".

Amendment No. 10

In line 23 of Subsection (e)(6) on page 12 of the Bill, following the word "has," insert the following: "willfully".

Amendment No. 11

In line 25 of Subsection (e)(6) on page 12 of the Bill, strike out the following: "promulgated" and insert in lieu thereof the following: "permitted".

Amendment No. 12

On page 13 of the Bill, strike out Subsection (f).

Amendment No. 13

In line 16 of Subsection (g)(1) on page 13 of the Bill, following the word "Code." insert the following: "Filing of a petition for judicial review by an aggrieved party shall operate as an automatic stay of such final action by the Secretary under this Section, until final termination of such judicial review."

Amendment No. 14

In line 12 of Subsection (g)(3) on page 14 of the Bill, following the word "evidence," insert the following: "on the record considered as a whole."

Amendment No. 15

In line 19 of Subsection (h) on page 14 of the Bill, following the word "who," insert the following: "willfully."

Amendment No. 16

In line 20 of Subsection (h) on page 14 of the Bill, following the word "promulgated," insert the following: "and permitted."

Amendment No. 17

In line 25 of Subsection (i) on page 14 of the Bill, strike out the following: "not".

Amendment No. 18

In lines 1 through 4 of Subsection (i) on page 15 of the Bill, strike out the following: "by a licensed physician, osteopath, dentist, or podiatrist who performs laboratory tests or procedures, personally or through his employees, solely as an adjunct to the treatment of his own patients" and insert in lieu thereof the following: "in interstate commerce".

Amendment No. 19

In line 8 of Subsection (j) on page 15 of the Bill, strike out the following: "or nonprofit private agency or organization".

Thank you for your courtesies in this matter.

Sincerely yours,

ROBERT S. BOURBON,
Counsel,
American Association of Bioanalysts.

Mr. ROGERS. Thank you. Our last witness this morning, and we will try to hurry through so members can get to the floor, is Miss Ruth Heinemann, research associate, the National Council on Medical Technology Education, appearing for the American Society of Medical Technologists. Miss Heinemann, it is a pleasure for the committee to have you here today and we would appreciate if you would file your statement and it will be made a part of the record, without objection and, if you could, quickly summarize for us your main points.

STATEMENT OF RUTH I. HEINEMANN, RESEARCH ASSOCIATE, NATIONAL COUNCIL ON MEDICAL TECHNOLOGY EDUCATION, APPEARING FOR THE AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS

Miss HEINEMANN. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you.

Miss HEINEMANN. The members of the organization which I represent have strived individually and collectively to maintain, voluntarily, a high caliber of performance in medical laboratory work. We realize, however, that there are factors that have prevented desired progress in this direction and we recognize the need to undertake regulatory measures such as those proposed in H.R. 6418 in order to assure the accuracy and precision that are imperative in the practice of medical technology.

As the legislation is drafted, the provisions do not include qualifications for laboratory personnel. We assume that this aspect will be included in regulations that are promulgated by the Secretary of the Department of Health, Education, and Welfare and further, that these regulations will apply to all personnel performing laboratory tests.

I would like to say that the provisions for licensing laboratories without providing for personnel is almost like training to drive a car without a steering wheel. Past experiences have demonstrated that all of the equipment manufactured is not effective for consistently producing valid results if it is not operated by a knowledgeable personnel.

I would like to call to the attention of the committee a paper or report written in January 1967, entitled "A National Laboratory Improvement Program" which comes out of the National Communicable Disease Center. I would also like to call attention to two studies that indicate the importance of education in qualifying personnel for laboratory procedures. Both of them have been done in the State of Min-

nesota, one in the field of clinical chemistry, and this indicates that in the performance evaluation studies well-trained medical technologists demonstrated a higher level of accuracy and precision than those who had less training.

In the field of blood banking the accuracy of test results signed by technologists was significantly better than the accuracy of those signed by other laboratorians.

The results of these studies as well as performance evaluation programs conducted by NCDC supports the need for high education qualifications, and we would like to call your attention to those that are appearing in the medicare regulations for independent laboratories.

It should be emphasized, however, that in these particular regulations the comparability and equivalence of education and experience should be carefully determined, bearing in mind the advantage and the value of medical technologists' broad background of education compared with the limited background of specialists in fields such as microbiology, biochemistry, et cetera.

We also would like to indicate our interest in the provisions in H.R. 6418 for grant or contract support for education and we note the parenthetical phrase of "and training." The need for financial aid for graduate and continuing education has been presented at the late Congressman Fogarty's hearing by his Committee on Appropriations which provided for a minimal amount of support for continuing education in medical technology, and extremely minimal, eight students a year, in graduate studies.

We also would like to call to your attention the fact that the needs for manpower in the medical laboratory field are as great as others. We hope that the kinds of appropriations for education will be diverted to the undergraduate student.

I have attempted to bring to your attention the value and needs of the people who play a vital role in the health care of the Nation, and I thank you very much for the privilege of appearing before you.

If there are questions I will be pleased to answer them.

(Miss Heinemann's full statement follows:)

STATEMENT OF RUTH I. HEINEMANN[1], AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS[2]

Mr. Chairman and members of the committee, my name is Ruth I. Heinemann. I am a medical technologist and serve as Research Associate of the National Council on Medical Technology Education. I am a past president of the American Society of Medical Technologists. The active membership of this organization consists of about 10,000 medical technologists whose educational background includes four years of academic and professional study of basic sciences related to health. After successful completion of the national certifying examination given by the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists, these individuals can use the title of M.T.(ASCP). These standards of education and certification are upheld by the

[1] Miss Ruth I. Heinemann, B.S., M.T. (ASCP), Research Associate of the National Council on Medical Technology Education, Memphis, Tennessee. Past President of the American Society of Medical Technologists.

Previous positions include Chief Technologist of Clinical Laboratories of Mount Sinai Hospital, Minneapolis, Minnesota; Medical Laboratory Consultant on Hospital Services Demonstration Program of the Minnesota Department of Health; Student Technologist Supervisor in Clinical Chemistry at University of Minnesota, Minneapolis, Minnesota.

[2] The American Society of Medical Technologists was organized in 1932 to promote higher standards in clinical laboratory methods and research. Membership is based on certification by the Board of Registry of the American Society of Clinical Pathologists, or graduate degrees in an area of medical technology such as biochemistry, microbiology, hematology, etc.

Council on Medical Education of the A.M.A. and recognized by the National Commission on Accrediting. About 40,000 of the 58,000 ASCP-certified medical technologists are actively engaged in clinical laboratory work.

I am appearing before you today on behalf of the American Society of Medical Technologists. Members of this organization have strived individually and collectively to maintain, voluntarily, the high caliber of performance which is vital to the public health and welfare of the people of our country. We realize, however, that many factors have prevented desired progress in this direction and recognize the need to undertake regulatory measures such as those proposed in H.R. 6418 to assure the accuracy and precision imperative in the practice of medical technology.

As this legislation is drafted, the provisions do not include qualifications for laboratory personnel. We assume that this aspect will be included in regulations promulgated by the Secretary of the Department of Health, Education, and Welfare, and, further, that these regulations will apply to all personnel performing medical laboratory tests—without exception. This situation (i.e., provisions for licensing medical laboratories without specifying qualifications for their personnel) can be likened to attempting to drive a car that does not have a steering wheel. Past experience has demonstrated that all of the laboratory equipment manufactured is ineffective for consistently producing valid laboratory results if it is not operated by knowledgeable personnel.

A report prepared by the National Communicable Disease Center in January, 1967, entitled "A National Laboratory Improvement Program" contains information indicating "that erroneous results are obtained in more than 25% of all tests analyzed" in medical laboratory performance evaluation programs. This report defines several problems which contribute to substandard laboratory performance and proposes programs for increasing laboratory competency, most of which include, directly or indirectly, the advantage of educationally qualified personnel.

The position taken in this paper is substantiated by studies such as that done recently in Minnesota [3] to determine "whether participation in an evaluation study over a period of time would cause improvement in laboratory results". The study demonstrates that—

> "1. Laboratories employing well-trained technologists demonstrate a higher level of accuracy and precision than those employing less-well-trained laboratorians.
>
> 2. Well-trained technologists are capable of significantly improving laboratory performance by participating in evaluation studies, while less-well-trained laboratorians gain little or no benefit from participation."

Another study in Minnesota,[4] conducted at about the same time, was devoted to blood bank procedures. This revealed that "Accuracy of test results signed by Medical Technologists was significantly better than the accuracy of results signed by other laboratorians."

Studies of these as well as the performance evaluation program conducted continuously by the National Communicable Disease Center support the need for high education qualifications.

Consequently, the personnel in the Medicare regulations for independent laboratories specifying academic degree requirements for clinical laboratory supervisors and technologists are believed to be appropriate for maintaining a desirable level of practice and should be considered for inclusion as personnel regulations applicable to the licensing of laboratories proposed in H.R. 6418. It should be emphasized, however, that the comparability and equivalence of education and experience provided in these Medicare regulations for supervisors and technologists (Sections 405.1313 and 405.1315) should be carefully determined, bearing in mind the advantage and value of the medical technologists' broad background of education compared with the limited background of specialists in fields such as microbiology, biochemistry, etc. This is of particular concern in relation to supervisors. It is open to question as to whether a specialist at the Master's degree level, even with four years of experience in a variety of laboratory procedures, is necessarily better qualified to supervise a laboratory than the technologist meeting the education requirements of Section 405.1315 b(1) with the same experience. The multitude of supervisory problems—technical and administrative—points out the need for preparatory experience in several facets

[3] Merritt, B. R., et al., A Two-Year Study of Clinical Chemistry Determinations in Minnesota Hospitals, Minnesota Medicine 48: 939–956 (July), 1965.

[4] Kimball, A. C., et al., Blood Bank Procedures, Minnesota Medicine 47: 91–104 (January), 1964.

of clinical laboratory work rather than in a single field of the profession. The determination of proficiency in professional practice may be an advisable means of verifying the appropriateness of experience considered in lieu of education.

Recognition of clinical laboratory experience does not preclude that of the necessity of education. The National Communicable Disease Center report mentioned earlier states that "Studies have reported that there is a strong positive correlation between the education of the supervisor and the quality of laboratory performance."

The efforts and interests of medical technologists in enhancing their abilities through educational opportunities is evident in an informal survey done this past year by the National Council on Medical Technology Education. This reveals a strong interest on the part of medical technologist educators in advanced degree study and non-teaching technologists in continuing education programs pertaining to recent developments in instrumentation, and special areas of clinical chemistry, microbiology, blood banking, etc. Many of the respondents in the survey indicated that they have not undertaken additional study because they cannot financially afford it. The cost of producing as well as attending continuing education programs of two weeks or longer is high. The need for financial aid for graduate and continuing education in medical technology was presented two years ago before the late Congressman Fogarty at hearings of the House of Representatives Subcommittee on Appropriations for Labor, Health, Education, and Welfare. Subsequently, grants were given by the Cancer Control Division for continuing education programs in several phases of clinical laboratory practice at the University of Alabama Medical Center and to the Universities of Minnesota and Vermont for teacher education programs. Graduate fellowships for about eight medical technologists a year were provided at Ohio State University and the University of Alabama. All of these programs have received many more applications than they can accept, thus demonstrating the combined need for additional programs and financial support.

Knowing this situation, it is encouraging to note that this draft of HR 6418 includes in Section 304 authorization for grants and contracts for "research, experiments, or demonstrations (and related training)" pertinent to health facilities and services. Evidence supports the need for designating such appropriations to support education programs and fellowships for the preparation of supervisors and technologists. The impact of application of medical research to clinical practice of laboratory medicine, the evolution of automation and its related instrumentation, and the resulting increasing demand for services further complicated by the introduction of the Medicare program all emphasize the need for this kind of support.

In addition to providing means which will enable incumbent supervisors and technologists to develop and maintain desired high caliber of services, we recognize the need to aid undergraduate students who will be the future practitioners of the profession. The estimated need for health manpower as well as the high costs of education and demands for physical facilities for these academic programs is well publicized. To meet the challenge of staffing clinical laboratories, the American Society of Medical Technologists has carried out an intensive program for recruitment of personnel for a number of years with the assistance of the National Committee for Careers in Medical Technology. Unfortunately these recruitment efforts are hampered by lack of monies for scholarships and loans for students in medical technology to aid those in financial need. Although the constituent societies of the American Society of Medical Technologists in many of the United States have such funds, their resources are limited to the extent that they offer assistance only to an average of one person per state with an average grant of $200 per person. This is not large enough to make a significant contribution to the educational expense nor is it available to enough people to make an impression on the solution of manpower deficits in our profession. Therefore the need for additional financial aid which will assist undergraduate students is as important as that for continuing and graduate study—if not more so.

In summary, I have attempted to bring to your attention the value and needs of a group of people who play a vital role in the health care of the nation—the medical technologists. Justification for incorporating regulations specifying academic degree and appropriate experience qualifications for supervisors and technologists in clinical laboratories licensed for interstate commerce as pro-

posed in HR 6418 has been presented. The potential for diverting contracts and grants specified for health facility development through research, demonstration and related training to provide financial support for undergraduate, graduate and continuing education programs which will enlarge the future manpower resources and enhance the abilities of incumbent personnel have also been presented. Your favorable consideration of this information can only lead to the realization of better health care for our citizens.

It is a privilege to appear before you. It will be a further privilege to provide assistance in the future as you may desire it.

Thank you.

Mr. ROGERS. Thank you so much, Miss Heinemann. Mr. Kyros.

Mr. KYROS. I just wish to say I appreciate Miss Heinemann's testimony. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Brown.

Mr. BROWN. Thank you, no, Mr. Chairman.

Mr. ROGERS. Thank you so much for your testimony. It is most helpful.

This will conclude our hearing for today and the committee will adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 12:32 p.m. the committee adjourned to reconvene at 10 a.m., Wednesday, June 21, 1967.)

PARTNERSHIP FOR HEALTH AMENDMENTS OF 1967

THURSDAY, JUNE 22, 1967

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

The committee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Samuel N. Friedel presiding (Hon. Harley O. Staggers, chairman).

Mr. FRIEDEL. The committee will now come to order.

We are meeting this morning for the purpose of further consideration of H.R. 6418, to amend the Public Health Service Act to extend and expand the authorizations for grants for comprehensive health planning and services.

Our first witness this morning will be Dr. John Mayne and Mr. Karl Ladner. They are representing Mr. Schuster, who was here but who had to leave. They represent the Mayo Clinic of Rochester, Minn.

STATEMENTS OF DR. JOHN G. MAYNE, FACULTY MEMBER, MAYO FOUNDATION; AND KARL J. LADNER, SECTION ON ADMINISTRATION, MAYO CLINIC, AND OFFICER OF THE MAYO FOUNDATION

Mr. LADNER. Mr. Chairman and members of the committee, I am Karl Ladner, an officer of the Mayo Foundation.

Accompanying me is Dr. John Mayne, a member of the faculty of Mayo Foundation, and an internist on the staff of the Mayo Clinic.

We will read the statement that Mr. G. S. Schuster, chairman of the board of trustees of the Mayo Foundation prepared. He has asked me to express his regrets that a prior commitment prevents his being here today.

I have handed to the committee staff a copy of the additional supporting data in written form.

Mr. FRIEDEL. If there is no objection, the material will be included in the record at the conclusion of your remarks.

Mr. LADNER. Thank you.

We are happy to be able to appear here this morning, Mr. Chairman, to express our views on some of the provisions of H.R. 6418, which provides in part for Federal support of research and investigation into improved methods of health care delivery. We direct our comments particularly to section 304, paragraph 2, subparagraph B, where we find the following words: "projects for development and testing of new equipment and systems, including automated equipment, and other new technology systems or concepts for the delivery of health services."

To make clear our interest in and support of this proposed legislation, I feel it necessary to state briefly the nature and character of the institution we represent.

The Mayo Clinic was established soon after the turn of the century as the outgrowth of the medical practice of the Mayo brothers. The Mayo Foundation was established in 1919 as a companion organization to the Mayo Clinic to engage in and conduct medical research and graduate medical education.

Thus, the two Mayo institutions, with their independent associated hospitals, comprise today a medical center located in Rochester, Minn., which has had for its primary orientation throughout more than half a century the provision of specialty medical care to its patients in close association with clinical investigations, basic medical research, and medical education at the graduate or residency level, as well as the postgraduate level.

The staff of the Mayo Clinic, which also supplies the faculty of the Mayo Foundation, now consists of 470 physicians and medical scientists. We have in the Mayo Graduate School of Medicine approximately 700 graduate physicians engaged in specialty or residency training.

We receive and care for some 200,000 patients each year, of whom approximately one-half require extensive investigation and treatment of complex medical problems. Some observers have credited us with providing medical services with efficiency. I will only say that since we serve a substantially nonresident population, we have endeavored throughout our history to so organize patient care that service is rendered with all the promptness and dispatch which is consistent with the highest standard of care of which our staff is capable.

In accomplishing this, we rely heavily upon our medical recording and reporting system, the basic principles of which were laid down as early as 1907. This system now contains the medical records of nearly 3 million patients, in some instances lifetime records.

In our efforts constantly and consistently to improve this medical information system, we have not hesitated under medical guidance to borrow the best principles and practices adaptable from the fields of industrial engineering, operations research, systems analysis, and business administration. We believe this is an efficient system—yet in common with other medical centers and doctors everywhere, we find ourselves unable to keep current with public demand for medical service.

I recite these facts simply so that the committee will understand that the current national interest in improved methods of health care delivery and the more rapid transfer of the great recent advances in medicine to the bedside of the sick patient has excited our interest also since it lies directly in the field in which we have been credited with some accomplishment and have at the very least a knowledge and a long period of usage of a system of medical practice which, among other systems, may be considered a logical one upon which to build.

Consequently, within the Mayo institutions we have been asking ourselves urgently how best we can serve the social interest in health care practices and have been examining our responsibility to use our resources for yet improved systems of practice.

Out of all the possible fields of study, we have selected one area in which to concentrate our efforts, and in which we now find ourselves heavily engaged. I refer to computer applications to the practice of medicine, or more properly, the application of modern information handling technology to existing medical information systems.

Here I wish to make a careful distinction. We are not speaking of the use of computers to solve problems in medical research. Such uses are already well advanced in our institution and others, particularly in the laboratory sciences. Nor are we speaking of computer technology for the storing of medical knowledge of the past as a library stores the knowledge of the past.

Rather, we are aiming at the utilization of electronic data processing methods as a tool for the practicing physician in which there can be stored, manipulated and made available for instant retrieval the necessary medical data of all patients under current care.

Here the computer is asked to function not as a calculating machine of miraculous rapidity, but rather, in its mode of storage and retrieval of mass data. Modern medical practice still records observations, medical histories, patient responses, doctors' orders, nurses' notes largely in handwritten form, except where time permits secretarial transcription. This system is not basically changed since the day of Hippocrates.

Gentlemen, we submit it is a proper source of national concern that modern electronic methods now commonplace throughout industry, commerce, trade, banking, have made such little progress in the service of our overburdened physicians and health care establishments, and yet the reasons for this defficiency are not far to seek.

First, it is an enormously costly undertaking to convert medical data to machine processable form.

Second, only recently has computer technology advanced to the point where the input-output devices, the sizes of the memory banks, the newer modes of time sharing, have brought the state of the art to a point of readiness to begin to deal with the vast mass of data required by a total medical information system whose inputs are not solely confined to the simpler forms of so-called "hard data," but which also contain narrative statements, X-rays and a substantial amount of material in graphic form.

A medical information system may be said to be the means by which a physician communicates with his colleagues in other disciplines, the means by which he communicates with himself from time to time, the means by which he records his observations and places them in storage for the future care of his patients by himself or by others, the means by which he communicates with and adds to the total body of medical knowledge available to our society.

The fact that this enormous system of medical communication still relies largely upon paper, pen and ink in an age when electronic impulses can be made to serve these same purposes constitutes perhaps the most substantial single constraint upon our medical profession in meeting the health needs of our Nation.

One observer has characterized this as a crisis in medical information. The physicians of America are submerged in a sea of paperwork at the very time their learning and knowledge is greater than ever before and needed as never before. The hope and prospect of time-

saving for doctors and their professional assistants cannot be dismissed without an effort.

Perhaps we can best illustrate the scope of the problem by stating briefly a few of the objectives we have set for ourselves in this work.

First, in our opinion, a modern medical information system must be total, flexible, and transferrable. No need to erect a system which will do only part of the job. No need to create a system of use only to one medical institution or group.

The system we envision must be usable by hospitals, by outpatient facilities of size, by groups of physicians of whatever number or form or organization, and by the individual solo practitioner as well, who may wish to correlate his practice with a regional system of medicine.

Secondly, the system upon which we are working is based upon the premis that physician, the nurse or other health professional must interact directly with the system. By this we mean that the record should come directly and without intermediary assistance from those having the requisite professional knowledge.

Thirdly, we believe that the physician must be able to utilize this new method of creating his records in a mode that is comfortable and practical for his purposes and without the necessity of learning new or uncommon skills. This Nation does not have the time to redesign its medical practitioners nor to remove them from the firing line of medical practice for such purpose.

Fourth, and perhaps most important of all, we aim to develop a system which will have no possibility of placing constraints upon the free action of the physician in his patient's best interests, and above all, no possibility of working a long-range diminution of his knowledge and skill. On the contrary, we believe a modern medical information system can increase the skill and the learning of the individual doctor. Such is the vast array of medical knowledge now available that the options in diagnosis and treatment vastly exceed the ability of one human brain to contain them all.

Yet by combining the knowledge and skills of various physicians into the memory banks and logic systems of a computer, we believe it is possible constantly to array before the individual physician a broader choice of alternatives than his skill alone can encompass. Thus, we forecast that modern information technology can create a virtuous upward spiral of learning among all users rather than a vicious downward spiral.

The cost of developing, testing, and evaluating a medical information system of the kind we need is very high. We believe that we can profitably employ in our work alone sums approximating $7 million per annum over the bulk of a 5- to 7-year program. We believe that 40, perhaps 50 man-years of physician-specialist time must be devoted.

We know that systems engineers, systems analysts, and programers must be brought into the work in substantial numbers. The Mayo institutions alone will have invested during the current calendar year roundly $1 million merely to study in a preliminary way the feasibility of such an electronic information system. Costs are high because this is no work for the inexperienced or partially trained. The most highly skilled systems engineers must put their minds to this problem.

We believe that only the most skilled physicians at the peak of their professional powers should be allowed to participate in what basically

is an effort to restructure the entire body of medical knowledge and convert it into machine processable form.

This is work of great national importance. Poorly done, the Nation's health needs will not be served. Brilliantly performed, the rewards can be very great. We do not believe that any workers, including our own, have penetrated far enough into this field to be able to state with confidence that such-and-such a percentage of physicians' or nurses' time can be saved by these more modern methods. Yet the preliminary indications are exciting.

We know, for example, that automated laboratory equipment already in use can record its results with a central computer without human intermediary. We have tested preliminary patient questionnaires which, machine processed, will serve to shorten the tedious question and answer process by which the physician elicits the medical history of his patient, and which, moreover, will speed the patient to that specialist most competent to deal with his health problem.

In the hospital field, small-scale computers have been harnessed in the scheduling of hospital beds and operating rooms and are yielding efficiencies equivalent to the construction of new, added facilities. Preliminary tests convince us that segments of the information base which the individual physician wishes to record can be done with time-saving on even the early input devices now available to us, which themselves require further development.

So far, we have spoken only of computer technology as a new tool for the practicing physician. A substantial auxiliary benefit is certain to follow from the recording of patient-care data is more retrievable form. I am told by physicians that answers to medical problems needed for decades are irretrievably locked up in the cumbersome and bulky records of the medical institutions of this country.

Tedious and time-consuming individual inspection of these records represents today too great a drain of medical manpower. The ability to question an electronic memory bank containing these data by programs simple to contrive represents no less than the prospect of another breakthrough in medical knowledge directly applicable to the care of the sick.

Gentlemen, in summary, industrial organizations and medical institutions have already made substantial commitents of money and time to the preliminary investigation of this problem. The accomplishment of meaningful results, we believe, lies beyond the power of the private sector of the economy, and should not constitute an additional burden on the costs of medical care.

What is needed from the Government, we believe, is an infusion of venture capital on a scale exemplified in the legislation and the estimates you have under consideration. These sums are modest by comparison with other Federal programs, but if in your wisdom they are to be offered, I can assure you that the private sector will respond, including, among others, the institution we represent, if found qualified.

(The attachments to Mr. Ladner's statement follow:)

INFORMATION TECHNOLOGY: A NEW RESOURCE IN HEALTH CARE

THE GROWING CRISIS IN HEALTH CARE

We who are adults today have seen more progress in the understanding and treatment of human ailments than has been made in the entire span of history

up to our time. This progress is attributable in part to a determined national policy in recent decades to find, through scientific research, ways to provide healthier and longer lives. Concurrently, we have become increasingly aware of the necessity of bringing the benefits of this research to all persons, whatever their age, their location, or their means.

This combination of scientific and social progress has resulted in a serious strain on our system for the delivery of health care, a system consisting of practicing physicians, professional and technical personnel in allied fields, and the facilities necessary to their practice. The growing insistence on application of increasingly complex knowledge and the constantly increasing number of patients needing care are creating a crisis in our ability to deliver medical care of high standards to all of the nation's people.

This problem has been recognized, and major programs to train more physicians and supporting personnel and to provide expanded facilities are in progress. However, these programs have well-recognized limitations which restrict the extent or rapidity of the solutions they afford. It is possible that expanding our present facilities without altering the organization of our health-care system may lead only to further suboptimal use of our health-care professional manpower.

Urgently required are additional creative efforts, complementary to those already in progress, to bring new resources to bear in achieving our common goal: To make medical care of the highest quality available to all who need it.

A NEW APPROACH: THE COMPUTER IN MEDICINE

It is likely that historians of the future will regard the use of computers as substitutes for the more routine functions of man's mind as at least as significant an event as the earlier use of machines as substitutes for the more routine functions of man's muscles. An essential part of the practice of medicine, and of medical education and research as well, is information processing—the collection, manipulation, retrieval, and communication of information. The application of computers to this process in certain areas of medical endeavor has, in recent years, become increasingly common. The widening scope of these applications is made possible by rapid developments in computer technology (or, more broadly, information technology). While more and more research projects in medicine are making fruitful use of these new techniques, until recently any attempt to effect revision of the processes of health care on a broad scale would have failed for lack of suitable information-processing techniques. This is no longer true. Now, real-time or time-sharing techniques have been developed to the extent that the computer is essentially at the instantaneous command of the user. New input-output terminals make possible the use of the computer by the physician, on his own terms without special training or skills. What remains to be done is to take information technology out of the laboratory and, on a systematic and comprehensive basis, place it in the hands of physicians in the day-to-day practice of medicine.

A GROUP EFFORT BETWEEN PHYSICIANS AND SYSTEMS ENGINEERS

The development of a medical information system of the kind we need is an undertaking of major proportions. Although no longer dependent on any scientific breakthroughs, it is dependent on a major restructuring of medical knowledge and practice on one hand and on systems engineering on a scale rivaled only by our larger military systems on the other. It is unlikely that physicians alone or systems engineers alone could succeed; rather, what is required is an effective working partnership between physicians and systems engineers.

The Mayo Clinic, a large institution dedicated to health care, has for some years directly experienced the increasing crisis in the delivery of health care. Through research programs during the past several years, the staff of the Mayo Clinic has been able to assess directly the potential contribution of computers in improving health care and increasing productivity of the health-care system.

Much thought was given to the manner in which the medical experience of the Mayo Clinic staff and systems engineering experience could be combined effectively to achieve a comprehensive medical information system which would freely exploit modern information technology as a new resource in modern medical practice. Mayo Foundation assembled a group of systems engineers, in September, 1966, to commence the first phase—systems analysis and design for a medical information system—of a broad effort to attain this goal.

THE PROGRAM

As is usual in systems engineering practice, the total program to achieve an operational medical information system at the Mayo Clinic and its associated hospitals has been planned in three broad phases—(1) systems analysis and design, (2) systems development, and (3) systems operation. The initial phase, systems analysis and design, is planned to require 1 year and commenced in Rochester on November 1, 1966. Its goals are to design an over-all system, with supporting task statements, budgets, and schedules for the second phase—systems development—and to test experimentally the medical feasibility and acceptability of this system in those areas in which the physician or the patient (or both) directly interacts with the system.

The system is best described in terms of a basic statement of purpose and objectives.

Purpose. The purpose of this program, the development of the Mayo medical information system, is to make a significant contribution to the practice of medicine throughout the world by successful demonstration of a transferable application of modern information technology to the corporate[1] practice of medicine. The approach to this goal shall be to apportion medical information processing activities among patient, physician, paramedical staff, and computer in accord with the resources of each, so as to utilize optimally the capabilities of those engaged in patient care and thus offer the best care possible to the increasing number of patients seeking care. Such a system would, by definition, be transferable to other corporate, regional, or group practices.

Objective. To attain this purpose successfully, the system must fulfill the following objectives:

1. The system must extend the ability of the physician, on his own terms, to care for a maximal number of patients consistent with the highest standards of medical practice.
2. The system must provide for the availability, organization, timeliness, and reliability of whatever information—about the patient, about previous clinical experience with other patients, and about the body of medical knowledge—is required by the physician for the optimal care of the patient.
3. The system must be acceptable to the physician and to the patient, and, as part of the clinical environment, it should enhance the physician-patient relationship.
4. The system must provide effective and powerful means for retrospective and prospective clinical research studies.
5. The system must meet the needs of medical education by allowing efficient and complete entry of data and convenient retrieval and review of information relating to diagnosis, therapy, and results.
6. The system must be readily adaptable to advances in both medicine and information technology.
7. The system must be consistent with ethical, legal, and accreditation requirements.
8. The system should result in a reduction in the cost of patient care, but this objective should not be allowed to interfere with the achievement of the other objectives.

For this phase of the study, management responsibility at the policy level lies with a special committee consisting of members of the Board of Governors of the Mayo Clinic and members of the Board of Trustees for the Mayo Foundation. Technical operating responsibility lies with a committee of Mayo Clinic physicians, and includes a principal physician-investigator representing the Mayo Clinic. For the first year, staffing is at an average level of 31 men, 8 of whom are practicing staff physicians.

FINANCIAL SUPPORT

The urgency of the need and the potential benefits of the solution are so great that the Mayo Foundation has committed itself to underwriting the cost of the first phase, and will seek private support for the feasibility study.

Of serious concern is the funding of the second phase, the systems development or implementation phase. It is difficult to offer a precise estimate of the require-

[1] This term as used herein is intended to mean the coordinated and integrated application of the various disciplines of medicine and other health professions to the medical problem of the individual patient without constraints stemming from organizational forms or, hopefully, from geography.

ments before the results of the systems analysis and design phase are available; however, it is currently estimated to be of the order of $30 million over a 5-year period.

There is some evidence that in ultimate operation the system may be substantially cost effective, provided there is no amortization of development costs. That is, the cost of operation could be offset approximately by the financial savings inherent in the system. Therefore, the financial burden is in the initial development, a one-time cost for the production of an operational system largely transferable to other medical institutions throughout the nation.

The expected costs for the systems development phase exceed the financial capability of the Mayo Foundation. They similarly appear to exceed the capability of any of the private financial sources dedicated to the advancement of health care. Thus, it appears essential to the success of this undertaking that Federal support be considered for this phase. In requesting Federal funding, a number of issues are raised which require thoughtful examination: (1) public responsibility vs. private responsibility, (2) Federal support of research vs. Federal support of systems development, (3) whether the timing is correct from the Federal point of view, and (4) optimal environment for this undertaking.

PUBLIC RESPONSIBILITY VERSUS PRIVATE RESPONSIBILITY

Health care in the United States historically has been primarily a responsibility of the private sector. The Federal Government, however, has a dual role in the field. First, it is directly responsible for delivery of health care to certain segments of our population, through the Department of Defense, the Veterans Administration, and the Public Health Service, and indirectly responsible for financial support of individual health care, principally through Medicare. Second, it acts as a catalyst in advancing the capacity for and quality of health care in the private sector by supporting medical research, education of medical manpower, and construction of medical facilities.

The concept of a medical information system fits directly into the second role as well as potentially serving the Government's direct health care responsibility. By supporting the development of a prototype system, the Government can make possible a reliable, transferable demonstration that can lead to application of this new technology throughout the nation.

This program can be an excellent example of what President Johnson has aptly called Creative Federalism—drawing on the best of the public and private sectors in partnership to advance the quality of our society. This program potentially represents the merging of the best skills of medicine and systems engineering, initial private financial support, and subsequent Federal financial support, all directed toward a common ultimate goal—the improved health care of people everywhere. In the ultimate sense, it provides an opportunity to capitalize on national investments already made, by virtue of using already-qualified physicians, already-performed medical research, and already-trained systems engineers. By this amalgamation of the best of our resources, it appears possible to make a significant advance in an important area of human need.

RESEARCH VERSUS SYSTEMS DEVELOPMENT

Traditionally, in the medical sciences the Federal Government has focused its support on basic research. The result has been enormous progress in the understanding and treatment of human ailments. The transfer of the results of this research to patient care takes place largely through the medical literature, medical and scientific meetings, or, in some cases, through industry.

This transfer process functions reasonably well for new knowledge that can be applied on an individual or small group basis. The practicing physician can learn from a journal, a lecture, or a representative of a pharmaceutical or instrument company and can apply this knowledge as appropriate in his practice. This process is not effective, however, for new knowledge that can be applied only on a large scale, such as a medical information system. No matter how well informed the physician becomes, and irrespective of his conviction of the value of the new technology to the care of his patients, the individual physician is unable to command the magnitude and scope of effort required for effective results. Practical application depends on the activities of dozens or even hundreds of persons—physicians, paramedical personnel, and systems engineers—in a coordinated program.

Thus, in the broadest sense, Federal support of systems development should not be viewed as an alternative to research but, rather, as a complement to it and in fact, as essential to bringing into application certain kinds of research results.

TIMING

Is this the optimal time to initiate such a program? The growing imbalance between the demand for and the capability of delivery of health care argues in favor of a prompt start. Careful assessment of the technology reveals that this undertaking is dependent not on any scientific breakthrough but, rather, on the systematic and integrated application of existing medical and engineering knowledge.

Wide-scale use of a transferable medical information system is expected in 5 to 15 years. Therefore, accomplishing the development now will place us in a position to implement this new technology widely when, hopefully, we will be able to afford to capitalize on this new resource for increasing our health-care capability. Failure to complete the development now will unnecessarily delay the ultimate availability of the system.

THE ENVIRONMENT

In considering Federal funding of the magnitude required for development of a medical information system, it is essential to evaluate carefully the environment for such a program in terms of what will best serve national needs. Clearly, the Government cannot afford extensive duplication of prototype development: it must support such development under conditions which offer the maximal probability of a successful result and the best possibility of transferability to health care throughout the nation.

We believe that the proposed plan offers the best climate for a successful result. It represents a working partnership between practicing physicians and systems engineers on a man-to-man, day-to-day basis. In a broader sense, there is represented here an exciting experience in combining two of our key national resources—physicians and systems engineers—on a heretofore unparalleled scale. The success of this project could have a profound impact on our ability to solve similar problems in other fields.

The Mayo Foundation has demonstrated competence in (1) the integrated group specialty practice of medicine and surgery (more than 198,000 patients cared for in 1966, the majority as outpatients and approximately 30% in 1,500 hospital beds); (2) medical research (1966 budget more than $7 million); and (3) medical residency training at the graduate level (700 residents enrolled in 1966). The work of the Mayo Clinic is performed by 470 full-time medical specialists, 700 residents, and 2,400 paramedical personnel.

Systems development in the present Mayo environment provides an opportunity to build this new technology into the medical practice of the future. The integrated group practice of medicine at the Mayo institutions is believed to possess most of the elements which, according to current trends, will be widely followed a decade from now. These elements include truly integrated group practice, a high degree of consultative practice, care of the maximal feasible percentage of patients on an ambulatory or outpatient basis, integration of all pertinent medical support services (such as clinical laboratories, diagnostic and therapeutic radiology, electrocardiography, etc.), integration with hospital care (including a common medical record) and sharing of many medical support services, a strong administrative structure keyed to the most efficient delivery of high-quality patient care (which is most likely to ensure unified direction of a project of the size and complexity of the one described), and, finally, a community of interest built on a common commitment to the group practice of medicine for the full spectrum of patient care.

In addition, an important resource basic to this project is the advanced and refined manual-mechanical information system already existing at the Mayo Clinic. Mayo Clinic medical record systems were originally established in 1907 and have been in use continuously ever since. They incorporate the outpatient as well as the hospital records of more than 2,700,000 patients; in thousands of instances, the complete lifetime medical records of local residents are on file. These records and their management constitute a medical information system which, during 60 years of daily use, has been subjected to improvement and refinement primarily by physicians, but also by the continuous application of systems technology, work simplification techniques, and the incorporation of innovations from the fields of library science, industrial engineering, and com-

merce. In the opinion of neutral observers, this system is the most advanced medical information system of the precomputer era and is, therefore, probably the optimal base for conversion to modern electronic data processing methods.

In any attempt to alter the organization of delivery of medical care, the characteristic resistance to change of the medical practitioner must be taken into account. Within the Mayo institutions, resistance to the corporate or group practice of medicine (no longer as obvious as it once was, but still viable) has of necessity been altered into a firm belief that this will be the only acceptable practice of medicine in the future. There has arisen among the staff of the Mayo Clinic the belief that medical information systems will be essential to the practice of medicine in the future. This has been evidenced by the increasing number of members of the Mayo staff who are involved in individual computer-based projects (41 in 30 research programs in biomedical sciences).

The Mayo institutions have served as a model of group (corporate) practice for 50 years. Their system of practice has proved to be eminently transferable. There are many reasons for this, but one of the most prominent is the residency training program. The residents who were trained in a group practice for the most part wished to continue in such a practice on completion of their training. If groups were not available they formed their own, frequently modeled on the Mayo system. It would seem reasonable that any new system devised under such conditions will first be accepted by those who had contact with it in their training. A medical information system developed in an institution having patient care as its central goal is, in our opinion, most likely to be acceptable to physicians. Thus, it would seem probable that any new medical information system developed within the Mayo institutions and acceptable to its staff would be highly transferable to its own (700 in 1966) and to other residents. Furthermore, a system developed within a group (corporate) practice would be highly transferable to other groups.

SUMMARY

Perhaps no more difficult task exists for those in positions of national responsibility than to exploit wisely the results of the almost explosive growth in science and technology that we have experienced in recent decades. But no goal is more worthwhile than the relief of human illness and disability. In this paper we have outlined what we believe to be a new and constructive contribution to this goal to which we have already committed our energies and resources. We sincerely believe that this undertaking—impossible without Federal support—merits Federal support. It is our hope that the Government will share with us the conviction that the potential benefit of harnessing technology for the improvement of medical care warrants the fullest measure of support.

BUDGET ESTIMATE—MEDICAL INFORMATION SYSTEM

Final system development costing has not been completed, but three generations of existing exercises have been undertaken to illuminate development sequence alternatives.

The following developmental cost estimates include physician time (40 man-years), programming (490 man-years), equipment development and lease, and developmental operations for a five-year program.

[In thousands]

Year	Cost	Cumulative
I	2,200	2,200
II	6,900	9,100
III	7,200	16,300
IV	7,300	23,600
V	6,600	30,200

These figures are pessimistically cast pending a convincing determination that applicable programming may be obtained from other sources, either projects or computer manufacturers. Availability of such programs could reduce total system development cost 5 to 15 per cent. Equipment costs are based on eight-year leases. Anticipated departures of equipment cost from present estimates might revise program development cost several per cent either way.

A demonstration of cost savings during on-going development may reduce net cost sharply, but to base firm projections of such reductions on available data would be premature. The figures above form a realistic representation of the sums to be required for such a program.

The possible and hoped for results of this program are:

1. An operational, integrated outpatient and hospital information processing system transferable in whole or in part, which will facilitate the more efficient use of medical manpower. These benefits can and will be estimated analytically during the course of the present study.

2. A successful prototype demonstration of a geographically compact system which is equivalent in equipment, programming and medical information traffic to a system serving a metropolitan area of one million, and transferable to such an environment with only minor modifications.

3. A generally applicable basic body of computer-manipulable medical content useful in other health-care information systems.

4. A system which encourages complete documentation of patient status, generates completely machine-processable records which, when operating in the complex referral practice environment of a large outpatient clinic, may constitute perhaps the most powerful clinical research tool now in prospect.

5. An opportunity to assess, on a realistic scale, the imlications for quality of patient care of the unambiguous communications, the tireless follow-up and the painstaking information retrieval of the computer.

6. An opportunity to assess objectively the implications of routine association of physicians and computers for enabling physicians to deal more effectively with the expanding body of medical knowledge.

Mr. LADNER. On behalf of the Mayo Foundation and its staff, I wish to thank you, Mr. Chairman and members of the committee, for this opportunity to appear before you.

Mr. FRIEDEL. I want to thank you for your statement, Mr. Ladner.

On page 7 of your statement you say the Mayo institution alone will have invested during the current calendar year $1 million to study in a preliminary way the feasibility of such an electronic information system.

I understand you have had this in effect for some time.

Mr. LADNER. Actually, we have been working on this for 3 or 4 years. We intensified our efforts beginning last November. The figure I quoted in this statement would be for the fiscal year from November 1 last year until this coming October 31.

Mr. FRIEDEL. Do you find that you take care of more patients because of this equipment?

Mr. LADNER. Mr. Friedel, at this time this is strictly in the feasibility stage. We have some experimental projects that are beginning to come onstream.

I might ask Dr. Mayne to describe one he has regarding the patients' questionnaire. We have some very preliminary data, but it is by no means in a form that can be used on a practical basis, day by day, to care for patients at the present time.

Dr. MAYNE. Mr. Chairman, we have found that many physicians must spend a considerable amount of time in clerical work, collecting information from sick patients about the nature of their illness.

The average time we have found at our institution for an internist to check the medical history of a patient is about 27 minutes, from a study we have completed in the past 6 months. We have found also that with the help of resident physicians that can be shortened by a matter of almost of 10 minutes.

There is no doubt that the availability of information given by patients to a resident physician, to clerks, to technicians, will appreciably shorten the staff physician's time necessary to learn some of the details

about his patient's problem, and through a period of a day adding up a number of these periods of time we hope that we can see one or two additional patients per physician.

The exact number of minutes that can be saved, the number of additional patients that can be seen, we hope to have some idea about at the end of our feasibility study in November, and will have had time to compare actual time measurements.

We know we can save time. I cannot specifically say how much time, but I know we can spend the time saved to the benefit of our patients, either in seeing additional patients or spending it specifically on the patient's problems, to give him the personal care and help that he needs.

I think what may sound impersonal is actually going to increase the rapport between doctor and patient and will help our treatment as well as shorten the time that we take to give it.

Mr. FRIEDEL. For instance, at Johns Hopkins Hospital in Baltimore, would your system be exchangeable with their's?

Dr. MAYNE. We are working on really the exchange of medical information. We are hoping, as much as possible, to make this independent of any specific hardware, to use programs that can be used at any institution.

The medical information exchange between patient and physician is common in all institutions. I would think it would be exchangeable; yes, sir.

Mr. FRIEDEL. Do you think it will take 5 to 7 years before the whole system is completed? How long will it take to complete the system?

Dr. MAYNE. The best estimate we can give at the present time would be 5 to 7 years. This is if full effort is put into it. The most difficult parts which deal with the narrative information and medical records, I think, will take 5 to 7 years, to organize the structure of medicine so that it can be actually manipulated by the physician and the nurse, not by the secretary. I think it will take 5 to 7 years of intensive effort to do this part. Other parts can be done in a very short period of time. Some are being done currently.

Mr. FRIEDEL. Mr. Springer?

Mr. SPRINGER. May I say I am very much interested in this.

I am not quite sure I understand all of what you are doing. Is this something similar to what I observed in the hospital recently; for instance, a heart patient who has this attached to him and you have something like a TV screen which tells the nurse of an emergency situation where three of them are handling a group of patients around a critical list?

Is this the kind of recording device you are talking about, or is that only a part of it?

Mr. LADNER. I believe we know what you are talking about, Mr. Springer. We do have a project. We call it a monitoring system, whereby a critical patient is connected by a series of transducers to some sort of a data collection device or display screen.

Of the system we talk about, this would be only a small part of it. The major part of the system would actually allow the physician to record by the use of a computer the information he secures from a patient or from laboratory tests and X-rays performed for the patient, in a form whereby it could be stored in a computer on magnetic tape or in the core memory.

It would be reproduced when he wanted access to it either on a television screen or typed by the computer in the form of typewriting on a piece of paper.

In most of the medical institutions, this is put down in handwritten form to make up the patient's medical record.

The other areas of which you speak, of which there could be a number, could provide the input from those recorders and transducers which would automatically be sent into the computer and recorded in the same fashion.

Mr. SPRINGER. I think I have your overall idea now. For a system such as Mayo, Carl, or Christie Clinics, this would be a tremendous help. But the point I am wondering about is if this is a practical thing for the ordinary doctor's office.

Mr. LADNER. We believe when it is developed, it will be, Mr. Springer. In fact, we think this is a system that could energize the entire regional program that the Congress and the Senate have approved and inaugurated in the last year or so.

One could visualize the solo practitioner could have a console connected by wires to a medical center in which there would be such a computer. In effect, this would supply him with medical information in the same way that one might wish to go to a library to secure this information. He could secure it right in his office.

Mr. SPRINGER. Do you mean by telephonic or electrical connection he could secure this information from you, for example?

Mr. LADNER. That is right.

Mr. SPRINGER. Is that what you have in mind?

Mr. LADNER. Actually, our intent is to work on the medical content and the systems or programing necessary to implement such a system within our own medical center.

As Dr. Mayne has said, we want to design this in such a fashion that it would be readily transferrable to other medical centers. We do not have an intent in our minds at this time to supply this in the form of a utility, as we would telephones, to doctors all over the country, but we envision that this probably will happen.

The probable result will be a regionalization. There will probably be a medical center within 500 or 800 miles that could serve the region and physicians in such a region.

Mr. SPRINGER. Are you familiar with the situation at NIH, their recording systems?

Dr. MAYNE. I am not personally familiar with it, Mr. Springer, but one of my associates has visited the center within the past 2 weeks and is writing a report. Those of us working on this type of project have a tendency to visit each other throughout the country.

I know Dr. Linden, who is working with us, has visited NIH in the past several weeks. But I have not visited it myself.

Mr. SPRINGER. You understand their recordings are all being recorded on tape for the purpose of storage. We don't have enough storage in this town to take care of all they produce out there if it is typewritten. Do you visualize this as a part of the system, the same kind of system?

Dr. MAYNE. I think so; yes.

Mr. SPRINGER. In other words, it would be a quick reference, is that right?

Dr. MAYNE. Yes, sir.

Mr. SPRINGER. You say that this would shorten time. I take it what you are doing, then, is that you are going to put into the hands of the technicians some of the questioning and answering, and so forth, in order to relieve the doctor of all of this writing down in longhand, which is transferred later to the medical record. You call this a total medical information system.

Dr. MAYNE. Yes, sir.

Mr. SPRINGER. What makes this so difficult to produce, in talking about 5 to 7 years?

Dr. MAYNE. The most difficult portion of the job is structuring or organizing the content of medical knowledge in such a way that it can be entered and retrieved through terminals and processed by computer. The physician, in caring for his patient, needs information on which to make decisions.

Mr. SPRINGER. What you want, then, is to be able to push a button on William Springer's file, is that it, instead of searching around to find out where it is?

Dr. MAYNE. It is very easy to enter numbers, but it is very difficult to enter text. Text is important and this is the part that is going to be difficult.

Mr. SPRINGER. Did you say that you are putting $7 million in this, or do you want $7 million to put into it?

Mr. LADNER. This fiscal year we will spend approximately $1 million, Mr. Springer. We believe to fully develop this system will require approximately $7 million annually for a 5- to 7-year period.

Mr. SPRINGER. How much?

Mr. LADNER. A total of about $30 million.

Mr. SPRINGER. To produce it?

Mr. LADNER. That is right.

Mr. SPRINGER. Are the results of this available to everybody?

Mr. LADNER. Yes, sir.

Mr. SPRINGER. Do you have the bill before you?

Mr. LADNER. Yes, sir.

Mr. SPRINGER. You refer to "research and demonstrations relating to health facilities and services," No. 2 on that page.

Mr. LADNER. Yes.

Mr. SPRINGER. That is to make contracts with public and private agencies. Are you asking for a grant or a contract?

Mr. LADNER. We could operate under either phase.

Mr. SPRINGER. That would be relating to developing utilization, quality, organization, financing of services for hospitals and other facilities, and on page 6 it refers to projects for new systems, including automated equipment and new technology equipment and concepts.

Have you anything to add to that?

Mr. LADNER. No, sir.

Mr. SPRINGER. Thank you, Mr. Chairman.

Mr. FRIEDEL. Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

As I understand it, the project you are working on is computerized first of all to give better service; but, secondly, it is to conserve the time, I presume, of the doctor and the nurse.

Dr. MAYNE. Yes, sir.

Mr. ROGERS. In the long run, we would hope to make a saving in the use of personnel. Is that basically the point?

Dr. MAYNE. Yes, sir.

Mr. ROGERS. What is your estimate for the future that this could bring about as far as the saving dividend? Have you projected this at all?

Mr. LADNER. We have to be honest about this. We would like to say that we have data that indicates or anticipates we could save a certain percentage. However, our feasibility study, that is, our intensified effort in this regard, is not at the stage as yet where we can give any specific figures. But this is actually our intent.

One of the major objectives of the study is to determine if health personnel can be utilized more efficiently in the care of patients.

Mr. ROGERS. What jobs do you anticipate can be taken over by an automated system?

Dr. MAYNE. I would say that the automated system can primarily process and store information. It is possible even for the patient himself to interact with a terminal, a bit of hardware, and to give portions of his own history. One can secure physiologic measurements with technicians.

I think at the present time this is a little early to count on saving much time. But it has definte potential. We have some definite experiments just completed within the past week which will be published. I really thought this was not very feasible, but it is.

The machines, as I envision them, would largely be used to process, store, reorganize, present, and retrieve material for the physician or the nurse to use in the care of the patient. But it is possible that we can go further and actually have the patient, himself, interact a portion of the time with the terminal, again further saving time.

Mr. ROGERS. In the overall problems with computers, what are some steps taken by hospitals today to reduce costs of hospitalization? Is it possible, for instance, for a number of hospitals to get together and have a joint effort on, say, their laundering, on bookkeeping, items like that? Is that projected?

Mr. LADNER. Mr. Rogers, I believe considerable work in this area can be done and that savings should result. In our medical center in Rochester, as you probably know, the Mayo Clinic does not own or operate either of the hospitals with which we are associated. St. Mary's has approximately 1,000 beds and the Rochester Methodist Hospital has about 570. Over the years we have worked very closely with these hospitals, and the hospitals have worked very closely with us.

We at this time do have a number of joint efforts in this regard. We are going to have some more in the future.

For example, our hospitals have had mechanical bookkeeping systems for their accounts receivable, their bed counts and this sort of thing. They have come to us recently and have said, "We do not think it is wise for us to continue this way. Wouldn't it be more economical for us if the three of us, the two hospitals plus the Mayo Clinic, embarked upon a joint venture to put all of the accounting, bookkeeping, and so on, into a central computer?"

The three institutions have agreed to do this. We are proceeding to implement this.

In the presentation we are making today, we are not talking about this kind of thing in our statement. We are talking about actually a computer being used in a different sense.

Mr. ROGERS. But you think there is a possibility to help reduce the overall costs?

Mr. LADNER. There is no question about it.

I would like to comment, if I may, a little bit on your earlier inquiry about the use of paramedical personnel. The Mayo brothers, as you know, are now deceased, but were believers in several things that I think we will see more and more of come to pass in this country.

One was that they shared the opinion that paramedical personnel could do many jobs that do not need a physician's training. There has been a ratio in the Mayo Clinic over these 20 years since I have been associated with it of approximately 5.2 paramedical personnel for every physician. This was started, as I said, by the two Mayo brothers.

We believe in the specialization of labor, not only physician to physician, in the specialty practice, but a division of labor of such nature whereby the physician's time should be devoted to those elements of patient care that the paramedical person cannot do.

I think we will see an acceleration of that in the future, not only in our institution, but in other medical centers.

Mr. FRIEDEL. The time of the gentleman has expired.

Mr. ROGERS. May I ask just one more question, Mr. Chairman?

Mr. FRIEDEL. You may.

Mr. ROGERS. Perhaps you can supply something for the record, but I would like to ask you about this. I am concerned about the type and quality of emergency service. It seems to me we are moving more and more to where people are having to come to emergency rooms to get services that in the years past you would go to the doctor's office for.

I don't know why there has been such a move. Particularly on weekends you may not be able to locate a doctor, so you have to go to the emergency room. From what I have seen in some of the hospitals, and from what I have heard, often the man on duty there is a man that someone else has paid to take his place on the roster. Sometimes he is the man who is not too active in practice, so here he is.

Maybe he is not the most qualified doing the emergency service, and perhaps when emergencies come in, he is perhaps the least qualified to give emergency treatment at the time the person needs it.

Could you comment on that?

Mr. LADNER. I think that is a good point. We have felt in Rochester for a long time that the emergency room in our hospitals should be used for true emergencies, and that patients who can be cared for on an out-patient basis should not be sent or directed to the emergency room.

If these patients are directed to this facility, the orderly care of patients who are in true need of emergency care cannot proceed promptly. In Rochester for many years we have had the philosophy that patients should be cared for as much as possible on an out-patient basis; that is, our doctors believe that only those patients needing hospitalization should be placed in a hospital.

Consequently, the major portion of our patients are cared for on an out-patient basis. They live in hotels or motels while they are being seen in our out-patient facility.

Mr. ROGERS. But I wonder if we will have to review our thinking and maybe have set up in a hospital a service for people who really don't have any emergency, as such, but need some help.

Mr. LADNER. Perhaps I didn't go into this in sufficient detail. We have in our out-patient buildings, which are separate from our hospitals, two facilities designed just to do this. One is called a children's health service and the other is the acute illness service, in which adults are cared for.

We try to direct as much as possible patients who do not need the elaborate services that are necessary in an emergency room to these other facilities.

Mr. ROGERS. If you would let us have the way you operate that, it would be helpful for the record.

Thank you.

Mr. FRIEDEL. Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

First, I want to welcome my fellow Minnesotans to Washington. I would like to send back my personal greetings to Dr. McCarty. There were some very anxious moments in our family not too long ago and thanks to his skill, everybody is happy. I notice your reference on page 7 where you indicate that it would require $7 million per annum over a time of 7 years to develop this program.

Is this strictly in the area of study and research? Does this include equipment? What does it include?

Mr. LADNER. Mr. Nelsen, we estimate that of this total, approximately two-thirds of the cost would be brain work; that is, the design work and the research that is necessary such as Dr. Mayne talked about, structuring the medical records.

In addition, it would require a sizable number of man-hours of computer programers to create a system by which this information could be entered into a computer. About one-third of this cost or this total budget would be devoted to rental of computers.

Mr. NELSEN. You have no way of knowing what the net gain would be at the moment. It would take experimental processing before you would have any idea what the real costs would be in the future after you have gone through the experimental stage?

Mr. LADNER. Yes, sir. We are not far enough along at this time to give an intelligent answer to that question.

Mr. NELSEN. I recall the Methodist Hospital that came in here with a plan for a circular structure. Has this facility been completed?

Mr. LADNER. Yes, sir. It was opened about the first of December last year. It has been accepted extremely well by physicians and patients. It is essentially fully utilized at this time.

Mr. NELSEN. Do you find it a satisfactory arrangement?

Mr. LADNER. Dr. Mayne can talk from the physician's standpoint about this.

Dr. MAYNE. My colleagues are very pleased with the facility, Mr. Nelsen. At present the people of Methodist Hospital are engaged in a research program to study the types of things you mentioned, for physicians and nurses, to compare the efficiency of work in different sizes and shapes of medical units.

Then there is the patient and physician satisfaction. Everyone seems enormously pleased not only with the physical facility, but with the

opportunity to experiment for the first time in finding out what is the best type, shape, and size of room, and so on, for caring for patients with different types of illnesses.

Mr. NELSEN. Getting back to the computer approach, the subject we are discussing, could a small-town practitioner, in order to get this information back, feed his file card index through a machine? How would this be transferred from his office, we will say from Hutchinson to Minneapolis, and then returned?

Dr. MAYNE. Probably through somewhat like a telephone exchange at the present time. I rather imagine that in the future, and this is guess work, computer facilities in areas will be somewhat like telephone institutions are at the present time.

This will be necessary if there is to be communication of large amounts of data, needing large processors over long distances. It is sort of like a telephone system or a local heating or electric plant.

Mr. NELSEN. Thank you very much.

Mr. FRIEDEL. Mr. Keith?

Mr. KEITH. I have no questions, Mr. Chairman.

Mr. FRIEDEL. Thank you very much, gentlemen.

Our next witness will be our colleague from Maryland, the Honorable Edward A. Garmatz, chairman of the Merchant Marine and Fisheries Committee.

Mr. ROGERS. Mr. Chairman, I want to join you in welcoming the chairman of the Merchant Marine and Fisheries Committee to our committee. I have the honor to serve on the Merchant Marine and Fisheries Committee as well.

I know our committee will benefit from his testimony today.

It is a pleasure to see you, Mr. Garmatz.

Mr. MURPHY. Mr. Chairman, I also serve on the Committee on Merchant Marine and Fisheries and have served for the last 5 years with the distinguished chairman of that committee, Mr. Garmatz.

I hope by his appearance here today he understands why sometimes I am absent from that committee because I am over here.

Thank you.

Mr. KEITH. Mr. Chairman, I am delighted to see our distinguished colleague here today.

Mr. VAN DEERLIN. Mr. Chairman, I will apologize for being late by stating that I was just over testifying before Mr. Garmatz.

Mr. FRIEDEL. You may proceed, Mr. Garmatz.

STATEMENT OF HON. EDWARD A. GARMATZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. GARMATZ. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I want to take this opportunity to thank you for affording me time to testify in connection with H.R. 6418.

It is my understanding that the purpose of this bill—amongst other matters—is to extend and expand the authorizations for grants for comprehensive health planning and services, et cetera—and to authorize cooperative activities between the Public Health Service hospitals and community facilities, and for the other purposes.

Presently the law affording medical care and treatment of seamen is set out in 42 USC section 249(a), and covered under Public Health

Service Regulations, Part 32, found in PHS Manual Laws and Regulations TN–137.

Copies of the code citation and pertinent excerpts from the PHS Manual Laws and Regulations are attached as exhibits 1 and 2.

Briefly the present law covers—

1. Seamen employed on vessels of the United States—and in some cases—American seamen of foreign-flag vessels.
2. Cadets at State maritime academies, or on State training ships.
3. Cadets at the Kings Point Maritime Academy.

However, the law does not now cover seamen trainees who are participating in maritime training programs—such as those jointly sponsored by labor management groups.

These cooperative programs are set up to help overcome the current serious deficiencies of seagoing personnel.

The labor management groups within the maritime industry has directed its attention to various maritime training programs designed for both the licensed and unlicensed seamen.

In my city—the great Port of Baltimore—which is part of my district—the MEBA apprentice program is operated jointly by the National Maritime Engineers Beneficial Association District No. 1, and Pacific Coast District, AFL–CIO and the Nation's leading steamship companies.

Basically this is a 2-year program, offered to young men generally, without any sea service experience, leading to a position as a licensed marine engineer.

The first 6 months at the apprenticeship school are devoted to academic studies, conducted at their facilities on shore.

The following year, the students sail aboard U.S. merchant marine vessels as apprentice engineers.

The remaining 6 months, the students are returned to school—and at that time qualify to sit for their Coast Guard licensing examination.

These students do not have the availability of medical care at public Health Service facilities during the first 6 months of their schooling—because they are not bona fide seamen at this point.

However, during the year at sea, according to the interpretation of the now existing law, the same students would be eligible for medical care at Public Health Service facilities.

And this same student would still be eligible for benefits for at least 90 days thereafter—once he then returns to school shoreside.

But he would not be afforded medical care at Public Health Service facilities during the last 3 months of this 2-year training program.

Because, unfortunately, the existing regulations do not extend coverage to the seamen trainee beyond 90 days from his last discharge from a ship.

In order to include students engaged in maritime training program within the scope of H.R. 6418, I propose—and urge—the adoption of the following amendment to H.R. 6418.

The text of the proposed amendment is as follows:

(d) subsection (a) of section 322 of such act is further amended by adding at the end thereof the following new paragraph:

"(8) Seamen-trainees, while participating in maritime training programs to develop or enhance their employability in the maritime industry."

In addition to students at the NEBA school in Baltimore, "seamen-trainees", without prior sea service—now participating in maritime programs through the efforts of the Seafarers International Union, and the National Maritime Union—would also be benefited.

Such schools are located in New York, Baltimore, Houston, and the Great Lakes area—as well as on the west coast.

I call attention to the fact that the aforementioned maritime training programs are financed through labor-management agreements and there is no direct contribution by the Federal Government.

Most of the seamen-trainees who would be covered by this proposed amendment would be young, able bodied American boys that would be afforded this coverage for a very limited period of time.

Continued coverage would depend upon whether or not they make a career at sea in the U.S. merchant marine.

I respectfully urge that you amend H.R. 6418 as suggested.

Thank you.

(The documents referred to follow:)

TITLE 42 U.S.C.—THE PUBLIC HEALTH AND WELFARE

§ 249. Medical care and treatment of seamen and certain other persons; foreign seamen; certain quarantined persons; temporary treatment in emergency cases; authorization for outside treatment.

(a) The following persons shall be entitled, in accordance with regulations, to medical, surgical, and dental treatment and hospitalization without charge at hospitals and other stations of the Service:

(1) Seamen employed on vessels of the United States registered, enrolled, and licensed under the maritime laws thereof, other than canal boats engaged in the coasting trade;

(2) Seamen employed on United States or foreign flag vessels as employees of the United States through the War Shipping Administration;

(3) Seamen, not enlisted or commissioned in the military or naval establishments, who are employed on State school ships or on vessels of the United States Government of more than five tons' burden;

(4) Cadets at State maritime academies or on State training ships;

(5) Seamen on vessels of the Mississippi River Commission and, upon application of their commanding officers, officers and crews of vessels of the Fish and Wildlife Service;

(6) Enrollees in the United States Maritime Service on active duty and members of the Merchant Marine Cadet Corps;

(7) Employees and noncommissioned officers in the field service of the Public Health Service when injured or taken sick in line of duty; and

(8) Persons who own vessels registered, enrolled, or licensed under the maritime laws of the United States, who are engaged in commercial fishing operations, and who accompany such vessels on such fishing operations, and a substantial part of whose services in connection with such fishing operations are comparable to services performed by seamen employed on such vessel or on vessels engaged in similar operations.

EXCERPTS FROM PHS REGULATIONS

§ 32.14 Evidence of eligibility.

(a) As evidence of his eligibility an applicant must present a properly executed master's certificate or a continuous discharge book or a certificate of discharge showing that he has been employed on a registered, enrolled, or licensed vessel of the United States. The certificate of the owner or accredited commercial agent of a vessel as to the facts of the employment of any seaman on said vessel may be accepted in lieu of the master's certificate where the latter is not procurable. When an applicant cannot furnish any of the foregoing documents, his certification as to the facts of his most recent (including his last)

employment as a seaman, stating names of vessels and dates of service, may be accepted as evidence in support of his eligibility. Documentary evidence of eligibility, excepting continuous discharge books and certificates of discharge, shall be filed at the station where application is granted. Where continuous discharge books and certificates of discharge are submitted as evidence of eligibility, the pertinent information shall be abstracted therefrom, certified by the officer accepting the application, and filed at the station.

(b) Except as otherwise provided in §§ 32.11 to 32.23, inclusive, documentary evidence of eligibility must show that the applicant has been employed for 60 days of continuous service on a registered, enrolled, or licensed vessel of the United States, a part of which time must have been during the 90 days immediately preceding application for relief. There may be included as a part of such 60 days of continuous service as a seaman time spent in training as (1) an active duty enrollee in the United States Maritime Service, (2) a member of the Merchant Marine Cadet Corps, (3) a cadet at a State maritime academy, or (4) a cadet on a State training ship. The phrase "60 days of continuous service" shall not be held to exclude seamen whose papers show brief intermissions between short services that aggregate the required 60 days: *Provided*, That any such intermission does not exceed 60 days. The time during which a seaman has been treated as a patient of the Service shall not be reckoned as absence from vessel in determining eligibility. When the seaman's service on his last vessel is less than 60 days, his oath or affirmation as to previous service may be accepted.

§ 32.15 Sickness or injury while employed.

A seaman taken sick or injured on board or ashore while actually employed on a vessel shall be entitled to care and treatment without regard to length of service.

* * * * * * *

§ 32.17 Lapse of more than 90 days since last service.

Where more than 90 days have elapsed since an applicant's last service as a seaman and he can show that he has not definitely changed his occupation, such period of time shall not exclude him from receiving care and treatment (a) if due to closure of navigation or economic conditions resulting in decreased shipping with consequent lack of opportunity to ship or (b) in the event the applicant has been receiving treatment at other than Service expense.

Mr. FRIEDEL. I want to thank you very much for your very frank statement.

The only question I would like to ask is this: Does this proposal have the approval of both labor and management?

Mr. GARMATZ. That is correct.

Mr. FRIEDEL. Mr. Rogers?

Mr. ROGERS. Sir, is there any estimate of about how many probably would be covered?

Mr. GARMATZ. I would think probably less than 600 average in a year. This varies in the various schools in various cities. Some classes have 150, some 300, some 80.

We have tried to sum it up and I would say, roughly, less than 600 per year, average.

Mr. ROGERS. Can anyone start one of these schools or are they pretty well set, the number of schools that would be covered? You mentioned the one in Baltimore, as well as the union schools that have been worked out by agreement with management in the various cities.

Mr. GARMATZ. The Masters, Mates, and Pilots have a school in Houston. But, naturally, they are experienced seamen and they are looking for an upgrading license, so they would automatically be covered.

But the youngsters in the schools such as Baltimore, Houston, New York, the various other cities, those are the youngsters who are not covered.

That is the reason for the proposed amendment.

Mr. ROGERS. Thank you very much.

Mr. FRIEDEL. Mr. Devine?

Mr. DEVINE. No questions.

Mr. FRIEDEL. Mr. Kornegay.

Mr. KORNEGAY. I have no questions, Mr. Chairman. I want to take this opportunity to welcome our good friend, the chairman of the Committee on Merchant Marine and Fisheries, and to commend him for his forthright statement this morning.

Mr. FRIEDEL. Mr. Keith.

Mr. KEITH. I am very grateful to the chairman of the Merchant Marine and Fisheries Committee for showing us once again the concern he has and that we should have in the Congress for the problems on the maritime industry and, in particular, their personnel.

Thank you, Mr. Chairman.

Mr. FRIEDEL. Mr. Van Deerlin.

Mr. VAN DEERLIN. No questions, Mr. Chairman.

Mr. FRIEDEL. Mr. Murphy.

Mr. MURPHY. Thank you.

I would like to congratulate the chairman of the Merchant Marine and Fisheries Committee for his statement and on this for bringing this statement to the committee while this legislation is before us. I serve on the Special Subcommittee for Maritime Training and, as such, have visited most of these schools about which the chairman has spoken, particularly the Seafarer's International School for Seamen as well as the National Maritime Union School for Seamen.

I think at this time the necessity and the need for supporting this amendment could be borne out by the fact that the various steamship companies have had to fly personnel from Houston to San Francisco just to make a ship sailing on time for a necessary move to the Far East to support our Vietnam shipments.

The cost of these schools is borne entirely in some instances just by the union and in other instances through joint union and management sponsorship. I think the inclusion of medical care for these apprentices in the trade, to go back and cover that first 6 months, is certainly a most worthy and necessary amendment to the legislation before us.

When we are in executive session, Mr. Chairman, I will be very carefully looking for this inclusion. Thank you.

Mr. FRIEDEL. Mr. Stuckey.

Mr. STUCKEY. I have no questions.

Mr. GARMATZ. Mr. Chairman, if I may say one thing about the school of Baltimore, and I don't brag because it is in my city and district, I saw the school start 6 months ago.

It is now operating out of the Southern Hotel in Baltimore. The seamen-trainees are high school graduates, very fine, clean-cut youngsters. They are studying hard. I visit there quite often. I know exactly how they are carrying on in the school trainees.

They have a gymnasium for them, a machine shop, and many other facilities. So it is carried on in a very high-class tradition. I am sure the other maritime training programs are handling them in pretty much the same manner. As Congressman Murphy said, he is on the Special Subcommittee on Maritime Education and Training.

They have visited all of these academies and training programs. I am sure it is a worthy cause that these boys get health protection at this time. Again, thank you very much, Mr. Chairman, for the opportunity to appear this morning.

Mr. FRIEDEL. Thank you.

Our next witness will be Mr. Richard Guttmacher, executive vice president of the Bionetics Research Laboratories of Falls Church, Va. You may proceed Mr. Guttmacher.

STATEMENT OF RICHARD GUTTMACHER, EXECUTIVE VICE PRESIDENT, BIONETICS RESEARCH LABORATORIES

Mr. GUTTMACHER. Thank you, Mr. Chairman.

My name is Richard Guttmacher. I am executive vice president of Bionetics Research Laboratories, Inc., an independent research laboratory with laboratories in Falls Church, Va., and Kensington, Md. We are grateful for the opportunity to appear here today in support of H.R. 6418 and hope that by our testimony we are able to contribute to the general strengthening and success of the bill.

I will be brief. The services performed by our laboratories fall into two categories. Our research division performs research under contract for the National Institutes of Health and other governmental agencies. The other phase of our laboratory operation—affected by H.R. 6418—our analytical services division, performs clinical testing services of the type contemplated for regulation under section 5 of the bill, appropriately termed the "Clinical Laboratories Improvement Act of 1967."

The Analytical Services Division of Bionetics Research Laboratories, which I shall hereafter refer to as BLR, was founded in 1964. This division was created and is perpetuated on the theory that broad utilization of advanced technological and scientific equipment will permit the performance of high-quality clinical testing services at the lowest cost. As such, we are representative of the modern, automated, computerized, large volume clinical laboratory.

We feel our contribution to the public's health is realized in the lower cost of our testing services as well as its higher reliability and quality.

By achieving the economies of volume, we have been able to provide physicians with more qualitative and quantitative information on the condition of their patients at a more affordable cost.

At present, BRL performs in excess of 5,000 tests weekly. We are qualified under medicare regulations for independent laboratories and provide our services on an interstate basis.

Federal regulation of clinical laboratories engaged in interstate commerce is long overdue. Lack of such regulation in the past has too often led to either substandard testing or has encouraged particular professional factions to attempt to impose self-serving restrictions foreclosing the field to other equally qualified professions. For these two reasons alone, we warmly embrace the concept of fair and uniform Federal standards as embodied in H.R. 6418.

In common with others who have testified before this committee, we believe that certain provisions of the bill, because they repose excessive discretion in the Secretary of Health, Education, and Wel-

fare are unnecessarily and undesirably vague. In our letter of May 19, 1967, to Chairman Staggers, we pointed out those provisions we believe objectionable and the ways in which they could be improved. In the interest of time I request that our letter and its attachments be printed in the record immediately following my statement.

Mr. FRIEDEL. Without objection that will be done.

Mr. GUTTMACHER. A synoptic restatement of the views expressed in that letter is that H.R. 6418 could be improved by—

(1) Specifying a single, uniform license fee not related to the costs of administering the program;

(2) Directing that the Secretary adopt standards under this act consistent with those imposed by he medicare regulations; and

(3) By providing adequate safeguards for a laboratory believed to be in substantial violation of the regulations by better delimiting the personal authority of the Secretary.

The committee willing, I would like to devote the remainder of my testimony to the complex problem, dealt with by section 353(k) of the bill, concerning the relationship of State regulation to that proposed at the Federal level.

BRL hopes steadily to expand the geographic area in which it offers its testing services. In view of the statutes in force in several States, however, which expressly or by interpretation prevent outside laboratories from doing business within the State, BRL and a number of similar competent and qualified laboratories will not be allowed to provide their services to that segment of the public.

We approve of section 353(k) which would allow States to impose additional or more stringent requirements for laboratories provided that these are not inconsistent with those imposed at the Federal level.

However, we believe that State statutes already exist which are contrary to proposed basic definitions of qualification at the Federal level, and we fear additional requirements might also take the form of discriminations against out of State laboratories and interfere with interstate laboratory commerce.

These discriminations can take the form of either purely geographical restrictions or restrictions which tie the geographical requirements to group or disciplinary exclusivity. I can best illustrate this by examples drawn primarily from our own experience.

New Jersey requires that a laboratory director be a resident of that State, thus impeding the use of out-of-State laboratories. In Texas, the attorney general has ruled that the operation of a clinical laboratory is the "practice of medicine": this ruling, in effect, restricting the operation of clinical laboratories in Texas to Texas-licensed physicians.

Until recently, Pennsylvania took the position that they could not inspect laboratories outside the State: thus this statute has been interpreted to mean that out-of-State laboratories no matter how well qualified, could not operate legally in Pennsylvania. Florida has statutes very similar to those of Pennsylvania.

On the other hand and to the best of our knowledge, New York, California, and Maryland have State laws in consonance with existing

Federal medicare regulations and have all seen fit to interpret them in an open and equitable manner.

There was historical explanation for some existing State statutory discrimination to the extent that many were put into effect at a time when no Federal statutes or standards existed and interstate commerce in the laboratory field was virtually nonexistent.

However, if Federal statutes are now enacted, as contemplated in the legislation before this committee, these arbitrarily varying State statutes, rather than helping safeguard public health may well have the opposite effect by depriving citizens of some States of the technical advances and lower medical care cost available from large, federally qualified, independent regional laboratories located outside of these States.

We would hope that the committee will recognize that these State discriminations pose serious problems for a business such as ours and do not result in any public benefit. We would suggest that the committee take whatever explicit action is necessary to insure that a federally licensed laboratory is not excluded from any State on the basis of geography or because one favored professional group or discipline is not represented within its complement of personnel.

If the regulations promulgated under this act are patterned after the medicare regulations for independent laboratories (as we would hope and expect them to be) the public will be adequately safeguarded.

Medicare regulations impose standards and qualifications for those supervising and performing laboratory procedures predicated upon ability and competence, as shown by both experience and academic degree.

These regulations are not restricted to members of a particular professional discipline. While the regulations are stringent and rightly conducive to the highest standards of quality in laboratory performance, it is hoped that they will operate to prevent the possibility of local monopolistic control of laboratory work by a single group or profession.

The ability to move freely across State lines is economically necessary for federally licensed private regional laboratories.

I can assure you that such laboratories will produce lower costs and greater technical progress. They will compete where local monopolies, quicker, and less expensive medical tests.

In this regard, we understand that the National Communicable Disease Center will shortly issue a report in which they endorse the concept of private regional laboratories and encourage their development.

We hope that the advent of Federal regulations will prevent the clinical laboratory field from becoming increasingly the victim of a patchwork of laws, the net effect of which will be to hamper advances in the state of the art and inhibit the improvement of laboratory procedures and practices which depend for their development upon new multipurpose instrumentation and the constant large volume of work they permit.

Accordingly we request that the committee strengthen section 353(k) by the addition of the following phrase:

Provided, however, That no State shall discriminate against any laboratory licensed pursuant to this Act on the basis of its location in another State or the professional discipline of the personnel of such out-of-State laboratory.

Again we wish to emphasize our earnest and complete support for H.R. 6418. By the adoption of the modifications suggested in our letter to Chairman Staggers, and especially by adoption of the nondiscrimination amendment that I have recommended here today, we believe that the overall success of the bill will be greatly enhanced.

In view of our proximity to the District of Columbia may I issue now an invitation before closing to visit our Falls Church location, if any committee or staff member is interested in seeing the operation of a modern automated laboratory.

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

(The letter and statement referred to follow:)

BIONETICS RESEARCH LABORATORIES, INC.,
May 19, 1967.

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

DEAR MR. CHAIRMAN: Bionetics Research Laboratories, Inc. welcomes this opportunity to support the "Clinical Laboratories Improvement Act of 1967" which is part of H.R. 6418. For several years, Bionetics Research Laboratories has been operating a fully equipped, modern laboratory facility of substantial size in the Washington, D.C. metropolitan area. The Analytical Services Division of BRL conducts examinations of a type proposed to be covered by the terms of the Bill. Its Research Division fulfills research contracts for the National Institutes of Health and other governmental agencies.

BRL has long recognized the value, both for the public and for the clinical laboratory industry, of careful governmental regulation. The Department of Health, Education and Welfare has recently provided such regulation, albeit in the somewhat limited area that is initially the scope of Medicare. (The Government will pay for laboratory tests, for persons eligible under Medicare, only if the tests are performed in a laboratory that satisfies standards that have been promulgated by HEW, which are as stringent as practical under the circumstances.) BRL, which has qualified under Medicare, regards H.R. 6418 as a logical extension of such regulation to all laboratories engaged in interstate commerce.

The clinical laboratory industry is a young, vigorous and rapidly growing one. State regulation, while adequate in some areas, is wholly lacking in others. There is a definite need for Federal measures to assure the public of the best in laboratory operations that present personnel and technology permit.

In the clinical laboratory field, as in many other fields of scientific endeavor, great strides in technological progress are being made which result in benefits to the public of more reliable, more comprehensive, quicker, and less expensive tests. These changes can and should prove to be of substantial benefit to both the family physician and to the specialist in diagnosing and treating their patients' ailments. To accomplish these ends, however, all concerned must be assured of the reliability of the persons performing the tests. Constructive Federal regulation has a large role to play here.

BRL has a few specific comments about H.R. 6418 and these are attached as Appendix A. We would be glad to submit further comments on the Bill. should the Committee desire. If any representatives of the Committee desire to visit a large-volume laboratory, with the personnel and equipment to perform several hundred tests, Bionetics would be glad to have them visit its clinical laboratory facilities here in Falls Church.

BRL requests the opportunity to testify in support of the Bill at such time as the Committee reconvenes hearings and would appreciate being notified of that date.

Thank you.

Very truly yours,

FRANCIS E. MILLER, *President.*

APPENDIX A

1. *Section 353(a)(1).* As pointed out in its letter to the Committee in support of the Bill, Bionetics conducts research activities on a large scale, for the

Federal Government. We doubt that it is the intention of the authors of the Bill, or of the Committee, that such activities of a laboratory be covered by the Bill, since the standards for such research are covered in other ways and the needs for such controls may be entirely different from those appropriate for regular clinical laboratory activities, oriented towards physicians treating individual patients. As presently worded, however, the definition of the term "laboratory" or "clinical laboratory" could be construed to include certain aspects of life-science research facilities engaged in work for Federal or State Governments. Therefore, it is suggested that an exemption be included at the end of Section 353(a)(1), exempting Governmentally sponsored research activities from the coverage of the Act.

2. *Section 353(d)(1)*. Section 353(d)(1) provides no specific guidelines for the Secretary to formulate regulatory standards to be promulgated under the authority of the Act. We think that this delegation is too broad. One remedy would be to add specific rules such as those contained in S. 894, which was introduced on February 8, 1967, and referred to the Senate Committee on Labor and Public Welfare. Another solution would be that the Committee make clear, in its report to the House, that the recently promulgated medicare regulations are the type of controls that are contemplated by H.R. 6418. An important feature of the Medicare regulations is that the standards and qualifications which they establish for those supervising and performing laboratory procedures are predicated upon ability and competence, as shown both by experience and academic degree. These regulations are thus based upon an individual's actual proven ability to perform particular procedures, rather than restricting opportunity to members of a particular discipline. Thus, while the regulations are, as we have said, stringent and are rightly conducive to the highest standards of quality in laboratory performance, they do not constitute an undue burden on competent laboratories nor do they permit the possibility of monopolistic control of laboratory work by a single group or profession.

3. *Section 353(d)(3)*. The provision for license fees is unnecessarily and undesirably vague as to the charges that the Secretary can impose. The aggregate maximum appears to be an amount, to be determined unilaterally and internally by the agency, adequate for "the purpose", which purpose is not defined. Moreover, the words "on the average" might be susceptible to an interpretation that would allow the agency to discriminate among laboratories, charging some more and some less.

We see no reason why any license fee should be charged. Such fees are inadequate and inappropriate as general revenue raising measures and since the purpose of the Bill is to promote the general welfare, general revenues should finance administration of the proposed legislation.

If any fees are to be charged, the agency should now be able to recommend a specific maximum figure, and the Bill should state what the maximum is. The Bill should also provide that fees shall be uniform; little, if any useful purpose could be served by variable fees, and the power to prescribe such fees entails substantial possibilities of unfairness and discrimination, whether unintentional or not.

4. *Section 353(f)*. Section 353(f) provides for the temporary suspension *without a hearing* of the license of any laboratory up to 60 days "if the Secretary determines that the public safety or welfare would otherwise be in imminent danger". Bionetics is in full sympathy with the problem with which this provision attempts to deal. However, we feel that the provision in operation could prove far too drastic. A suspension of even 30 days almost certainly would put a laboratory out of business. Such power should not be vested in the hands of the office that also promulgates and enforces the regulations under this Bill. We submit that it would be adequate if the Secretary instead were expressly authorized to bring suit in court to obtain a preliminary injunction, pending ordinary administrative hearings, in cases where he (or his subordinates) concludes that an imminent danger to the public health may result from interim action or inaction by a laboratory licensed under this Bill. Such a procedure would be as speedy and effective as the unilateral determination by the Secretary, but would afford the valuable safeguard of having a disinterested party make the decision that could well have the effect of putting a laboratory out of business.

5. *Section 353(g)(3)*. Bionetics suggests that the last sentence of this provision be changed to comport with the normal standards of administrative review by adding after the words "substantial evidence", the customary modifying phrase: "on the record as a whole".

6. *Section 353(k)*. Bionetics has no objection to the present provision, which presumably would allow States to provide higher standards for laboratories than the Federal Government provides. We doubt, however, that as a practical matter this area of State freedom will result in any significant public benefit insofar as laboratories engaged in interstate commerce are concerned; the Federal standards will be adequate.

There is, however, a danger of in-State discrimination against out-of-State laboratories. Some State statutes presently prohibit out-of-State laboratories from engaging in interstate commerce within that State (by means such as requiring that the laboratory director be a resident of the State). While these prohibitions are of dubious Constitutional status, they do act as a substantial deterrent to the expansion of laboratory activities. Such State prohibitions are particularly unfortunate in view of the fact that recent and continuing technological advances, and the imposition of stringent personnel qualifications by the Federal Government (qualifying fewer personnel), are making the optimum size of a laboratory steadily larger. To operate efficiently, and to provide the public the best in laboratory facilities and services, laboratories should have access to the widest possible markets.

For example, BRL personnel daily pick up samples and specimens for testing from physicians and medical institutions in the Virginia and Maryland suburbs of Washington, in Washington itself, and in the Baltimore metropolitan area. All of the tests are performed at Bionetics' laboratory in Falls Church, Virginia. Written results of these tests are returned to the physicians, generally on the following day, either by mail or by personal delivery. It is clear that if Bionetics' activities were restricted to the State in which its laboratory facilities are located, it could not operate economically on a technologically optimum basis, unless it substantially increased its charges. Yet some States (not including Maryland or the District) entirely bar out-of-State laboratories.

The effect of such barriers is plainly deleterious. The Sheltered in-State laboratories are ensured a monopoly, and monopoly is never conducive to the public interest. On the other hand, the advent of Federal regulation of laboratories engaged in interstate commerce removes, entirely, whatever justification there otherwise might have been for a State to bar out-of-State laboratories.

Accordingly, Section 353(k) should be amended by the addition of the following: "Provided, however, that no State shall discriminate against any out-of-State laboratory licensed pursuant to this Act".

Mr. ROGERS (presiding). Thank you.

Mr. Kornegay.

Mr. KORNEGAY. Thank you, Mr. Chairman.

In your two-pronged operation, the second is the Analytical Services Division which you say is affected by this bill. How many people do you employ in that Division?

Mr. GUTTMACHER. I would say roughly 45, sir.

Mr. KORNEGAY. And you employ automation: computers, and that sort of thing?

Mr. GUTTMACHER. Yes, sir.

Mr. KORNEGAY. What type of tests do you generally run there? What is your general activity as far as medical tests are concerned?

Mr. GUTTMACHER. They encompass the disciplines of biochemistry, microbiology, serology, immunology.

Mr. KORNEGAY. Sputum, blood, and so forth?

Mr. GUTTMACHER. Yes. I have a fee schedule if you're interested. We offer some 300 different tests.

Mr. KORNEGAY. If I had the time, I would like to go out and visit your laboratory. It would give me a better understanding of what we are talking about, to see what you are doing.

I appreciate very much your coming before the committee to give us the benefit of your situation.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Devine.

Mr. DEVINE. I have no questions, Mr. Chairman.
Mr. ROGERS. Mr. Van Deerlin.
Mr. VAN DEERLIN. No questions, Mr. Chairman.
Mr. ROGERS. Mr. Keith.
Mr. KEITH. No questions, Mr. Chairman.
Mr. ROGERS. Mr. Pickle.
Mr. PICKLE. Thank you, Mr. Chairman.

Mr. Guttmacher, I notice on page 6 of your testimony that you think the bill could be strengthened by adding an additional section. The language of your suggestion would be that no State can discriminate against a laboratory on the basis of location in another State or the professional discipline of the personnel.

You referred to that also in your testimony. What do you mean by the professional discipline of the personnel?

Mr. GUTTMACHER. May I first say that the language we suggested—and I don't pretend to be a constitutional lawyer—says if a laboratory is licensed pursuant to this act, States should not be permitted to have location or discipline as a basis for discrimination.

Implicit in that would be that the laboratory would have to be fully qualified under the standards that will be promulgated under the act. The professional discipline problem that I referred to is exemplified by State jurisdictions which require that clinical laboratories be either owned, operated, or run, by licensed physicians.

Mr. PICKLE. You mentioned my State of Texas and you said they have a law that says you cannot operate a clinical laboratory unless it is operated by a physician. Is it the intent of your amendment to make this illegal?

Mr. GUTTMACHER. I did not say the law in Texas. As I understand it, it is an interpretation of the law by the attorney general.

We would like to see, with the advent of Federal regulation, laws in States consistent with the rules that will be promulgated.

The rules, for example, in the medicare regulations make it amply clear that the business of running a laboratory is not the practice of medicine.

Mr. PICKLE. You would then seek a change that would prohibit my State from limiting itself strictly to physician-operated laboratories?

Mr. GUTTMACHER. We would seek a change which would enable out-of-State laboratories, fully qualified under the proposed Federal law to operate in the State of Texas as well as other States.

Mr. PICKLE. You keep stating it positively. The net of it would be to, in effect, overrule whatever my attorney general has said in his interpretation, as I see it.

To follow on through on that question, do you think that insurance companies which have clinical laboratories of their own should be excluded or could be excluded from the provisions of this act? That is, they would not have to comply with all the State standards set?

Mr. GUTTMACHER. I can think of no reason they should be excluded. I would think they should be included.

Mr. PICKLE. They don't operate a clinical laboratory in the sense that they are trying to find ways to cure a disease or prevent the spread of communicable diseases.

They operate primarily an investigatory type of laboratory. Why should they be subjected to all these standards?

Mr. GUTTMACHER. I must disqualify my intimate knowledge of the way the insurance business operates. I would think, though, that in the absence of a substantial national activity in preventive medical screening of individuals to anticipate in a preliminary way the presence of disease, these insurance company laboratories are to some extent filling a void.

If they come up with an erroneous result that would indicate someone is either a diabetic or not, for example, I would think that this could have medical consequences to the individual who might not otherwise have seen a physician. From that point of view I would think they would be fairly brought under this act.

Mr. PICKLE. I don't know that I agree with you on that analysis. It seems to me like what you would want to do is to be in favor of legislation that would increase the standards for these laboratories.

It would follow to me, at least, that if you had laboratories operated by physicians you come nearer to the higher standard than you do if you had a laboratory operated by someone with 1, 2 or 3 years of college.

Mr. GUTTMACHER. I would agree with you if those were the only alternatives. But I think, as with the medicare regulations, the standards for nonphysician recognized doctoral degrees in chemistry, microbiology and so forth are equally high.

This is the kind of thing we believe is very salutary, high standards recognizing the specific situation—the specific scientific disciplines in these various and specialized areas.

Mr. PICKLE. I would like to ask you one more question. I want to make one more run at you. When you used the phrase professional discipline of the personnel, what do you mean? Can you put it in layman language, language that I would understand?

Mr. GUTTMACHER. I am afraid I can't more clearly than I said before. I think we are talking about a controversy that perhaps goes back some time. I think with the advent of medicare it is only now becoming clarified at the national level. That is this question of whether the business of performing laboratory analysis, objective data derived from analytical determinations, is or is not the practice of medicine.

We quite firmly believe that it is not the practice of medicine and feel that this view which is now coming to light on the Federal level should pervade throughout the States as well.

Mr. PICKLE. Thank you.

Mr. KORNEGAY. Would the gentleman yield?

Mr. PICKLE. Yes.

Mr. KORNEGAY. In order to run these tests competently, you do not have to be a physician. Is that correct?

Mr. GUTTMACHER. Yes, sir.

Mr. KORNEGAY. But at the same time it does require training, education, and experience in the field relating to the test?

Mr. GUTTMACHER. Yes, sir.

Mr. KORNEGAY. I would suspect you probably have people in your laboratory among these 45 whom you say you employ, some of whom are competent in one field and maybe not in other fields. Is that right?

In other words, they are specialists within the field of the laboratory?

Mr. GUTTMACHER. That is correct. And specialists with a very high degree of particular training. We have four doctoral level people immediately employed in our analytical services division and then we have approximately 20-odd doctoral level people associated with that activity in the research division or available for consultation.

We very firmly believe that people with Ph. D.'s in the specific disciplines have certainly comparable and perhaps greater expertise in which are becoming increasingly specialized and complex areas.

Mr. KORNEGAY. Thank you very much.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. I am impressed by your statement. I think it is certainly quite good. However, I, too, am interested in your so-called professional discipline as regards to personnel. I believe you stated you had 45 employees in your clinic. Is that correct?

Mr. GUTTMACHER. Yes, sir.

Mr. CARTER. Could you give me about the average qualification of these people as to their professional qualifications, a median?

Mr. GUTTMACHER. I can give it to you approximately, sir. I think there are approximately four individuals at the doctoral level, that is, doctors of philosophy, principally, in chemistry or microbiology.

There are 4 masters level people in chemistry or microbiology, and approximately 14 individuals at the bachelor's level with some years of particular experience in a laboratory run by someone who has a doctoral level.

Mr. CARTER. These 14 whom you say have bachelor's degrees, I suppose that is in laboratory techniques, technology, and so on?

Mr. GUTTMACHER. I think certainly the great preponderance are bachelor-of-science degrees with laboratory experience, specific laboratory experience.

I can't say that I am sure that is exclusively so.

Mr. CARTER. Or they have spent time in teaching institutions?

Mr. GUTTMACHER. Practical experience.

Mr. CARTER. Practical experience but not as students in institutions?

Mr. GUTTMACHER. Perhaps not. But, again, consistent with the regulations promulgated under medicare, the individuals by and large have had the requisite number of years in working at a research institution or a hospital laboratory directed by someone at the doctoral level.

Mr. CARTER. They have had practical experience, not necessarily experience as students in school, I take it?

Mr. GUTTMACHER. Yes, sir. These individuals would be technologists.

Mr. CARTER. How much actual schooling in technology have they had, these 24 people you have spoken of?

Mr. GUTTMACHER. The median of the 24?

Mr. CARTER. The median of the 24 technologists you spoke of.

Mr. GUTTMACHER. Of practical experience?

Mr. CARTER. No, as students. How much formal training have they had in technology in recognized institutions?

Mr. GUTTMACHER. I just don't think I can generalize. We have some who have bachelor's degrees in medical technology, although I think they are in a minority.

Mr. CARTER. I think you said you had four, and three doctors.

Mr. GUTTMACHER. No, four at the master's level, with four at the

doctoral level. Of the medical technologists, I believe we have a few who have their bachelor's degrees in medical technology.

Mr. CARTER. You have a few, but you can't give me the median?

Mr. GUTTMACHER. I am afraid I can't.

Mr. CARTER. What is the average requirement as to time spent to acquire certification in technology?

Mr. GUTTMACHER. I am not sure there is any average.

Mr. CARTER. There is bound to be an average, or a median.

Mr. GUTTMACHER. I think it depends on the standard you are referring to. There are some organizations that I don't believe require bachelor's degrees, and others that do. Then the experience would also vary with the particular group.

Again, I think one of the salutary things about the medicare regulations is that it brings forth one standard that everyone can apply.

Mr. CARTER. You still have not answered my question, we have not gotten to the basic issue, of how much time then it requires to make a medical technologist in the States. What is the average time in the United States that it takes to make a medical technologist?

Mr. GUTTMACHER. I don't know. My own opinion would be that a bachelor's degree which would indicate a thorough understanding of theoretical and basic scientific concepts, plus 2 or 3 years of practical experience in a properly run laboratory, would be about it.

Mr. CARTER. Most States only require 12 to 24 months of experience. I believe then it was brought out in this committee some time ago about the licensing requirements being very lax in the great State of Oklahoma.

Certainly we want to see that our technologists all have proper training. I am sure that in your case this is true, since you do have the several doctors, and also those who possess their masters degree. I wish it were that way all over the country.

Mr. MURPHY. Will the gentleman yield?

Mr. CARTER. I yield to the gentleman from New York.

Mr. MURPHY. Doctor, didn't we amend a bill last year on medical technological training to make junior colleges eligible for Federal funding under the act when the original proposal from the Department of Health, Education, and Welfare had limited it to a 4-year colleges on medical technical training?

Mr. CARTER. That is possibly true, but that has nothing to do with the requirements of the several States in this case. Only a few months in many cases are required for a degree in technology. I am happy that we did provide this, because certainly we should raise the standards of this particular group.

Mr. MURPHY. Doctor, we have the problem of the definition of the medical technologist in the different States also. I don't think we ever resolved that problem.

Mr. CARTER. That is quite a problem. I hope we can arrive at a happy solution to it.

Mr. ROGERS. The gentleman from New York.

Mr. MURPHY. I have no other questions.

Mr. ROGERS. Mr. Kuykendall.

Mr. KUYKENDALL. I want to compliment the gentleman on his outline of his facilities, and I appreciate the invitation to visit the facility. However, I really can't see that that is the point here today.

I am a little bit disturbed about what you are asking this committee to do. Dr. Carter in his discussion and Mr. Murphy in his questions indicated a concern about minimum standards and I think we all recognize the fact that when you have a national program, such as medicare, that our job is to set "minimum standards."

It seems to me that your request here is to get us to set some maximum standards so that you can operate in Texas. Seriously, are you a businessman in business?

Mr. GUTTMACHER. Yes.

Mr. KUYKENDALL. Are you not seeking the best of both worlds here?

Mr. GUTTMACHER. I think you misinterpreted what we tried to say. We are perfectly delighted if States want to impose standards of proficiency so long as the standards are consistent with the basic delineation of qualifications for the various laboratory specialties that hopefully will be promulgated at the Federal level.

Mr. KUYKENDALL. Isn't that what Texas has done, set a standard that is a little too high?

Mr. GUTTMACHER. No. It is simply a different standard. If by interpretation Texas or any other State has ruled that to operate a laboratory one must be a physician, that imposed a qualitative standard which I think is not consistent with, for example, the medicare regulations which say a properly qualified individual with a doctor of philosophy in chemistry, plus certain prerequisite experience, can be a director of a laboratory.

Mr. KUYKENDALL. Do you not feel if it were physically possible, and certinly it is not, that we would have better medical practice if every laboratory in the country were headed up by a physician?

Mr. GUTTMACHER. I am not sure I could share that view.

Mr. KUYKENDALL. I thought they knew more about medicine than anybody else?

Mr. GUTTMACHER. That is precisely our point. The business of running a laboratory is really quite different than medicine. We are dealing in analytical determinations that yield objective data. We don't involve ourselves in the diagnosis of disease or many other medical responsibilities that a physician has.

We are laboratorians, chemists, and microbiologists, and we feel that we do know that severable part of the continuum of the total diagnostic process.

Mr. KUYKENDALL. The thing that bothers me is that even though you are in the area of medicine, you have stated yourself that you are a businessman in business. It would seem to me that you are asking us to get into some areas of the regulation of interstate commerce that we have never dared to get into before.

This is the reason I believe one of the gentlemen mentioned insurance. There are insurance companies all over the United States. When they go into a specific State they are required to live within the laws of that specific State. I think the State of New York is one of the States recognized as having the highest standards.

Therefore, they have fewer companies practicing there. I am quite sure some of the weaker companies would love to have a Federal regulation that would make New York lower their standards so they could go in there.

I see great validity in your specific request but I see great dangers in the broad implications of it when it gets into interstate commerce. Since you are in commerce, I think we have to look at this in the broader sense.

Mr. GUTTMACHER. We said at the outset it was a complex problem. We see very clearly the difficulties you suggest. We do feel that it is worth trying to wrestle with anyway because it can have salutary implications for the future as the field of laboratory technology becomes increasingly complex and increasingly demanding.

Mr. KUYKENDALL. I want to compliment you for trying.

Mr. CARTER. Would the gentleman yield?

Mr. KUYKENDALL. Yes.

Mr. CARTER. I just want to say that I am sure the very distinguished witness today comes from a well qualified, exceptionally well qualified group. I am sure of that. I just wish that it were possible that we could have such groups widely dispersed throughout our country. I regret that such is not the case.

Mr. ROGERS. Mr. Stuckey.

Mr. STUCKEY. I have no questions.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. No questions, Mr. Chairman.

Mr. ROGERS. I just want to ask one question. Where you say we should delimit the personal authority of the Secretary if a laboratory is believed to be in substantial violation, by that you mean you should have a special public hearing or something like that?

Mr. GUTTMACHER. Yes, sir. That was a reference which we amplified in our submitted statement to the question of suspension of license without a hearing in the event of suspected substantial violation.

Mr. ROGERS. As I understood, the point you are making is that people who are specializing and who have been recognized by degrees to do laboratory work, if these are the type of people who are in a laboratory, you think they should be recognized if they are licensed by the Federal Government to do that, to do interstate laboratory work?

Mr. GUTTMACHER. Yes, sir.

Mr. ROGERS. Thank you very much. Your testimony is helpful to the committee. We appreciate your having been present.

Mr. GUTTMACHER. Thank you, sir.

Mr. ROGERS. The next witness is Dr. Kerr White, School of Public Health, Johns Hopkins University, Baltimore, Md.

It is a pleasure to welcome you, Dr. White. You may proceed with your statement.

STATEMENT OF DR. KERR L. WHITE, PROFESSOR OF MEDICAL CARE AND HOSPITALS, JOHNS HOPKINS UNIVERSITY

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

I welcome this opportunity to appear before you in support of H.R. 6418 and, in particular, of section 304, pertaining to research and development relating to health facilities and services.

In addition to practicing internal medicine for a number of years I have had a longstanding interest and commitment to health services

research. More recently I have been responsible for a research and training program in health services administration and medical care research.

For about 8 years I was a member of the Health Services Research Study Section of the Public Health Service and for 4 years I was Chairman of that group.

Among our activities was the sponsorship of a two-volume series of scholarly papers on the present scientific state of health services research both in this country and abroad.

The field is well described in these papers. The needs and opportunities are defined, the methods delineated and the unsolved problems frankly presented. Clearly, health services research is a viable field; widely recognized in the United States and other countries.

This morning I do not intend to dwell on the absurd position of the health services industry in the United States with respect to research and development.

Health services research is concerned with scientific and logical inquiry into the problems or organizing, administering, and financing effective and efficient health services.

It is concerned with delivering medical care promptly to those who need it and can benefit from it.

Physicians, scientists, nurses, other health professionals, economists, behavioral scientists, operation engineers, systems analysis, and others do undertake health services research.

The field has been described in two volumes of scholarly papers sponsored by the Health Services Study Section.

Mr. ROGERS. Are these the two volumes that you refer to?

Dr. WHITE. Yes.

Mr. ROGERS. We have these available to the committee.

Dr. WHITE. These sorts of studies can be undertaken by health departments, hospitals professional associations, research institutes, universities, industry, and other individuals or groups capable and interested.

There are three reasons why I would like to support the legislation before you and particularly section 304.

First of all there is the economic argument. I believe this is perhaps the least important. But I would like to draw your attention to the fact that the health services industry of this country this year will amount to about $45 billion. We are currently spending annually on research, development, and evaluations something less than one-tenth of 1 percent of this sum.

I would submit that this is an absurd relationship and that any industry of this magnitude or any other services system that spent such a trivial proportion of its resources on evaluating its results would find itself inevitably in difficulties.

The economic argument would suggest that there should be at least 1 percent, and other people would suggest 2 or 3 percent of the annual expenditures, devoted to health services research, in the interests of improved efficiency and hopefully of some economies.

The second argument is the organizational argument. I think there is no question that the current state of the organization of health services in this country is leading to its breakdown in certain sectors and possibly to chaos.

The natural history of this sort of experience lies in either of two directions. One to move a monolithic national health service, which I personally would deplore because of the rigidity of the system and the difficulties of introducing change of any kind.

I think this has been the experience with other national health service systems. Here the other direction is one of encouraging innovations, experimentations, health competition, and of doing this associated with the evaluation, with experimentation, with research.

If we are to deliver medical care services effectively to people who need them, we need to develop a series of diverse competitive health services systems which are responsible and responsive to the people who need them.

This, therefore, involves research and organization of the systems, and the evaluation of the results of this.

The third argument, I think, is the humanitarian one and I believe this is the most persuasive. We need to undertake health services research in the interest of delivering better medical care and reducing the science service gap to the people who need it.

I think you are entitled to have specific examples of the kinds of things I mean by health services research. You already heard some from the Mayo Clinic group with respect to the application of computers.

I would like to give other examples which are in my testimony.

One study has shown that the case fatality rates, that is, the number of patients dying per 100 admitted to hospitals, for a number of common diagnoses, are about twice as high in nonteaching hospitals as they are in teaching hospitals.

Mr. ROGERS. You say in nonteaching hospitals the death rate is twice as high?

Dr. WHITE. The case fatality rate in several studies showed that the number of individuals dying per 100 admitted with specific diseases was, on the average, about twice as high in the nonteaching; that is to say, those not affiliated with a university.

Mr. ROGERS. How many hospitals were used in the study?

Dr. WHITE. This was a study done in Britain. A sample was made of all the teaching hospitals with a sample of the nonteaching hospitals. It was a national sample. Similar studies cannot be done in this country because we have no data on patients admitted to hospitals by characteristics of the patients and by discharge diagnosis.

We do not have the data available in this country.

Mr. ROGERS. We don't keep such data?

Dr. WHITE. It is kept to varying degrees of adequacy, but not available for investigation.

Second study found that about 20 percent of the consecutive patients admitted to a general hospital experienced some adverse reaction to a drug, treatment or investigative procedure. About 7 percent of these patients died. A third study showed that the mortality rates for patients moved unexpectedly from one nursing home to other nursing homes was twice as great as might have been expected if the transfers had not taken place.

A fourth study showed a close relationship between the nurses turnover in hospitals and the longer the patients stayed in hospitals.

A fifth study, a group of general practitioners looked at their prescribed habits and found that something on the order of one-third of

their prescriptions were for drugs which they believed to have a known specific or probably beneficial effect on the conditions for which they were prescribed.

In another study, samples of patients in two similar hospitals were studied to ascertain the amount and kind of nursing care needed by the patients.

In another study of three different areas, each with different ratios of physicians, nurses, and beds to the population, of those patients experienced great discomfort in the previous 2 weeks, 1 out of 5 had consulted physicians about it.

These are brief examples of health services research bearing on the effectiveness of medical care.

In summary, there are three arguments, I believe, which merit consideration. First is the economic argument, second is the organizational and third is the humanitarian. Where we can cure diseases, we are clear in what we should do.

Frequently we cannot cure the disease, but only alleviate its disability, diminish the discomfort in some way.

That is what medical care is all about, I believe the bill, which endeavors to support health services research, is sound, and I would advocate its support.

Thank you.

(Dr. White's prepared statement follows:)

STATEMENT OF DR. KERR L. WHITE, PROFESSOR OF MEDICAL CARE AND HOSPITALS, THE JOHNS HOPKINS UNIVERSITY

Mr. Chairman and members of the committee, I welcome this opportunity to appear before you in support of H.R. 6418, and in particular of Section 304, pertaining to "Research and Development Relating to Health Facilities and Services".

In addition to practicing internal medicine for a number of years, I have had a long-standing interest and commitment to health services research. More recently I have been responsible for a research and training program in Health Services Administration and Medical Care Research. For about eight years I was a member of the Health Services Research Study Section of the Public Health Service and for four years (1962–66) I was Chairman of that group. Among our activities was the sponsorship of a two volume series of scholarly papers on the present scientific state of Health Services Research both in this country and abroad.[1] The field is well-described in these papers. The needs and opportunities are defined, the methods delineated and the unsolved problems frankly presented. Clearly Health Services Research is a viable field; widely recognized in the United States and other countries.

This morning, I do not intend to dwell on the absurd position of the health services industry in the United States with respect to research and development. In 1967 the total annual expenditures or costs, depending on your point of view, of the health services industry, will be about 45 billion dollars. Less than one tenth of one per cent will be spent on examining the effectiveness and efficiency with which these vast resources are being used in the interests of the patients and potential consumers. I doubt if there is any other industry, or even any other services system approaching this magnitude, which spends such a trivial part of its resources on research, development, and evaluation. The Bill before you is a small effort to remedy this imbalance. Although the economic arguments may be persuasive from the viewpoints of improving the efficiency with which health services are delivered, and of obtaining better value for the funds expended, there are, I believe, more cogent reasons for supporting H.R. 6418.

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[1] Mainland, D., *Health Services Research*, Milbank Memorial Fund Quarterly, 44: Nos. 3 and 4, Part 2, 1966.

The arrangements for delivering needed medical care in this country are, I believe, less than optimal, in the light of our organizational, technological and scientific capabilities. Public dissatisfaction is mounting, and as some have predicted, reduction of financial barriers to medical care can only compound the organization problems. The latter are infinitely more complex than the financial problems. Changes in the organizational arrangements for providing medical care are inevitable; the real question is the direction of change. One possibility is that we shall experience a series of major breakdowns in our health services system, and that, as a result, we will gradually move towards a monolithic national health service. I personally would deplore this; not because I am so worried about how doctors are to be paid, but because it would be so difficult to modify any vast national system. Built in rigidities would inevitably make the rapid introduction of desirable change based on new knowledge exceedingly difficult. The other alternative, and the one in keeping with our traditions of pluralism, diversity and healthy competition, is to positively encourage innovation, experimentation and evaluation of present and future arrangements for delivering scientific medicine through diverse health services arrangements and systems. In order to develop and evaluate these new methods of delivering medical care, I believe it is essential to encourage a tradition of research in health services which will emulate our accomplishments in biomedical or laboratory research. The present Bill is designed to encourage and stimulate this tradition.

There is no one "best" method for delivering medical care. I doubt if there ever will be or should be, in this country or elsewhere. Hopefully, there will be a continuing improvement in the arrangements for delivering medical care which is based on research and development. To undertake this work, we need to encourage health departments, hospitals, professional associations, private entrepreneurs, voluntary agencies, group practices, universities, industries, research institutes and others with the capability and competence to undertake research in this field. My experience with the Health Services Research Study Section and my university responsibilities have persuaded me that there is rapidly growing interest in this field and, what is much more important, a substantial number of talented individuals who would like to undertake health services research. In addition to physicians, dentists, nurses and other health professionals, there are operations engineers, systems analysts, behavioral scientists, economists and others prepared to apply the methods of epidemiology, operations research, systems analysis and the social survey to the problems of delivering optimal health services to all the people. Surely one per cent of the total expenditure of the health services industry would not be an excessive amount to invest in this endeavor? This would amount to $450,000,000 annually. The appropriations proposed to you, for the next four years, do not approach this sum.

Let me now give you some concrete examples of health services research that have been completed. You are entitled to know what has been done, in addition to hearing suggestions about what can, should or might be done if you approve H.R. 6418.

One study has shown that the case/fatality rates, i.e. the number of patients dying per 100 admitted to hospitals, for a number of common diagnoses, are about twice as high in non-teaching hospitals as they are in teaching hospitals.

A second study found that about 20% of consecutive patients admitted to a general hospital experienced an adverse reaction to a drug, treatment or investigative procedure. About 7% of these patients died from these reactions.

A third study showed that age-specific mortality rates for aged persons moved unexpectedly from one nursing home, to which they were accustomed, to another home, were twice as great as they would have been had the transfers not taken place.

A fourth study showed a direct and rather strong association between the length of patients' hospital stay for five common conditions, with the rate of nursing turnover in the hospitals studied. The higher the labor turnover among the nurses, the longer the patients stayed in the hospital.

In a study of referral patterns to a university clinic, it was found that for only 40% of the referrals was there evidence in the medical records of any written communication from the referring physician which gave any medical information, even so much as the referring physician's diagnosis, or the area in which he thought the patient's problem lay.

In a fifth study, a group of general practitioners participated in an anlysis of their own prescribing habits. They found that only about one third of their prescriptions were for drugs which they believed had a known specific or probably beneficial effect on the conditions for which they were being prescribed.

In a sixth study, samples of patients in two similar hospitals were studied to ascertain the amount and kind of nursing care needed by the patients. It was found in different parts of the country that for at least one third of the patients, doctors and nurses differed substantially with respect to the kind of nursing care needed by specific patients.

Finally, studies using identical methods in three different areas, each with different ratios of doctors, nurses and hospital beds available to the population, showed that four out of five persons experiencing "great discomfort" in the previous two weeks, from one or more of twelve common conditions, had not consulted a doctor about them during that period.

These are all brief examples of health services research bearing on the effectiveness of medical care and on the problems of organizing health services so that contemporary scientific knowledge can be delivered promtly to the people who need it and can benefit from it. Much of our biomedical research will be of little avail until we can make useful preventive, therapeutic and rehabilitative knowledge generated in the laboratory accessible to all the people. In essence, health services research is designed to reduce the gap between medical science and medical service.

To summarize, I have advanced three reasons why I believe we should rapidly increase our national effort in health services research. There is first the "economic" argument. Our arrangements for delivering health services should be more efficient. The experience of other industries and service systems suggests that to spend 45 billion dollars a year without spending at least 1% on research, development, and evaluation may be wasteful.

There is the "organizational" argument. If we are to avoid chaos, if not collapse, in our present health services system, and if we are to move from what one observer has called a "cottage industry" to diverse responsible systems for delivering medical care, we should encourage innovation, experimentation, evaluation and healthy competition. To accomplish this we need to develop a tradition of competence and excellence in health services research which is the equal of our record in biomedical research.

Thirdly, and I believe most importantly, there is the "humanitarian" argument. It is through health services research that we can make health services themselves more effective. It is through prompt delivery of useful scientific knowledge that we have the greatest expectation of helping people at the earliest stages in the natural history of disease. Where we cannot cure disease, we can at least diminish disability and alleviate discomfort. That is what medical care is all about.

Thank you for allowing me to testify on behalf of H.R. 6418; I urge you to take favorable action.

Mr. ROGERS. Mr. Van Deerlin.

Mr. VAN DEERLIN. No questions.

Mr. ROGERS. Mr. Kuykendall.

Mr. KUYKENDALL. Let me ask you to comment for a moment on a remark made by a witness in the last few days. He mentioned the lack of automation, and I use this in a sense that has to do with medicine and not industry. He mentioned that as being very prevalent in your profession, and he considered your profession very backward in the area of using all of the automated equipment and so forth possible.

I think he mentioned specifically can you imagine a man who is paid as much as a doctor writing out his own instructions in longhand?

What do you see in the future as to the effect that extensive use of automation can have in the health practices?

Dr. WHITE. I would agree in summary with what your previous witness said. There are about six different applications of computer technology and automation, I think, to the health services industry.

There is no doubt that the recordkeeping in medicine is antiquated. It is badly in need of overhauling. The studies such as at the Mayo Clinic are designed to improve that; there are six different areas in which there can be application of computer technology.

First is the fiscal and accounting area where it is used very commonly now. Second is with respect to inventory, supply systems, diet control, bed availiability, keeping track of admissions, operating schedules, this type of airline application, if you like, of governing the management of the institution.

Linen supplies, appointments, schedules, nursing staff, this sort of thing. Then there is the diagnosis contribution with respect to the automated laboratory, with respect to storing the data, of estimating the probabilities of different symptoms and diseases occurring in the populations, and storing the contemporary wisdom with respect to diagnosis.

Then there is the application more specifically to automation of things like electrocardiograms, X-ray reading, and other laboratory functions. There is the application of multiphasing screens, in the interest of rapidly evaluating a large group of patients with respect to certain parameters and there is the application of the physiological monitoring in which the physiological changes in, say, heart rate, breathing, other characteristics of the particular individual can be seen on a screen and be monitored promptly.

Finally, there is the development of the health services information system, the medical care bed record, in which we can keep track of moving patients within populations and with respect to the kinds of medical care they receive.

The real problem in applying all these is not so much the hardware as it is the software, and the preparation of physicians in medical schools to use this kind of equipment and think about it, and perhaps the medical professions to approach these new technologies and applications with an open mind.

Mr. KUYKENDALL Thank you.

Mr. ROGERS. Mr. Stuckey?

Mr. STUCKEY. No questions.

Mr. ROGERS. Mr. Kyros?

Mr. KYROS. Dr. White, my question is under the concrete examples you gave of the health services research on page 3. You said that in a study of general practitioners, it was found that only about one-third of the prescriptions were for drugs which they believed had a known specific or beneficial effect.

Do you mean to suggest that the general M.D. was prescribing drugs where he didn't know they had a beneficial effect?

Dr. WHITE. This was a group of some 19 or 20 physicians in England. Two of these were English studies, or three of them were. There were occasions where they wrote up prescriptions and on the back of the prescription indicated whether they thought this drug would be for a specific purpose, whether it would be probably beneficial, possibly beneficial, or whether it was for the purpose of pleasing the patient, to placate him at the time.

When they finished keeping their experience and analyzing it, they found, to their surprise, that only about one-third of the prescriptions were specifically or probably likely to be beneficial.

That doesn't mean that the others may not have had a useful effect, may not have helped the patients. But they were at least not in the first two categories.

Mr. KYROS. The other question I had was this: On the first page of your statement, you say you want to avoid any monolithic national health services. How would the research service that you want to provide through the act avoid such a monolithic standard? Can you give us the national standard of performance?

Dr. WHITE. I think it is highly improbable, because I think by encouraging innovation, the addition of experimentation and evaluation, one would hope to encourage health competition. I see the pattern of the health services as becoming a series of competitive, smallish health services systems within regions and even within States, even within counties and cities.

Hopefully, each would seek to evaluate its own care, to improve its care, to improve the efficiency and effectiveness of the care. This would, therefore, improve the quality of the care, the distribution of the care, and would not lead to the kinds of breakdowns that result from public demand for some quick solution in the form of a national health service of some kind.

Mr. KYROS. Thank you.

Mr. ROGERS. Doctor, I think the figures you gave on the delivery of health services in this country are quite shocking. I also recall a study about a teaching hospital where I think they said 25 percent of the patients either were given the wrong drug or were not given the proper drug, were not given it at all, or at the wrong time.

Are you familiar with such a study?

Dr. WHITE. There have been studies done on adverse drug reactions and of such reactions resulting in patients being admitted to hospitals. Dr. L. Cluff, now at the University of Florida, has done such a study. The particular study I quoted here was done by Dr. E. Schimmel in New Haven, at Yale, in one of its teaching hospitals.

Twenty percent of the patients experienced some adverse drug reaction. There are always risks in being in a hospital and not being in a hospital. You don't want to undergo those risks if you don't need to.

The point, I think, is that there is a substantial risk and that patients who do not need to be in a hospital should hopefully be treated in the vertical position and be kept out of the hospital.

This sort of study has to be duplicated in other hospitals. If all hospitals did this, or a number, we would have a better idea of the validity of this particular finding.

Mr. ROGERS. What would you estimate is now being spent on research of health services?

Dr. WHITE. I haven't calculated it for the current year, but I did a couple of years ago and it is something on the order of $20 million a year, I believe.

Mr. ROGERS. Are you doing a great deal of work at your university?

Dr. WHITE. Yes, we are undertaking a number of different studies, of different kinds.

Mr. ROGERS. What are the main fields you are investigating?

Dr. WHITE. We are concerned with the end results of patient care. For example, we are looking at cardiac failure, a common condition

in elderly patients, seeing the extent of the kinds of treatments generally conceived to be beneficial.

We are interested in the problem of continuity of patient care. In spite of many exhortations, there is no real data on continuity of the patient-physician relationship. In fact, it decreases with the use of laboratories, and we are looking at this problem to see if we can get some objective data of that kind.

We are looking and comparing medical care utilization in a number of different areas, two areas in this country and a number of other countries, in an effort to see if we can get any common understanding of the way people use health services.

It looks, for example, as if no matter what kind of system you have, population in general tends to visit physicians about five times a year, through Sweden, Britain, Canada, and this country. We need to get some general observations of this kind in order to understand the system better.

We are looking at regionalization and the development of the computer model for a population of 2 million individuals, to see the extent that people move from a general physician, to a physician, to a hospital, to a nursing home, trying to get some general understanding as to the various kinds of care needed.

We are looking at the content of medical practice. We know very little about exactly what doctors do in their offices. We are, therefore, conducting a study with a number of physicians to attempt to find out precisely what it is that physicians do in terms of the diagnosis they see and the problems presented to the physician.

We think this will be helpful in education. We are concerned with new arrangements for delivering medical care. This comes less in the field of health service research than it does the organizational care. We have some plans for changing some of the patterns of care. We are evaluating these.

These are some examples.

Mr. ROGERS. I presume the latter study mentioned is geared also to the possibilities of reduction in the cost of delivery of services. Does it tie in with that at all? Are you doing any study to see how delivery of services could be brought about with a reducation of cost to the patient?

Dr. WHITE. We are designing some forms to provide medical care which we believe should eventually reduce the costs of care. I think it is illusory to think that we are going to reduce the cost too much by these sorts of activities. I think where you improve the services and improve the quality of care, you increase the demand rather than decrease it.

I think what we can do is deliver better care to more people for the same investment of funds. I think this is where cost reduction would occur.

I would always expect there to be some increase, but not as rapid an increase. For example, we are hoping to use nurse practioners or physician assistants working with teams of medical students, residents, fellows, supervised by senior attending physicians, providing direct services to a refined population of patients.

Mr. ROGERS. The figures they are providing us with now show such a dramatic increase of the cost of hospitalization that if this trend con-

tinues we are going to have to do some very dramatic work, I think, in research in trying to reduce the cost.

Dr. WHITE. I think one of the answers to reducing the costs of hospital care is to keep people out of hospitals and to provide both the hospitals and the physicians with some incentive for using other facilities.

One of the suggestions is that Kaiser Permanents is able to reduce the use of hospitals and the length of stay because there is an incentive for all the physicians and all the management there to use these resources efficiently and effectively. I believe this is why the approach using multiple, competitive health services systems is designed to provide this sort of opportunity and incentive to decrease costs.

At present there is very little incentive for hospitals to reduce costs or physicians to reduce costs.

Mr. ROGERS. Mr. Springer?

Mr. SPRINGER. Doctor, on this language that Mr. Rogers was pursuing, is it likely that costs are probably going to increase as time passes?

Dr. WHITE. Absolute costs, I think, will certaintly increase. We are now spending 6 percent of the gross national product on health services, $45 billion a year. Most countries get away with 4 or 5 percent of the gross national product. Some people suggested that we may spend 20 or 25 percent of our gross national product in health services.

I think this is highly unlikely myself. I suspect that the pressures are now on to keep the figure in the order of 6, 7, or 8 percent of the gross national product.

Mr. SPRINGER. It is probably going to run about that?

Dr. WHITE. Yes.

Mr. SPRINGER. Also, may I ask: Is it likely that hospital care cost is going to increase?

Dr. WHITE. I would say if we go on using hospitals for patients who are essentially vertical patients and admit them to hospitals, yes. If we go on using emergency rooms as the source of primary medical care because of lack of availability of other sources for primary care, they will probably increase.

The trick will be to develop arrangements so people can get access to primary medical care and then can get consultant care, and be admitted to a hospital when they have to be, and not come to the emergency room of the hospital.

Mr. SPRINGER. This is one of the things that is very difficult for this committee, as time passes, to follow. We have been going into this for some 10 years. We have seen costs gradually increase, and some spectacularly in parts of the country, especially for hospital care.

We are wondering, frankly, about it. The wealthy people can probably afford it. But as I looked at a hospital bill for my own family recently, I was considerably startled. I would consider myself in the upper income tax group, at least with my present salary and income.

I mentioned this to my wife. I said, "How do people in the lower income groups," talking about the lower middle income group, and on down, "afford this kind of care?" I presume when they go into a hospital, it is relatively the same for them.

Do you have any recommendations on this?

Dr. WHITE. I think we need to incorporate the notions of graded patient care so that only those patients who need intensive care with

all of the personal attention from physicians, nurses, the accompanying technological and scientific equipment, to monitor and care for acute, serious illnesses, should be confined to that group.

Then I think we have the intermediate care, which is more the traditional hospital bed. We need much more in the way of self-care so that patients can go to the cafeterias, make their own beds, take their own drugs. We need more in the way of overnight care, rather the austere, motel-type arrangements, where a patient can lay down for a couple of hours or a couple of days without necessarily being admitted to a hospital, with all the associated costs and risks.

Mr. SPRINGER. The only progress we have seen along this line, what I would call substantial, has been in one area, and that is nursing homes. I am not technically acquainted with everything that has happened, but the Subcommittee on Health and Safety does try to keep up with it. This is the only one, major breakthrough we have seen since I have been in the Congress, which is some 17 years.

Could you name another?

Dr. WHITE. Well, of course, the Public Health Service was interested in progressive patient care some years ago, but I believe there are only one or two hospitals that introduced the full spectrum of care. There are a number, not a large number, maybe four, five, six, or 10 hospitals that have motel-like arrangements for patients who are coming for diagnostic services. There are a few which have self-care units in varying degrees.

Mr. SPRINGER. There is one further thing I would like to ask you, and I think you have done very well in answering what I wanted to know.

We, of course, handle the Hill-Burton. We expected, or at least I was very frank in my opinion last year when we passed the Health Services Act, and medicare and medicaid, that we were going to see hospitals overloaded with older people. Thus far that has not happened. Can you explain that?

Dr. WHITE. I think probably because better care has been given outside the hospitals. I think many of the admissions are for very long periods. They are terminal illnesses.

Actually, where these sorts of measures have been introduced, there has not been a great increase in utilization. This was true of the British National Health Service. It has been true of the introduction of other sorts of services. There isn't a great surge in the utilization. There is some increase.

Mr. SPRINGER. The British did have it at the beginning because I was there twice. I saw their hospitals and they were especially overloaded with people who had been wanting to have operations for years.

They introduced a regional system and the doctor traveled over the countryside, from town to town, performing the operations.

I understand, however, they have worked out from under that now. I was expecting we would get the same kind of surge they got from 1947 to about 1953. Thus far, however, we have not.

Dr. WHITE. There was some surge in Britain. I don't know that all of it can be attributed to the National Health Service. I think it was the result of the end of the war, some the result of a shortage of personnel, and so on. There were some surges, that is true, and then it quieted down again afterward.

The surge has not been as great here, but it may be that other people who were paying the bills found other ways of dealing with the problem.

Mr. SPRINGER. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much, Dr. White, for your testimony. It has been most helpful.

Dr. WHITE. Thank you, sir.

Mr. CARTER. I wanted to ask a question, if I may.

You mentioned that 20 percent of the patients admitted to a hospital had drug reactions, and of that number, 7 percent died. That means out of every 100 patients going into that hospital, one died as a result of a drug reaction. That is a tremendous mortality rate.

Dr. WHITE. These were not all drug reactions. They were also reactions to investigative procedures, and accidents, people falling out of bed, for example, and injuring themselves in some way.

Mr. CARTER. The way it says it, it is the result of adverse reaction to drugs.

Dr. WHITE. No; you have to read the next line also.

Mr. CARTER. Yes. But still that is 1 percent of every person who goes to a hospital, 1.4 percent, one out of every 100, does not come back.

Dr. WHITE. If this study is true, my suggestion is that we conduct many more of these kinds of studies to find out if it is true in other hospitals, if this is a general pattern. It may be higher or lower in other hospitals.

Mr. CARTER. If it is a general pattern, something must be done about it.

That is all. Thank you.

Mr. ROGERS. Thank you, Dr. White.

Before we adjourn, I want to recognize the presence of our former colleague, the Honorable Kenneth Roberts, who chaired the Subcommittee on Public Health for many years, and who is a real expert in the health field. We are delighted to have you with us this morning.

The committee will stand in recess until 2 o'clock this afternoon.

(Whereupon, at 12:10 p.m. the committee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Paul G. Rogers presiding.)

Mr. ROGERS. The committee will come to order, please.

We will continue our hearings now. The first witness this afternoon will be Dr. Myron E. Wegman, who will testify on behalf of the American Public Health Association.

Dr. Wegman, it is a pleasure to have you with us.

STATEMENT OF DR. MYRON E. WEGMAN, REPRESENTING THE AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. WEGMAN. Thank you very much, Mr. Chairman.

In the interest of brevity, I ask permission to leave a statement for the record, and to summarize.

Mr. ROGERS. Your statement will be admitted into the record without objection.

Dr. WEGMAN. Thank you, sir.

I wish to explain that I am here chiefly as the chairman of the executive board of the American Public Health Association, but because of the brevity of these hearings, my colleague, Dr. Trussel, dean of the School of Public Health of Columbia University and president of the Association of Schools of Public Health, has asked me, as immediate past president to make a brief presentation on behalf of the Association of Schools for Public Health as well. Perhaps I might deal with that matter briefly.

Mr. ROGERS. All right.

Dr. WEGMAN. The Association of Schools of Public Health has a deep interest in one section of this bill, while it supports the entire objective, because of the feeling of the schools of public health that comprehensiveness in the approach to health is an exceedingly fundamental attitude and one which represents a great step forward.

As a matter of fact, the schools of public health take pride in the comprehensiveness of their own approach to training for public health. We train physicians, engineers, nurses, sanitarians, statisticians, nutritionists. I could go on at great length.

Because of this wide range of interests, and because of the fact that at present 13 accredited schools have to provide for all of the needs of the 50 States of the Union, the Congress saw fit some years ago to aid in the cost of instruction by providing a formula grant under legislation originally introduced by Senator Hill and Congressman Rhodes.

This bill, H.R. 6418, that the committee is considering provides for extension of this authority for formula grants for another 4 years, and makes provision for appropriation for such sums as may be necessary.

Our association supports enthusiastically this provision, Mr. Chairman, because of our very great concern for the needs of trained people in view of all the tremendous character of health legislation that has been passed by the Congress recently.

Mr. ROGERS. Doctor, may I say at this point that this committee probably will not authorize such sums as may be appropriated, so it might be helpful to the committee if you would give specific figures for the next 3 years that you feel you can justify.

Dr. WEGMAN. I would be very happy to, Mr. Chairman. I realize that the committee does have this point of view.

We support the idea of such sums chiefly because not only are the costs of instruction in the individual schools going up, not only is the number of students being trained increasing, but new schools are appearing.

For example, two additional schools of public health have just passed the definitive review step by the examining committee and will be accredited, in all likelihood, within the next week, but certainly in time to be officially accredited by the 1st of July. Therefore, they will be entitled equally to participate in these funds. That means 15 schools will need to share in the appropriation.

There are three additional schools which are in the offing. The University of Alabama is well along in preparation. The University of Illinois has studies going on for a school of public health. The University of Texas has studies in progress leading to a school of public health. There will be other schools as well.

This means that the total costs are going up. But considering just the immediate group of schools that we have, Mr. Chairman, the present authorization is for $5 million. The schools were surveyed and asked to provide information on their minimum needs for the basic support which is underwritten by the formula grants. This figure came, for the current year, to just over $6 million. Unfortunately, the President's budget saw fit not to accept the recommendation of the Department of Health, Education, and Welfare which was for $5 million and the budget has been cut a quarter million dollars from last year's level to $3.5 million.

So for the coming year, 15 schools, that's two additional, have to share a smaller appropriation. This means, in my own instance, for example, that we will have $65,000 less, two teachers that we must let go along with supporting staff and cutting down on teacher equipment.

I know that appropriations are not a direct concern of this committee, but I make this illustration only to indicate the needs.

We have undertaken a survey of the needs of the schools for 1972 as the target goal for this legislation. The 15 schools which we know now will be accredited have needs totaling just over $10.5 million. These are minimum needs for the basic instruction, and take into account the fact that other legislation will provide for special kinds of preparation for needs in such fields as medical care, health services administration, which you have been discussing this worning, for family planning, and other health activities.

But this does not underwrite the basic costs of running the schools, of teaching, and we would anticipate, therefore, that our minimum needs in 1972, if there were no more than the present 15 schools, would be $10.5 million.

Now, Mr. Chairman, if I may, I would like to turn my attention from the portion of the bill dealing with schools of public health to the general considerations of the bill and the American Public Health Association's interest in it.

In our written statement we have indicated the major purposes that we have, the very broad support that American Public Health Association in the overall objectives of the bill, its comprehensive character, and the fact that it is a new and most important approach.

In this short time, I would like now just to underline three or four issues which seem to me to put the bill in perspective and perhaps to comment on some of the previous testimony which has been given before you.

In the first place, the new pattern that this bill provides for in strengthening the official and local health agencies seems to me the only real way to get at the problem. If this country has as its greatest strength local initiative and local activity, then local planning based upon local needs is the only way to meet our needs. This bill provides the machanism for just that.

But by the same token, Mr. Chairman, it seems to me of tremendous importance to do something about the level of appropriations, because without adequate appropriations, the purpose of the bill is going to be vitiated and the hopes and the theory of the bill simply aren't going to work.

Let me give you one example. Dr. Carter, Congressman Moss, and others on the committee are interested in the field of family planning.

They have introduced bills authorizing $20 million to family planning services. This is a program in which our own school is very deeply interested in training programs which are expanding rapidly.

But if this is going to work, it has to fit into the overall comprehensive health plan and health services in the individual States are going to need more adequate support. Family planning is just one of the very many health programs that are necessary in the States.

Another issue of very considerable importance is that of the interrelationship between this bill and Public Law 89–749, and Public Law 89–239, the Regional Medical Programs Act.

We see these bills as complementing each other in a very important way. The regional medical programs are designed to bring the techniques and abilities of the universities and medical centers down to the individual practitioner and the individual citizen for three specific diseases. But these three specific diseases again need to be fitted into the total context of health needs and of the many other priorities for action.

I have to interpolate, Mr. Chairman, that I am originally and still basically a pediatrician. I am interested in the care of babies. I would like to see comprehensive planning that will take into account the total lifespan, which would include concern with heart, stroke, and cancer. But I see the total business as the responsibility of this act.

There is another issue that has interested me very directly. That is the relationship to hospital planning and the regional health facilities councils. The Governor of our State asked me to chair one of the most interesting committees I have ever worked on, to try to draw up some plans for the State of Michigan in regard to health facilities.

One of the things that became clear to us early was that the problem of health facilities represents a total continuum of interest. For example, this morning there was extensive discussion of the problem of hospital costs, hospital needs, and of the possibilities of other health facilities.

Someone mentioned a sort of motel arrangement that could be used, with other steps to take away from the cost of the actual hospitalization. I, for one, don't see any prospect of any diminution of the cost of hospital care itself. I see great possibilities for diminution in the total expense for health care by making better use of other ways of taking care of patients.

Our association is very deeply interested in the problem of home care, but just the very beginning has been made of getting adequate nursing services, adequate supporting services, for comprehensive home care. There is no reason why good physical therapy and occupational therapy and other services cannot be done at home at much less expense than in the hospital.

Thus, we see the regional hospital and health facilities planning as dovetailing very neatly with the total need for comprehensive health planning.

This bill, Mr. Chairman, in the opinion of our association, represents an enormous step, with enormous potential, for really getting at the heart of the problem of meeting the health needs of the country by giving Federal support to local initiative. We are very happy to sup-

port it and hope that the Congress will not only approve the bill, but authorize appropriations to implement it properly.

Thank you, Mr. Chairman.

(Dr. Wegman's prepared statement follows:)

STATEMENT OF DR. MYRON WEGMAN, IN BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association is pleased to support pertinent objectives of H.R. 6418, especially those portions which would extend the authority of P.L. 89–749. It is because of the potential of this Act to improve the public health of this nation that we are unstinting in our support. The APHA has over 18,000 members engaged full time in the promotion of better health, working in city, county, State and national official and voluntary health agencies. We are overwhelmingly convinced of the merits of this new changed approach to providing Federal support to public health programs and urge this Committee to give the most serious consideration to current and future health problems and the potential for improvement.

While we urge substantially increased health grant support, we are not unmindful of the many serious financial responsibilities and commitments of our Federal Government. We are cognizant and most appreciative of this Committee's and the Congress' generous support of health endeavors including health research, the training of physicians, dentists, nurses, and other health personnel; the NIH fellowship and training programs; the Regional Medical Programs for Heart Disease, Cancer, Stroke and related diseases; plus health services for mothers and children, for school children, for the elderly, the disabled, the indigent, and for those who need rehabilitative care. But just as the Congress, in P.L. 89–749, has asked States and areas to study their total public health problems, to assess severity factors, and then to assign available personnel and financial resources appropriate to need, we ask that you study carefully the urgent health needs and the requisite level of Federal grants for State and local public health programs to meet them.

The American Public Health Association supports the conclusions of this Committee and the policy enunciations contained in P.L. 89–749. We agree that health services should be tailored to the needs of people where they live, and further that appropriate determinations cannot be made solely on the basis of national statistics. We agree that careful planning is necessary to eliminate duplication of effort, to avoid gaps in services and to insure the greatest emphasis on greatest need, including the best use of a too short supply of trained personnel.

Three basic elements of P.L. 89–749 provide a significantly improved mechanism for more effective Federal support of public health programs. Planning grants will assist States and areas to make more thorough studies of total health needs and to assign priority values so as to better organize programs and services to meet these needs. The formula grant authority will provide the flexibility necessary to allocation of grants appropriate to health need. The project grant authority will permit both continued efforts on specific severe disease problems and initiation of programs to counter newly emerging health problems. We believe these mechanisms provide the basis for an effective working partnership. But to achieve this potential, support by each partner is required. As was stated in our communication to this Committee on October 10, 1966, the present level of Federal support of State and local public health services, when compared with that of the States and communities themselves, relegates the Federal Government to the role of minor stockholder. If health services are to be increased, improved, sharpened in focus; if services are to meet health needs (and they should); the Federal appropriations under P.L. 89–749 must be sharply increased over the next few years.

The American Public Health Association believes that such increase in support would be an excellent investment. May we cite one example. This nation has undertaken a program to provide health care for the aged. We support this program. But, as we have pointed out to the Ways and Means Committee, fiscal integrity of the program requires that necessary care be provided economically and effectively. We are convinced that almost all if not all of the aged prefer not to be hospitalized. When effective care can be given in the home the patient is happier and the cost is greatly reduced. But the nationwide development of

home care programs is in its infancy. If the capability to provide effective home care and to reduce cost is to be forthcoming, P.L. 89-749 is the source for Federal support. Health services must be provided. We are persuaded that the most effective and the most economical means to accomplish this objective is to build upon the competency of State and local health departments whose contribution in the solution of other health problems is well known.

In addition to home care, other health areas which urgently need more money are family planning, urban health problems (particularly slum health problems), need for facilities, shortages of trained personnel in all fields, lack of rehabilitation facilities, and the problem of infant mortality.

The provisions in this bill for extension and expansion of the program for formula grants to schools of public health (Section 309(c) Public Health Service Act) are particularly important in view of the sharply increasing needs for trained personnel, generated by the remarkable health legislation of recent years. The 13, soon to be 15, accredited schools of public health have the basic responsibility for broad and comprehensive health training for a wide variety of personnel, including physicians, dentists, nurses, engineers, veterinarians, health educators, statisticians, nutricianists, mental health workers and many others concerned with all aspects of health. All of the schools are emphasizing planning in their general curricula and the training is thus particularly germane to the overall purposes of this legislation.

It is clearly essential that authorization provide for considerable expansion in appropriations under Section 309(c). Current and forthcoming health legislation, involving necessary increase in numbers of trained health personnel will require establishment of new schools. Those at the University of Oklahoma and Loma Linda University have just been recommended for accreditation and advanced planning is underway for establishment of schools at the University of Alabama, the University of Texas, and the University of Illinois. Public health schools are necessarily national schools, as is evident from Federal Government sponsorship of more than half the students at these schools. Formula grant appropriations must keep pace with the sharply increased personnel needs.

An orderly approach to providing needed health services, foreshadowed by the mechanism of P.L. 89-749, we believe will result in improved health services. But the rearranging of administrative procedures alone will not provide adequate care. We urge this Committee and the Congress to increase the authorization for formula and for project grants for 1968 from the current ceiling of $125 million to $200 million with significantly practical increases in each of the succeeding three years.

CLINICAL LABORATORY LICENSING

Another proposal contained in H.R. 6418 would provide for the licensing of clinical laboratories which deal in interstate commerce. We support this action. Improper performance of a laboratory procedure may induce an erroneous diagnosis or contribute to the selection of an inappropriate method of treatment, resulting in illness or unnecessary disability, hospitalization, injury, or even death. Despite the rapidly increasing complexity and scope of laboratory procedures, demanding a greater knowledge of developing scientific techniques, a minority of States have laws regulating procedures and practices of clinical laboratories and blood banks.

The APHA believes certain actions would improve this situation. First, the U.S. Public Health Service should develop recommended minimum standards for services of clinical laboratories and blood banks. Second, Federal legislation should be enacted to regulate the practices of clinical laboratories engaged in interstate commerce. Third, following State health department assessment, State legislation should be enacted to regulate practices in clinical laboratories and blood banks in meeting established standards.

Quite clearly the proposal contained in H.R. 6418 would assist in accomplishing these objectives. We believe that the total laboratory services program would be strengthened if, as is proposed on page 15, lines 5 through 10 of H.R. 6418, the Secretary would, wherever possible, utilize the services of State and local public health agencies who already have authority in this area. Further, we suggest that the Secretary, through grants and contracts, strengthen the competency of these agencies to perform better their responsibilities in protecting the public health by assuring high quality, effective laboratory procedures.

Your careful consideration of this request is most respectfully urged.

Mr. STUCKEY (presiding). Thank you. Mr. Keith?
Mr. KEITH. No questions, Mr. Chairman.
Mr. STUCKEY. Mr. Kyros?
Mr. KYROS. No questions, Mr. Chairman.
Mr. STUCKEY. Mr. Watkins?
Mr. WATKINS. No questions, Mr. Chairman.
Mr. STUCKEY. Thank you very much for your testimony. We certainly appreciate your having been with us today.
Mr. ROGERS (presiding). The next witness will be Dr. Wellington B. Stewart, chairman, Board of Registry of Medical Technologists, the American Society of Clinical Pathologists.

STATEMENT OF DR. WELLINGTON B. STEWART, CHAIRMAN, BOARD OF MEDICAL TECHNOLOGISTS OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGY

Dr. STEWART. I am here primarily to represent the registry of medical technologists and its board. The board of registry, which was established in 1928 by the American Society of Clinical Pathologists, is charged with developing and guarding high standards of training and certification of medical technologists. These highly trained staff members, chiefly women, are the pathologists' indispensable assistants in conducting tests for the diagnosis and treatment of disease.

The legislation before you, the clinical laboratories improvement section of the partnership for health amendments, will inevitably be concerned with standards of qualifications of medical laboratory personnel. We would like you to know what pathologists and medical technologists have done about the qualifications of medical technologists through the registry of medical technologists. Our experiences may provide helpful background and guidance for your deliberations and decisions.

When the registry was established in 1928, clinical laboratories were relatively simply workrooms, vastly different from the complex installations found in modern hospitals today. However, even then, physicians could not take the time to run nor to check and rerun each procedure on which diagnosis and treatment of the patients depended, although the accuracy of those procedures was essential to the patients' welfare.

Nor could the laboratory assistants, even then, put together the various elements of medical testing and read the correct answers from the resulting reactions unless they had some understanding of the principles upon which the tests were based.

Accordingly, to insure standards of training that would protect patients' welfare, the board of registry, composed of eminent pathologists and medical technologists, was assembled, standards of training were developed, schools were established in accredited hospitals, and annual examinations initiated.

Since that time almost 60,000 medical technologists have "passed their boards," and as Harper's magazine put it a few years ago in an article titled "Danger in Our Medical Laboratories":

> Ever since then, the initials MT(ASCP)—meaning a medical technologists certified by the American Society of Clinical Pathologists—have stood for basic competence in the laboratory.

This recognition has been achieved and maintained through dedicated efforts of educators and physicians. As laboratory procedures and, consequently, the training required to do them became more complex, it became necessary for the American Society of Clinical Pathologists to establish a board of schools of medical technology to set standards for schools and to see that they were maintained.

The board of schools, established in 1949, inaugurated a system of school inspection to assist the Council on Medical Education of the American Medical Association in accrediting schools that meet and maintain its standards. There are now nearly 800 AMA-accredited schools in the United States. All must be located in hospitals where they have access to the clinical specimens essential for adequate training, and many are also associated or affiliated with colleges or universities.

I think it important that you note that over the years the training of the medical technologist is required more and more in basic education. Students originally were enrolled in approved schools in hospitals after 1 year of college, with some courses in chemistry and biology.

In 1938 the academic requirement was changed to 2 collegiate years, and in 1962 to 3—with heavy prerequisites in biological sciences. Correspondingly, the instruction given in the year of hospital training has steadily increased in complexity and comprehension. At completion of this training, nearly all students acquire a bachelor's degree. This is either acquired before they enter the school or given concurrently by the college or university for the work that they do in the hospital laboratory phase of their training.

The board of registry of medical technologists has had nearly 40 years' experience in qualifying and certifying medical technologists and certain other laboratory workers. We are constantly revising and updating our examinations for these personnel, and have begun to study the problem of equivalency examination.

We are considering the possibility of selecting at least in part by examination those individuals who may be qualified by training and experience—rather than only by a formal educational program—to be certified as registered medical technologists.

The laboratory director has increasing need for well-educated and experienced personnel. The complexity of the modern laboratory requires great skill, knowledge, and responsibility on the part of the higher level laboratory workers. Moreover, the clinical laboratory each year becomes more important to patient care. We must work to improve the quality of laboratory work and at the same time increase our ability to do more.

As the demands upon us increase, it seems probable that only modern technology, such as automation and high-speed data processing, can provide the answers we need. To serve in this complex environment, now and in the future, requires highly educated and trained individuals, many of whom, as pointed out to the committee this morning, are not available. They must be trained.

The medical technologist, as presently trained and certified, approaches the type of individual described above. In the future, he must in actuality be that type of person. I want to emphasize that there is room in the laboratory for individuals of other levels of train-

ing and skill. In fact, if the medical technologist, as we now know it, becomes this high-level worker, we believe more of the individuals at other levels will be trained less extensively, but they do not all need baccalaureate training as medical technologists.

This important point, gentlemen, is that high-quality work, around the clock and around the week, be maintained in our clinical laboratories. As a physician and a pathologist, it is my professional duty to my patients and to those of other physicians to urge that any legislation enacted results in improvement rather than deterioration of laboratory standards throughout the Nation, and, moreover, is sufficiently flexible to meet the needs of a rapidly changing situation.

Thank you, sir.

Mr. ROGERS. Thank you very much. Mr. Stuckey?

Mr. STUCKEY. No questions, Mr. Chairman.

Mr. ROGERS. Mr. Keith?

Mr. KEITH. Thank you, Mr. Chairman.

As I was reading section 5 on page 10 of the bill, subsection 2, with the following subsection B, a question comes up which I might explain the background on for its coming to my mind.

I used to be in the life insurance business. They have trained examiners in every community. An agent, in order to get an insurance policy issued, has to get a urinalysis of the prospect, as well as other examinations required by the insurance company.

The relationship exists between the doctor and the insurance company, of course. A doctor under these circumstances would be unable to make a simple urinalysis and send the results to an insurance company?

Dr. STEWART. No, sir; I don't believe the legislation as now written, nor the intent of any of my remarks, would restrict what a doctor would be able to perform on his own for the benefit of his own patients or those of an insurance company.

This is a somewhat different problem than the problem of the actual care to sick patients in the hospital.

Mr. KEITH. I am reading from the bill, and it says, "No person may solicit or accept in interstate commerce, directly or indirectly," and so forth.

Dr. STEWART. That is unless the laboratory is licensed. I am not a lawyer, sir. However, there is a statement in here that exempts a physician's own laboratory work for his own patients.

Mr. KEITH. But not for an insurance company perhaps.

Dr. STEWART. I am not sure what the situation is if the patient comes to a physician for an insurance examination. He generally mails the specimen to the insurance company's laboratory anyway.

Mr. KEITH. He makes sugar tests and other tests right there.

Dr. STEWART. I think there is a distinction between the laboratory run by the insurance company and the laboratory set up primarily for the ongoing care of the patient. The insurance company laboratory, if it makes a mistake, has perhaps called the patient uninsurable when he is not, which is too bad, and costs him money.

Mr. KEITH. You miss the point. All I want to know is can a doctor make a simple analysis for sugar and forward it to the insurance company under this legislation as currently posed in this bill?

Mr. ROGERS. Perhaps we should ask counsel about that. I don't believe you feel you are qualified to answer that question.

Dr. STEWART. I don't feel I can answer that question. It depends on how it is implemented. Perhaps it is so broad now that that would be true. My interests are more in the ongoing patient care.

Mr. KEITH. It wouldn't be your intent, as sponsor of this legislation, to prohibit such an examination on the part of a doctor?

Dr. STEWART. No, sir. My interest is maintaining high standards, higher than we now have them, if necessary, to carry on the patient care.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. Is it my understanding, Doctor, that you and your group are in favor of this legislation which is before us?

Dr. STEWART. The group I represent actually is not taking a stand in favor or against this legislation. My role here is to try to explain to this committee the Registry of Medical Technologists, its purposes and what it has already accomplished in terms of standards of laboratory care in this country.

I personally feel that, on the whole, this is an excellent bill. There are many things in here that are fine, and I would agree with many of the comments made this morning, the opportunity to try new methods of patient care with data processing. But I don't wish that to be a statement of my organization.

Mr. KYROS. But personally, you are in favor of this legislation?

Dr. STEWART. Yes; I am, sir. But I want to be sure than the laboratory licensing regulations which may be issued lead to an improvement rather than a deterioration in standards of laboratory personnel.

Mr. KYROS. Did you have any specific proposal that is different from the bill?

Dr. STEWART. No, sir. I have no changes to suggest. Other representatives have made a few suggestions, of course. A few days ago there was a discussion in the committee concerning the overall problem.

Mr. KYROS. Thank you.

Mr. ROGERS. Mr. Watkins?

Mr. WATKINS. I have nothing in particular to ask about.

I would like to say to you, Doctor, that your statement is very clear. I hope you continue with your good work.

Dr. STEWART. Thank you, sir.

Mr. ROGERS. Thank you very much, Dr. Stewart, for your testimony.

Dr. STEWART. Thank you.

Mr. ROGERS. We have been called to the floor of the House.

Would the next witness like to proceed? We may have to leave on the second bell and then come back.

The next witness will be Dr. Ernest E. Simard.

Dr. SIMARD. Mr. Chairman, the decision, I think, is really yours. We are perfectly willing to wait, or to proceed.

Mr. ROGERS. We might as well begin your testimony now.

Dr. Simard is accompanied by the Honorable Kenneth A. Roberts, a former member of this committee and former chairman of the Public Health Subcommittee.

STATEMENT OF DR. ERNEST E. SIMARD, PRESIDENT, COLLEGE OF AMERICAN PATHOLOGISTS; ACCOMPANIED BY HON. KENNETH A. ROBERTS, LEGISLATIVE COUNSEL; AND OLIVER J. NEIBEL, JR., EXECUTIVE DIRECTOR AND GENERAL COUNSEL

Mr. SIMARD. Mr. Chairman, I am Dr. Ernest E. Simard, of Salinas, Calif., president of the College of American Pathologists.

As you indicated, I am accompanied by the Honorable Kenneth A. Roberts of Washington, D.C., our legislative counsel, and by Mr. Oliver J. Neibel, of Chicago, Ill., our executive director and general counsel of the college.

Mr. ROGERS. We are delighted to have you gentlemen with us today.

Dr. SIMARD. The College of American Pathologists is a professional society of doctors of medicine representing approximately 5,000 physicians who practice the medical specialty of pathology in hospitals, both private and governmental; medical schools; clinics; and research institutions as well as in private offices throughout the country.

I appear before you today representing these physicians and presenting their views on that portion of H.R. 6418 which seeks to provide for the Federal licensing of clinical laboratories.

It is our considered opinion that pathologists, as physicians practicing their medical specialty, should not be included in this legislative proposal. Therefore, we shall limit our testimony before this committee to those aspects of the legislation now before you for consideration which directly affect our medical specialty—section 5, entitled "Clinical Laboratory Improvement."

What is pathology? Pathology is that branch of natural science which concerns itself with the causes and nature of disease, together with the anatomical and functional changes incident thereto. The practice of human pathology is that specialty in the practice of medicine which contributes to the diagnosis, treatment, observation, and understanding of the progress of disease or medical condition.

This the pathologist accomplishes by means of information obtained from morphologic, microscopic, chemical, microbiologic, serologic, or any other type of examination. Such diagnostic procedures may be conducted in a medical laboratory, made on the patient himself, or on material obtained from his body.

In order to be recognized as a specialist in pathology as much as 13 years of higher education are necessary. Like other doctors, the pathologist spends 3 or 4 years in college, followed by 4 years in medical school and a year of internship.

Following this, he undertakes a rigorous 4 years of specialized training in the art and science of pathology itself. Subsequent to this lengthy, intensive training, a prospective pathologist must pass a comprehensive examination given by the American Board of Pathology, one of the medical specialty boards organized under the aegis of the American Medical Association.

If he successfully passes this examination, he is officially certified as a specialist in that branch of medicine which he has chosen to practice.

Nor is that the end. Because of the nature of his practice, a pathologist must go right on studying for the remainder of his professional career if he is to adequately provide the services for which he is trained. A pathologist consults with physicians in every medical

specialty; consequently, he must keep abreast of all new medical developments in all branches of medicine.

A survey conducted by our college reveals that most pathologists devote from 5 to 10 hours each week to the reading of medical journals. In addition, he constantly must attend medical and scientific meetings on a local, regional, and national basis.

Our sister society, the American Society of Clinical Pathologists, an organization to which most pathologists belong, is dedicated to the continuing education of pathologists and the proper training of medical technologists.

Mr. ROGERS. The committee will have to recess at this point and answer the call to the floor of the House.

(A short recess was taken.)

Mr. BLANTON (presiding). The committee will please be in order.

We will hear Dr. Simard continue with his statement.

Dr. SIMARD. If I may, Mr. Chairman, I will backtrack just a small bit to the beginning of the paragraph with which I was engaged before the recess.

Our sister society, the American Society of Clinical Pathologists, an organization to which most pathologists belong, is dedicated to the continuing education of pathologists and the proper training of medical technologists.

Through its commission on continuing education and its councils on anatomic pathology, clinical chemistry, radioisotopes and cytopathology, forensic pathology, hematology, immunohematology, microbiology, and special topics, it maintains the most highly developed, continuous postgraduate education program in medicine.

Its manuals and other publications, as well as its seminars and workshops in all aspects of pathology, are well attended by most pathologists on either a regional or national basis.

The College of American Pathologists which has been designated the spokesman for pathology in the legislative halls, likewise conducts on a continuing basis additional programs ever striving for professional excellence in all aspects of the practice of our medical speciality. Since its inception the American Board of Pathology has certified approximately 6,000 physicians in our medical speciality.

Of those certified by the American board, approximately 5,000 or roughly 90 percent of the living, board-certified pathologists in the service practice of pathology are members of the college and support in a variety of ways its continuous ascent toward its goal of excellence.

The college programs of excellence are too numerous for detailed enumeration here. Let me, however, mention a few.

The inspection and accreditation program of the college was established in 1962 in furtherance of our conviction that progress and maintenance of high standards of laboratory medicine can be assured only by a continuous program of professional evaluation.

Because of the unique manner in which laboratory medicine is practiced we are convinced that responsibility for evaluation of highly specialized laboratory operations and competence of staff can be adequately determined only by pathologists—physicians specially trained and long experienced in laboratory medicine.

Modern laboratory medicine is dynamic and complex—it encompasses many operations and each laboratory must be completely evaluated in accordance with its particular functions. Over 600 laboratories

are concurrently in our inspection and accreditation program and the number is growing daily as representatives of local and State governments, as well as individual administrators of hospitals recognize, as does the Joint Commission on Accreditation of Hospitals, the value of this scientific program of evaluation and accreditation.

Through its standards committee, the college has maintained for a number of years comprehensive surveys of laboratory performance not only for its membership but also for any laboratory directed by a doctor of medicine.

Although this program has been active for many years last year it was significantly enlarged to become a continuous program of self-evaluation with a series of laboratory unknowns being distributed each month in order that both the individual physician and the profession could be aware of the level of laboratory performance.

Last year also saw the initiation of our basic or small hospital survey series which quartely checks laboratory accuracy on the procedures most frequently performed in private offices and small hospital laboratories.

This survey program has achieved the acclaim of the scientific community. With the advent of medicare and the standards for participation of independent laboratories our basic survey has achieved official recognition by the Communicable Disease Center of the U.S. Public Health Service as being approved for proficiency testing of independent laboratories by State agencies.

The State health departments in Illinois, Oregon, and Washington, subscribe to the basic laboratory survey for the independent laboratories in those States.

Numerous other State agencies accept participation in our survey program as meeting the proficiency testing requirements under medicare.

The aqueous standard solutions distributed by the college to all laboratories provide a basis for reliable calibration of instruments and reagents.

The PathCAPsule series of professional education pamphlets describing for the benefit of nonpathologist doctors, various laboratory tests and their clinical significance, has been a widely recognized educational effort in the medical community.

The publication of the systematized nomenclature of pathology developed in conjunction with the American Cancer Society has been hailed as a significant international landmark in the nomenclature and classification of disease.

With this rather extensive background as to the nature of the medical specialty of pathology and the continuing efforts at the national and regional level to provide constant opportunity and stimulus for the continuing education and self-evaluation of all board-certified pathologists, I would like to now specifically direct your attention to that provision of H.R. 6418 which particularly is of great concern to the college and those it represents.

Subparagraph (i) of section 353 of section 5 of the bill provides that clinical laboratories operated by licensed physicians, osteopaths, dentists, or podiatrists, who perform laboratory tests or procedures personally or through their employees solely as an adjunct to the treatment of their own patients, are exempt from licensing provisions of H.R. 6418.

No such exemption is granted to those physicians who are best equipped by education, background, and experience to operate clinical laboratories. Recognition of professional excellence is denied to that small group of physicians who have individually and organizationally dedicated their professional lives to excellence in the art and science of laboratory medicine—the board-certified pathologists of this country.

There has been a significant amount of testimony before this committee which is coupled in terms of regulation of the clinical laboratory business or the growing laboratory industry.

Pathologists directing clinical laboratories are not engaged in business or commerce. Pathologists thus engaged are practicing medicine and are not engaged in commercial intercourse.

Each pathologist laboratory director is licensed to practice medicine by the State in which he practices. It has been repeatedly held by the American Medical Association, the courts in a number of States, and by statute or rule and regulation in other States, that laboratory direction when performed by a pathologist physician is the practice of medicine.

Accordingly, my appearance before you today is dedicated to the proposition that if any physicians are exempted from licensing provisions of this law, it would be those physicians who are recognized by whatever standard or measure you might care to use as being the best equipped educationally and the most skilled professionally to provide quality laboratory medicine.

We would specifically urge this committee to give thoughtful consideration to the amendment of paragraph (i) of section 353 in such a manner and so as to exempt from the provisions of the clinical laboratories improvement section (sec. 5) any laboratory operated by a physician who has been certified by the American Board of Pathology.

The College of American Pathologists is deeply grateful for the opportunity you have offorded us to submit this statement for the record and for the opportunity to make our views personally known to you on this most important proposed legislation.

Mr. STUCKEY (presiding). Thank you very much. Do we have any questions?

Mr. KEITH. Thank you, Mr. Chairman.

I appreciate very much your statement, Dr. Simard. It is helpful to us as we consider this proposal.

You heard the line of questioning that I directed to the previous witness?

Dr. SIMARD. The one in regard to the insurance companies?

Mr. KEITH. Yes.

Dr. SIMARD. Yes, I did.

Mr. KEITH. I want to make sure it is not your attempt to require a doctor and nurse to have a certification of some sort prior to their furnishing whatever the insurance company wants from that doctor?

Dr. SIMARD. It is not my attempt to require that, Mr. Keith. It is my understanding of the law as presently written, the insurance companies would be required to become certified under the provisions of the law as it presently exists.

Mr. KEITH. I can understand how an insurance company might have

to get some kind of certification, that which is required, in order for the work that they are doing, for someone who was not a policyholder, something like that.

But when the purpose of the examination is to give or issue insurance, and they have a lot of doctors, thousands of them, throughout the country who have to make routine checks satisfactory to the insurance company, they are the ones who are carrying the risk, with the doctor working for them and not for the patient, you would not intend to make it difficult for the issuance of policies based upon that kind of information, would you?

Dr. SIMARD. No, sir, I would not intend to make it difficult for them. As I said, as I understand the legislation as it exists at the present time, they would have to comply. I would support the concept that a laboratory operated by an insurance company under the aegis of a qualified physician should be exempt.

Mr. KEITH. Thank you, Mr. Chairman.

Mr. STUCKEY. I believe before the last recess our counsel was going to look into that point. That was the discussion about section 5.

Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman.

If I understand your testimony, Doctor, the problem is as to exempting the pathologist from the operation of their clinical laboratories, is that correct?

Dr. SIMARD. That is correct.

Mr. KYROS. In connection with the remainder of the bill, the College of American Pathologists is in favor of the legislation, other than the problem that you have just talked about?

Dr. SIMARD. We have taken no position on any other portion of the proposed legislation sir.

Mr. KYROS. I presume you have read these, haven't you?

Dr. SIMARD. Yes.

Mr. KYROS. Well how do you feel about them personally?

Dr. SIMARD. Well, it would be a personal opinion, sir. I would feel that it is reasonable legislation.

Mr. KYROS. Going back to the problem you have raised, what specific language are you proposing in which section of the act to exempt the regular pathologist from the operation of clinical laboratories and licensing?

Dr. SIMARD. The specific section that we are discussing is paragraph i, section 353, at the bottom of page 14 and the top of page 15.

Mr. KYROS. What would you do there?

Mr. NEIBEL. If I may answer that, Mr. Kyros, for Dr. Simard, we would expand section I to say that the provisions of this section shall not apply to any clinical laboratory operated by a licensed physician, osteopath, dentist, or podiatrist, who performs laboratory tests or procedures personally or through his employees solely as an adjunct to the treatment of his own patients and to any laboratory operated or directed by a pathologist certified by the American Board of Pathology.

Mr. KYROS. That would remove from the licensing provisions and regulations by the Secretary all clinical laboratories operated by pathologists?

Mr. NEIBEL. Yes.

Mr. KYROS. Would it also, exclude those clinical laboratories operated by osteopaths, dentists, podiatrists, who are so licensed?

Dr. SIMARD. Yes, I believe that would be so, sir.

Mr. KYROS. Thank you.

Thank you, Mr. Chairman.

Mr. STUCKEY. Are there any further questions?

If not, Doctor, thank you very much for your testimony, Mr. Roberts and Mr. Neibel.

Mr. KEITH. Mr. Chairman, I am supposed to be at the Merchant Marine and Fisheries Committee on the seizure of fishing vessels by foreign powers and the compensation for such seizure. I hope to leave as soon as another member of the minority arrives.

If you would, I would like for you to call out of order this gentleman who is with the Equitable Life Assurance Society. If the other witnesses would not mind, I would like to hear his testimony.

Mr. STUCKEY. If we hear no objection at this time, we will call Mr. Howard Ennes, the assistant vice president of Equitable Life Assurance Society of the United States, appearing in behalf of the Health Insurance Association of America.

Is there any objection to Mr. Ennes proceeding at this time with his statement?

STATEMENT OF HOWARD ENNES, ASSISTANT VICE PRESIDENT, THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. ENNES. Thank you, Mr. Chairman.

I appreciate very much this opportunity to be with you this afternoon and to be taken out of order in this way.

My name is Howard Ennes. I am assistant vice president of the Equitable Life Assurance Society of the United States and director of community services and health education on the staff of the chairman and chief executive officer of the Equitable. I appear before you today in behalf of the Health Insurance Association of America.

The association has 330 member companies who write approximately 80 percent of the health insurance provided by companies. As you know, insurance companies provide protection against the costs of health care to more people than any other type of insurance program—public or private.

We wish to endorse the concept of comprehensive health planning as embodied in Public Law 89-749 and as proposed for extension through section 2 of the bill you have before you, H.R. 6418.

We endorse the concept of section 2 of H.R. 6418. We endorse putting this concept into operation, and we endorse participation of the public in the planning process.

We support the concept because we feel that a comprehensive approach is vital to the efficient delivery of quality health services to the public at reasonable cost.

We support the bill's method of encouraging planning at the State and local level because we are convinced that the closer the planning process is to the community the more relevant and responsive it will be.

This is where the health care delivery system is located—at the community level. This is where its problems must be resolved.

This is where the resources can best be used.

We support the participation of consumer representatives in the planning process for two reasons. First, consumers have a vital interest in both the quality and the cost of health care. Secondly, consumers can bring their own resources of ideas and energy to the many problems that confront the future of health care in America.

In a very real sense, we in the health insurance business are representatives of consumers—for some 95 million people who have health insurance with insurance companies.

We recognize both the public interest and a business interest in health care. In fact the public interest and the business interest are essentially the same—for we want for the health consumer the same things the health consumer wants for himself and his family. Access to quality care at reasonable cost.

And so I am here today to register the endorsement by the Health Insurance Association of America of the comprehensive community health planning concept you have fashioned, both for reasons I have stated, and for others.

It has become apparent that certain obstacles stand in the way of reaching the generally accepted goal of adequate health care for all.

Some of these obstacles are fragmentation among, and gaps between, services and coverage; variations in quality of care; scarcity of trained manpower; limited resources; jurisdictional overlapping; and undefined priorities. If these obstacles are to be overcome, there must be effective cooperation between government, the providers of care, the representatives of consumers.

Public Law 89–749 which this bill would extend, appears to underscore the pluralistic nature of the planning process. Under it decisions are reached and acted upon by the voluntary, professional, and governmental sectors concerned with the delivery of health care in cooperation with representatives of consumers—including management, labor, and private health insurers—to whom health care is delivered.

In our view, the approach of Public Law 89–749 represents a new and welcome advance in government-private relations. It seems to us that it is a move to put responsibility and decisionmaking backed up with resources where it properly belongs with the States and in the communities.

In short the act recognizes that the efficient delivery of quality health care to the public is a problem in which we all share responsibility.

Alone it is doubtful if any of us could mandate a solution. But together we can hope to compose one. Most of the methods have undergone some testing and we feel that the comprehensive approach now deserves a chance to be tried fairly.

We in insurance are committed to support—with manpower and with administrative and technical skills this planning process in all 50 States.

Mr. Chairman, the insurance industry appreciates that we not only have an opportunity to participate in this approach, but that we have a sense of responsibility to do so—to share our experience in management and administration gained over many years of serving in behalf

of the one out of two Americans who have entrusted to us custody of their care, their health care protection resources.

To get ready to fulfill that purpose we have expanded the scope of our Health Insurance Council which through its 50 State network, has over 20 years served as our liaison with the providers of health care the hospitals, the physicians, dentists, and other professions with a community of interest in health care and its financing.

A special Health Insurance Council project for community health action planning has been created. We refer to the project as HiCHAP. Our program is geared to provide experienced and competent personnel of insurance companies for participation in community health planning activities where they may be needed and can serve usefully in the public interest.

To back up our manpower we are organizing to expand our information programs to include trends and developments in comprehensive community health planning, and to provide additional research data and other information in the field of health insurance as this will relate to planning activities.

Through this approach we are seeking to serve all elements of American society with respect to this vital area of comprehensive health planning.

On a request basis, we shall make our services available to the maximum reasonable extent to the private sector and to consumer groups, to leadership of health and medical care professions and organizations, to public officials, and governmental agencies, and to civic leaders and voluntary organizations.

This program is under the general supervision of a special committee of the chief executives of 25 of the Nation's leading insurance companies.

Its chairman is Mr. Orville E. Beal, the president of the Prudential Life Insurance Co. of America. With your permission Mr. Chairman I would like to submit for the record the membership of our Committee on Community Health Planning.

Mr. STUCKEY. Without objection, that will be included in the record at the conclusion of your statement.

Mr. ENNES. I am able to report to you that in the short time since HiCHAP was authorized on May 1, we have been in touch with most State Governors to acquaint them with our commitment in the public interest.

We have also assigned to each State a HiCHAP coordinator to organize and make effective our support of health planning organizations, State and local.

In Chicago on June 6th and 7th we held an initial briefing session on comprehensive health planning for our new HiCHAP team from all over the country.

We were honored to have as active participants in this briefing outstanding representatives of the Surgeon General of the Public Health Service and regional office of the Service, the eminent director of Public Health of Illinois, directors of five leading area wide and community health planning agencies, and observers from the American Public Health Association, the American Medical Association, the American Dental Association, and the American Hospital Associa-

tion, and the American Nursing Home Association and the National Health Council.

Thank you, Mr. Chairman, and gentlemen, for this opportunity of registering the active commitment of the insurance industry to the concept of comprehensive community health planning.

There is another section of the bill, Mr. Chairman, section 5 relating to licensing of clinical laboratories, the scope of which appears to create major problems for the insurance business. We are in the process of studying this section and, with your permission, we would ask leave to file a supplemental statement relating to this section.

Thank you, Mr. Chairman.

(The membership list referred to follows:)

MEMBERSHIP OF COMMUNITY HEALTH PLANNING COMMITTEE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Orville E. Beal, *Chairman*, President, The Prudential Insurance Company of America
J. H. Abrahams, President, Chairman of the Board, Security Benefit Life Insurance Company
Gerhard D. Bleicken, Senior Executive Vice President, John Hancock Mutual Life Insurance Company
Earl F. Bucknell, President, Bankers Life Company
John L. Cameron, Chairman of the Board, The Guardian Life Insurance Company of America
John W. Carlton, Vice President and Actuary, Liberty Mutual Insurance Company
Earl Clark, President and Chief Executive Officer, Occidental Life Insurance Company of California
John W. Clarke, President, Hartford Life Insurance Company
James E. Devitt, Vice President for Underwriting, The Mutual Life Insurance Company of New York
R. Howard Dobbs, Jr., President, Life Insurance Company of Georgia
Ardell T. Everett, Chairman of the Board, The North American Company for Life, Accident and Health Insurance
E. J. Faulkner, President, Woodmen Accident and Life Company
Gilbert W. Fitzhugh, Chairman of the Board, Metropolitan Life Insurance Company
John A. Henry, President, Continental Casualty Company
John A. Hill, President, Aetna Life & Casualty
Howard Hutchinson, Senior Vice President, Nationwide Mutual Insurance Company
Robert L. Maclellan, President, Provident Life and Accident Insurance Company
Charles W. V. Meares, Executive Vice President, New York Life Insurance Company
Fred H. Merrill, Chairman of the Board and President, Fireman's Fund American Insurance Companies
H. Lewis Rietz, President, Great Southern Life Insurance Company
Henry R. Roberts, President, Connecticut General Life Insurance Company
J. W. Scherr, Jr., Chairman of the Board, Inter-Ocean Insurance Company
V. J. Skutt, Chairman of the Board and Chief Executive Officer, Mutual of Omaha Insurance Company
J. Henry Smith, President, The Equitable Life Assurance Society of the United States
Sterling T. Tooker, President, The Travelers Insurance Company
Travis T. Wallace, Chairman of the Board, Great American Reserve Insurance Company

(The following letter containing a supplemental statement was subsequently submitted by the Health Insurance Association of America:)

HEALTH INSURANCE ASSOCIATION OF AMERICA,
Washington, D.C., June 26, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: On June 22, 1967, when Mr. Howard Ennes appeared before your committee on H.R. 6418, he indicated that the scope of Section 5 relating to the licensing of clinical laboratories created problems for the insurance business and received permission for us to file this supplemental statement relating to that section.

In this supplemental statement we are joined by the American Life Convention and the Life Insurance Association of America. The life insurance companies which are members of these Associations write approximately 97% of the life insurance business written in the United States.

Insurance companies evaluate the medical history and findings on examination (including laboratory examination) to determine the insurability of an individual, and the eligibility for policy benefits such as waiver of premium and disability income. This is done in a number of ways, three of which will serve to point out the problems which would be encountered under Section 5:

1. Insurers engage physicians to examine and run tests on applicants and submit reports of such tests to the insurer.
2. Insurers maintain laboratories which receive specimens through interstate commerce to assess the insurability of an individual.
3. With permission of the applicant, insurers receive reports of prior treatment by his physician including tests performed at that time.

None of the reports on these tests are received or used by the insurance company for the purpose of diagnosis and treatment of the individual. The sole purpose is to assess the insurability of the individual or his eligibility for policy benefits.

Under Section 5 of H.R. 6418 a laboratory so operated by an insurer or tests made by a physician in the field above referred to would require the licensing of the laboratory or the physician since the tests were not made by "a licensed physician . . . solely as an adjunct to the treatment of his own patients."

Insurance companies must rely on information and the services of nearly every practicing physician in the normal conduct of their business. Since the exemption accorded the practicing physician under this legislation only applies to laboratory services for his own patients, the insurance industry would be able to utilize the services of only those physicians electing to obtain a Federal license. This would seriously impair a vital part of our operational procedures. We do not believe it is in the public interest or would be the purpose of Congress that licensing of practicing physicians by the States be over-ridden by superimposed requirements for Federal licensing simply to perform insurance tests.

We do not believe that the intent of Section 5 of H.R. 6418 is to reach examinations and laboratory tests of the type referred to above. Channelling all such tests through specially licensed laboratories and specially licensed physicians would necessarily be costly. For some companies the cost would be prohibitive and certainly it would result in increased premiums to the public without any commensurate public benefit and without in any way furthering the underlying purpose of Section 5 which is to improve the performance of clinical laboratories.

For these reasons, Mr. Chairman, we request that Section 5 be amended to exclude from its application laboratories maintained by insurers or tests made or used for insurance purposes. Language to accomplish this purpose is attached.

Yours respectfully,

ROBERT R. NEAL,
General Manager,
Health Insurance Association of America.
GLENDON E. JOHNSON,
Vice President and General Counsel,
American Life Convention.
RALPH J. MCNAIR,
Vice President, Federal Government Relations,
Life Insurance Association of America.

H.R. 6418—PROPOSED AMENDMENTS

Section 353(i) of H.R. 6418 is amended to read as follows:

"(i) The provisions of this section shall not apply to—

(1) any clinical laboratory operated by a licensed physician, osteopath, dentist, or podiatrist who performs laboratory tests or procedures, personally or through his employees—

(*a*) solely as an adjunct to the treatment of his own patients, *or*

(*b*) *where such tests or procedures are made or used for insurance purposes;*

(2) *any clinical laboratory maintained by insurers or to any tests or procedures made or used for insurance purposes.*"

Mr. STUCKEY. Thank you, Mr. Ennes. You are to be commended for the approach that HiCHAP has taken with the governments of various States.

How has your program been received? I notice you stated you do have a HiCHAP coordinator in each State.

Mr. ENNES. Yes, sir.

Mr. STUCKEY. What is the reception?

Mr. ENNES. Excellent. A couple of weeks ago in Chicago we had representation from a wide segment of professional voluntary and the governmental health community. I am very happy to say that I think we are building a fine working relationship and understanding, that our commitment in this field and our concern about it is very truly in the sense of doing the best we can possibly do to protect the interests of the people who need the services.

There is beginning to be a recognition that we have talent, experience, and understanding that can be brought to bear in this field.

We are ready to do that. We have already had requests from a good many Governors for participation and assistance. We are involved in a good many of the areawide planning agencies. We stand ready to help to do this job the best we can.

Mr. STUCKEY. We thank you for your statement, and your devotion to this problem, which has been so well received.

Mr. ENNES. Thank you, sir,

The CHAIRMAN. Mr. Ennes, I, too, want to congratulate you for coming to give us the benefit of your views. I did not get to hear all of your statement, but I did read the summation of it. I am glad to see that you endorse the council concept.

Mr. ENNES. Surely.

The CHAIRMAN. I believe this strengthens the bill.

I want to thank you. I have no questions.

Mr. Keith.

Mr. KEITH. Thank you, Mr. Chairman.

It is good to see the insurance companies playing such a positive role. I think Equitable has consistently done such a role in measures of this sort. I can recall back in about 1946 when President Parkinson announced that the Equitable was making a grant of $30,000 to help research for heart disease. This cooperative effort is an indication of the continued consciousness of the life insurance and health insurance industry. I only wish you had played a more positive role in the question of medicare some years ago. I think we might have had much better legislation and much sooner if the insurance companies had taken that position.

I look forward to your statement on section 5. I note section 353, under section 5, I would invite your attention to the fact that a laboratory means a facility for the biological or other examination of materials, or the assessment of the health of man. It seems to me that is quite broad in scope, something which should be studied by this committee, as it has indicated it would.

I have no further questions, Mr. Chairman.

Mr. STUCKEY (presiding). Mr. Kyros.

Mr. KYROS. Thank you.

Mr. Ennes, I also want to commend you on your excellent testimony in support of this legislation. I would like to note, coming from the State of Maine, that no one on the Community Health Planning Committee, none of the 25 executives include anyone from the mighty Union Mutual Insurance Co. Do you know why such an absence occurred?

Mr. ENNES. I cannot explain that, but I can tell you that the Union Mutual has been very active in Maine and at our meeting in Chicago that I referred to a moment ago. There were at least two representatives of the company present, who we are working with very carefully, and we have also had discussions with the Governor and the department of health and welfare already in connection with this.

Mr. KYROS. I am delighted to hear that.

Thank you, Mr. Chairman.

Mr. STUCKEY. Dr. Carter.

Mr. CARTER. I also was pleased with the presentation.

Our insurance companies certainly have terrific salesmen and an abundance, evidently, of managerial talent. I understood that there was a little difficulty in spite of all the smoothness and splendor of the speech, with some disagreement about the laboratories. Is that true?

Mr. ENNES. I think I indicated that we would like to have the opportunity to put a statement before you. I am personally not qualified to comment on that. I think it is apparent that this is a major problem. I suspect there has not been clear understanding of some of the implications of this in terms of underwriting, in terms of assessment for issuance of life insurance in particular, which is neither a matter of diagnosis or of treatment, and which has behind it the very powerful motivation on the part of the individual who wishes to understand as well as possible and get as adequate coverage as possible, the commitment and the interest of the insurer in making sure there are no hidden problems that will underline the economic commitment that we are making to that individual.

Everything points in the direction of our being concerned with the highest possible quality of information from the clinical laboratory staff or any other staff.

Mr. CARTER. I don't want to trouble the waters at this point, but I understood there was some objection to the matter of laboratories. I think it is perhaps a valid one, by the way, in that it does constitute a problem for insurance companies. The specimens must be examined, but the question is whether in certain States it would be done under the Federal law or the State law.

The approach by such a group that might conduct such examinations might not always be favorable. To that extent, it does present

quite a problem. Federal regulation and Federal licensing of such groups may cause some difficulty.

I thank you for your wonderful statement. You are a master of the King's English.

I yield back the balance of my time, Mr. Chairman.

Mr. STUCKEY. Mr. Ennes, thank you again for your statement.

Mr. ENNES. Thank you, sir.

Mr. STUCKEY. The next witness will be Mr. Tom Robinson, who is accompanied by Mr. Vander Zee.

STATEMENT OF TOM ROBINSON, PRESIDENT, INTERNATIONAL SOCIETY OF CLINICAL LABORATORY TECHNOLOGISTS; ACCOMPANIED BY REIN J. VANDER ZEE, ATTORNEY

Mr. ROBINSON. Mr. Chairman and members of the Interstate and Foreign Commerce Committee. I would like to introduce Mr. Rein J. Vander Zee, our counsel.

My name is Tom Robinson, and I am the president of the International Society of Clinical Laboratory Technologists, an organization of clinical laboratory personnel with almost 3,000 members residing in all 50 of the United States. My home is in Tulsa, Okla., where I direct a clinical laboratory. Our society maintains its administrative offices at 805 Ambassador Building, St. Louis, Mo. Dr. Stanley Reitman, a practicing physician and a member of the accrediting commission of our society, who was to testify with me, had to return to St. Louis, Mo., and consequently will not be here today.

I have been personally active in the clinical laboratory as a technologist and a laboratory director for over 16 years and I was for 6 years chief laboratory technologist at the Oklahoma Osteopathic Hospital, Tulsa. Since 1957, I have operated the Robinson Laboratories in Tulsa. Dr. Reitman has been most active in the field of laboratory medicine for the past 12 years and has won international recognition as the codeveloper of one of the most widely used laboratory techniques, the Reitman-Franekl transaminase procedure. In addition, Dr. Reitman has been active in the training of laboratory personnel as the director of one of the oldest schools of medical laboratory technology in the United States, the Gradwohl School in St. Louis.

This afternoon we wish to testify on House bill No. 6418, limiting our testimony to that portion of the bill which pertains to clinical laboratory improvement. I am quite sure that you are all aware of the news stories of the past few months which point out the need for regulation in this vital health service field. However, we believe that certain fundamental concepts should be carefully considered by this committee so that the legislation which is enacted shall be meaningful and designed to provide a high degree of protection to the patient public.

We feel we must be frank with the committee in recognizing that a chaotic situation exists today in the clinical laboratory. We regretfully report that a great deal of this unfortunate situation has been financially motivated. In fact, the U.S. Department of Justice presently has an antitrust suit pending against the College of American Pathologists. We earnestly recommend that this committee secure a

copy of the Department of Justice's complaint in that case so that it might be studied in connection with this and other legislation which comes before you.

Our society has made every effort to work with representatives of organized medicine and the Department of HEW and yet, whenever we have asked the organized medical groups to establish standards and permit us to work with them in upgrading the profession, they have issued a blanket refusal. We feel that it is only through the efforts of the representatives of the public, such as the members of this committee and your counterparts in the various State legislatures, that we will begin to make the necessary improvements in the laboratory field.

First, we wish to emphasize that any regulations which cover the clinical laboratory (the four walls or physical plant), and perhaps the laboratory director, are entirely inadequate. It is the official policy of our organization, and my own personal conviction, that such limited regulations are not only insufficient but ineffective and that the only true public safeguard exists in insuring that the laboratory personnel at all levels are competent to do the work required of them.

To achieve this, we recommend one of two alternatives, the first being the licensing of laboratory personnel, that is, all individuals who perform work in the laboratory, or, No. 2, to provide for the proficiency testing of laboratories as a unit.

Since we are discussing here today Federal legislation and since the Federal Government would probably be hesitant to go into licensing activities, we believe the second alternative would be the preferable in this situation. Furthermore, we feel that the legislation presently before you should not be passed merely as a type of enabling legislation but rather should establish specific qualifications and standards with specific provisions for their enforcement.

Enabling legislation which leaves it to an executive agency of the Government to establish qualifications can many times frustrate the original intention of the Congress or other legislative body. As a recent example of what can happen in this manner, we would point to the regulations propounded by the Department of HEW pursuant to the Medicare Act. As we pointed out before, the Department of Justice has an antitrust suit pending against the College of American Pathologists which alleges that the pathologists have created a monopoly in the clinical laboratory field. Despite the pending suit, we find that members of the defendant organization apparently enjoy a high degree of influence with the Department of HEW and when HEW drew up its regulations pursuant to medicare, these regulations actually assisted in perpetuating the monopoly that the Justice Department is attempting to break.

Therefore, we would most urgently ask this committee that no exemptions or exceptions be provided in this legislation and that all laboratories which come within the legislative scope of this proposed act be treated equally. We notice that an exception from this bill is provided in lines 21 through 23 on page 14 and lines 1 and 2 on page 15 for physicians, osteopaths, dentists, or podiatrists who perform laboratory tests "solely as an adjunct to the treatment of his own patients." We would ask the committee to reconsider the basis for this exemption since it would appear that such laboratory operations would not in

any event be in interstate commerce. Therefore, we would question the reason for such exemption.

Finally, to conclude my portion of this statement, I would like to reiterate to this committee that while is sounds good in theory to establish personnel standards for laboratory directors and thereby feel that this guarantees the quality of the performance of that laboratory, it simply does not happen in actual practice, particularly when there is no counterbalancing limitation placed on the number of laboratories to be supervised by that director.

The remainder of the testimony is Dr. Reitman's. I would like to read it.

"Mr. Chairman and members of this committee, I may add to what Mr. Robinson has stated pertaining to qualifications of directors of laboratories. As a physician with a special interest in the laboratory, I would like to emphasize that there are many laboratory disciplines where scientists who are not physicians are, in my opinion, eminently more qualified than physicians, including most pathologists. These scientists are highly qualified to be laboratory directors and should be recognized as such. In this connection, a provision in this legislation requiring proficiency testing of the laboratories without setting standards for laboratory directors and personnel would permit this recognition.

"Under the medicare regulations previously mentioned, there is a provision which allows an individual to direct as many laboratories as he can possibly put under his control. The provisions for private laboratories establish that a full-time director is limited to three laboratories unless he has an assistant director. An assistant director is likewise limited to three laboratories. Therefore, based upon these regulations, the laboratory director's only limitation on the number of laboratories he may direct is simply three times the number of assistant directors that he will be able to find, plus three.

"One of the most indefensible practices that we can cite is the itinerant or circuit riding director. We submit that it is physically impossible for any director to competently direct the activites of more than two or, at the most, three laboratores. Despite this fact, the medicare regulations just described perpetuate this loose practice which presents a greater danger to the health and welfare of the patient public.

"The city of New York has recognized this danger and has limited a director to two laboratories. Even so limited, a laboratory director cannot supervise each and every test performed in the laboratory. We think this fact, more than anything else, establishes the absolute necessity for requiring that the competence of laboratory personnel be established either, as we have said, through proficiency testing or individual licensing as the first step in assuring competent performance in the clinical laboratory. In other words, it is our feeling that in order to safeguard the public welfare, standards for laboratory personnel, as in almost all areas of human endeavor, must be built from the bottom up rather than from the top down.

"The medicare regulations established two categories of laboratory workers, technologists and technicians, and anyone who has had experience in this field will find that the qualifications established for those two categories are identical to the training programs which are

controlled by the pathologists. The technologist level is the 4-year American Society of Clinical Pathology program, and a new category of technician was established which requires simply a 1-year AMA approved program. The technician level also includes the graduates of the Armed Forces schools of medical laboratory technologists.

"We think it is imperative that Members of Congress fully understand that the programs which have been approved by the AMA all consist of on-the-job training programs. Technologists are required to complete 3 years of college as a prerequisite, while the second category of training requires only a high school diploma. This second category is called the 'assistants program' by the ASCP, yet it is upgraded to the technician category as defined in the medicare regulations.

"It is our contention that no one should be allowed to perform laboratory tests on specimens from actual patients until he has had acceptable formal instruction and satisfactory laboratory experience. We feel that laboratory technology and techniques should be taught in institutions of learning, and that individuals who desire to work in the laboratory should be required to attend such schools. This has been the training program of the Armed Forces schools, as well as the program of the private schools of medical technology.

"We do not understand how the Department of HEW can equate a 1-year, on-the-job training program with formal courses of instruction which are the equivalent of 60 semester hours of training. We believe the inherent danger to the public is quite obvious in the on-the-job training programs, and I have personally in my private practice had some unfortunate experience because of these programs. The individuals responsible for these on-the-job training programs claim that there is always strict supervision, but I have had sufficient contact with several of these so-called schools to know that this is simply not a fact.

"We believe it is urgent that regulations be enacted controlling the activities within the clinical laboratory, but in view of the facts we have cited, we feel that such regulations must begin with the laboratory personnel, and that they should be enacted by the legislative branch of the Government rather than delegated to the executive branch. One of the fundamental concepts of licensure statutes is the historical right of the individual States to enact such legislation. We feel that the States should enact licensure statutes for clinical laboratory personnel, and that the Federal Government should encourage the States to do so. The policing of laboratories will eventually be a function of State agencies, as is now the case with the medicare regulation and we, therefore, feel that the States should be given every opportunity to exercise their rights. We know of no profession which is licensed on a national basis by the Federal Government.

"At this very moment there is intensive activity in many States to enact licensure statutes. We are proud to report that our society is playing a leading role in these activities. The most recent instance of the enactment of a statute is in the State of Nevada. In addition, there are intersociety groups meeting to draft laws in the States of Oklahoma, Missouri, Texas, Massachusetts, Florida, and Michigan. We sincerely feel that within the next 2 years a majority of States will have enacted licensure statutes. Despite this, the Department of HEW has seen fit to superimpose Federal controls on top of State controls.

"We have here a model licensure statute which was prepared by our society 3 years ago, and I respectfully request that it be made part of this testimony."

Mr. ROGERS (presiding). Without objection, it is so ordered, to be placed at the end of your testimony.

Mr. ROBINSON. Thank you.

"This is the type of legislation which we offer to this committee for its consideration as a possible alternative to proficiency testing. As we stated before, however, we feel that this committee will probably prefer proficiency testing for the reason that they would not care to go into the licensing of a profession on a national scale. However, the committee might possibly desire to pass a licensure statute which will apply only to States which do not have a licensing law. The effect of this, we feel sure, would be to encourage all the States to pass adequate licensing laws at the earliest possible time.

"We sincerely appreciate the opportunity given to us to state our position and we will always be available to work with this committee as well as other parts of the Federal Government in establishing the necessary regulations for the protection of the public."

(Material furnished by the society follows:)

PROPOSED MODEL STATE LICENSURE STATUTE

(Prepared by International Society of Clinical Laboratory Technologists)

AN ACT To provide for the registration and licensing of personnel working in clinical laboratories describing unlawful acts hereunder, the amount of fees for licenses, the denial, revocation and suspension of licenses and permits, and making an appropriation to the State Board of _____ for its expenses in carrying out the provisions hereof.

The people of the State of _____, represented in *Senate* and _____, do enact as follows:

TITLE I—CLINICAL LABORATORY TECHNOLOGY

Section

I. Definitions.
II. Administration and regulation.
III. Application of this title.
IV. Licensing.
V. Offenses against this title.
VI. Revenue.
VII. Denial, revocation, and suspension of licenses and permits.

Section I. Definitions.

A. "Person" includes firm, association, and corporation.

B. "Department" means the State Board of _____.

C. "Clinical laboratory technologist" means any person licensed under this title to engage in the work and direction of a clinical laboratory.

D. "Clinical laboratory technician" means a person other than a licensed laboratory technologist who is licensed under this title to perform the technical procedures called for in a clinical laboratory under the direction of a clinical laboratory technologist or physician and surgeon.

E. "Clinical laboratory technician intern" is any person who has successfully pursued a course of study in clinical laboratory technicque for a minimum of 60 semester hours or equivalent (1550 clock hours) instruction, both theoretical and practical including, but not limited to, the following:

a. Microbiology (including parisotology).
b. Clinical Microscopy.
c. Serology.
d. Bio-chemistry.
e. Hematology.
f. Histopathological techniques.
g. Blood Banking.

F. "Student" is any person regularly matriculated in any college or university accredited by the American Association of Universities or in any legally chartered school approved by the Board and who is pursuing a course of study in clinical laboratory technique. This course shall include, but not be limited to, both theoretical and practical study in the following subjects: a) Michobiology (including parisotology); b) Clinical Microscopy; c) Serology; d) Bio-chemistry; e) Hematology; f) Histopathological techniques; g) Blood Banking.

G. "Clinical laboratory" means any place where microbiological, serological, chemical, hemotological, biophysical, cytological or pathological examinations are performed on materials derived from the human body, to obtain information for use by licensed practitioner of the healing arts in their diagnosis, prevention or treatment of a disease or assessment of a medical condition.

Section II. Administration and regulation

A. The Board may employ special examiners, and the Board may make regulations for the conduct of examinations under this title.

B. The Board may approve schools providing instruction in clinical laboratory technique which in the judgment of the Board will provide instruction adequate to prepare individuals to meet the requirements for licensure under this title.

C. The Board shall make such regulations as may be necessary for the enforcement of this title which regulations shall include a provision prohibiting the employment of personnel directing or performing the technical procedures called for in a clinical laboratory who is not licensed under this title.

D. Each biennium the Board may compile and may thereafter publish and sell a directory of persons within the state licensed under the provisions of this title who hold unforfeited and unrevoked certificates. This directory is to be distributed without charge to licentiates of this title. The directory may also contain a copy of the provisions of this title and regulations relating thereto and such other information as the department may determine advisable. Each person licensed under this title shall file his address with the Board and shall report within fifteen days any change of address, giving both the old and the new address.

Section III. Application of this title

A. This title does not authorize any person to practice medicine and surgery or to furnish the services of physicians for the practice of medicine and surgery. This title does not repeal or in any manner affect any proivsions of law relating to the practice of medicine in this state.

B. This title does not apply to a clinical laboratory operated by any of the following:

1) The State of _____, or the United States of America, or any department, official, or agency thereof.

C. A duly licensed clinical laboratory technologist or clinical laboratory technician may perform venipuncture or skin puncture for withdrawing for test purposes upon specific authorization from any person in accordance with the authority granted under any provision of law relating to the healing arts.

D. A student regularly matriculated in any college or university accredited by the American Association of Universities or in any legally chartered school approved by the Board or a clinical laboratory technician intern in any clinical laboratory approved by the Board may perform venipuncture and/or skin puncture as a part of the necessary training program when done under the direct and responsible supervision of a licensed clinical laboratory technologist, technician, or physician and surgeon.

E. The provisions of this title do not apply to bona fide investigational or consultative clinical laboratory procedures performed by members of the faculty in the course of their employment in institutions accredited by the American Association of Universities, or in any legally chartered school approved by the Board for the training of persons in clinical laboratory technique.

Section IV. Licensing

A. The Board shall issue a clinical laboratory technologists license to each person who is a lawful holder of a degree of bachelor of arts or bachelor of science or equivalent degree issued after a full course of resident instruction in one or more established and reputable institutions maintaining standards equivalent, as determined by the Board, to those institutions accredited by the American Association of Universities with a major work for such degree in one of the

biological or chemical sciences who has had a minimum of four years' experience, at least one year of which must have been immediately antecedent to admission to the examination, either as a licensed clinical laboratory technician or its equivalent performing clinical laboratory work embracing the various fields of clinical laboratory activity in a clinical laboratory satisfactory to the Board, and whom the Board finds by written, oral, and practical examination to be properly qualified. Persons who are lawful holders of an associates art degree shall comply with the above provisions except that such persons must have a minimum of six years experience. (The Board shall establish by regulation the required courses to be included in the college, university, or junior or community college training.) The following may be accepted as equivalent of, and substituted for, experience for a maximum of three years for such experience; (1) a master's degree in fundamental medical sciences, one year; (2) a doctorate in fundamental medical sciences three years.

B. The Board shall issue a clinical laboratory technician's license to each person found by it to be properly qualified and it shall hold written, oral, or practical examinations to determine the qualifications of applicants. The examinations for license to work in a clinical laboratory as a technician shall cover the fields of microbiology (including parisotology), clinical microscopy, serology, biochemistry, hematology, histopathological techniques, and blood banking, except that the examination for a special clinical laboratory technician's license in biochemistry, microbiology (including serology and parisotology), clinical microscopy (including hematology, urine and gastric analysis), blood grouping and blood banking, and histopathological techniques shall be concerned only with the subject or subjects in which the license is to be issued. The prerequisites for entrance into the examination shall be one of the following:

1) Completion of a regular four-year college or university curriculum in medical or clinical laboratory technique with a degree of bachelor of arts or bachelor of science in a college or university approved by the Board, the last year of which course shall have been primarily clinical laboratory procedure; provided, however, that if the curriculum did not include practical clinical laboratory work, six months as a clinical laboratory technician intern or the equivalent as determined by the Board in a clinical laboratory approved by the Board shall be required; or

2) Graduation from a college or university maintaining standards equivalent, as determined by the Board, to those institutions accredited by the American Association of Universities with a bachelor of arts or bachelor of science and a major in bacteriology, biochemistry, or essentially equivalent subject or subjects as may be determined by the Board plus one year as a clinical laboratory technician intern or the equivalent as determined by the Board in a clinical laboratory approved by the Board. One year of practical experience in a public health laboratory may be accepted if such experience or if university or college courses included practical work in clinical bio-chemistry and hematology;

3) The Board shall issue a clinical laboratory technician intern's license to each person found by it to be properly qualified and it shall hold written, oral, or practical examinations to determine the qualifications of applicants. The prerequisites for entrance into the examination shall be any person who has successfully completed a course of study in clinical laboratory technique for a minimum of 60 semester hours or 1550 clock hours of formal instruction, both theoretical and practical including, but not limited to, the following: a) microbiology (including parisotology); b) clinical microscopy; c) serology; d) bio-chemistry; e) hematology; f) histopathological technique; and g) blood banking. Persons granted a license as a technician intern must perform as such for a minimum of 12 months, after which time the intern must pass such other oral or practical examinations for qualification as a technician (as the Board deems necessary or advisable).

C. Persons licensed as technician interns may serve as such for no more than a maximum of 24 consecutive months from date of licensing.

D. Licenses issued under this title may cover work in any one basic science, or may cover proficiency in the entire field of clinical laboratory work.

E. Any person maintaining, conducting, or operating a clinical laboratory shall display in a prominent place in the clinical laboratory, the clinical laboratory permit, and the license or registration certificate of each person performing the technical procedures called for in a clinical laboratory.

F. A license or permit under this title may be suspended or revoked by the Board for good cause after hearing on notice.

G. Upon filing application therefor containing such information as the Board may require, and the payment of the license or certificate fee, the Board shall issue to any person duly licensed under this title a duplicate license or registration certificate for one previously issued or, where there has been a change of name, another license or registration certificate in lieu of one previously issued.

H. Grandfathers clause: Persons performing clinical laboratory procedures in a clinical laboratory immediately prior to the effective date of this act shall be issued the appropriate license upon application and without examination provided that;

1) A person must have performed a minimum of 5 years as a clinical laboratory technologist with a total of 10 years experience in the clinical laboratory to qualify as such;

2) A person must have performed a minimum of 5 years as a clinical laboratory technician to qualify as such;

3) A person must have performed a minimum of 24 months as a clinical laboratory technician intern to qualify as such.

4) Each 30 semester hours of college work (or 400 clock hours) in an acceptable course of instruction, shall be credited as 2 years of experience. (Note: each college semester shall be equal to 1 year of experience).

5) The person so licensed under this provision must pay the appropriate fee as set forth above.

6) Persons otherwise qualifying under this provision must apply for the appropriate license within one year from the effective date of this act or be subject to the examination procedures set forth herein.

Section V. Offenses against this title

A. It is unlawful for any person to act as a clinical laboratory technologist unless he is licensed in that capacity under this title.

B. It is unlawful for any person to act as a clinical laboratory technician unless he is licensed in that capacity under this title.

C. It is unlawful for any person to act as a clinical laboratory technician intern unless he is licensed in that capacity under this title.

D. It is unlawful for any person to make any test or examination in a clinical laboratory unless the person is one of the following:

1) A licensed clinical laboratory technician in the subject or subjects concerned with the test or examination.

2) A licensed clinical laboratory technologist.

3) An individual licentiate of the healing arts.

4) A clinical laboratory technician intern under direct and responsible supervision.

E. It is unlawful for any person conducting, maintaining, or operating a clinical laboratory to employ any person to perform clinical laboratory procedures except a licensed physician and surgeon, a licensed clinical laboratory technologist, a licensed clinical laboratory technician, or a licensed clinical laboratory technician intern.

F. It is unlawful for a licensed clinical laboratory technician intern to work or to be employed in a clinical laboratory unless there are on active duty in the laboratory one or more licensed clinical laboratory technicians, or one or more licensed clinical laboratory technologists.

G. It is unlawful for any person to operate a school or conduct any course for the purpose of training or preparing persons for a license hereunder or to perform any of the practices or acts herein defined without having first secured the approval of the Board herein provided.

H. It is unlawful for any person conducting, maintaining, or operating a clinical laboratory to employ more than one licensed clinical laboratory technician intern for each (1) licensed laboratory technologist and (1) technician (total 2).

I. Any person who violates any provision of this title is guilt of a misdemeanor.

J. Any clinical laboratory may accept assignments for tests only from and make reports only to persons licensed under the provisions of law relating to the healing arts. This section does not prohibit the referral of specimens or such assignment from one clinical laboratory to another laboratory providing the reports indicates clearly the laboratory performing the test.

Section VI. Revenue

A. The amount of application and license fee under this title shall be as follows:

1) The application fee for a clinical laboratory technologist's license is one hundred dollars.

2) The annual renewal fee for a clinical laboratory technologist's license is twenty-five dollars.

3) The application fee for a clinical laboratory technician's license is fifty dollars.

4) The annual renewal fee for a clinical laboratory technician's license is fifteen dollars.

5) The application fee for a clinical laboratory technician intern's license is twenty-five dollars.

6) The annual renewal fee for a clinical laboratory technician intern's license is ten dollars.

7) The application fee for a duplicate certificate is three dollars.

B. The application fee required by this title covers the examination, the license fee and the issuance of the license valid for the remainder of the calendar year during which the license is issued.

C. An application fee is returnable only when the applicant is not admitted to the examination.

D. The annual renewal fee set under this title shall be paid on or before the first day of January of each calendar year. Failure to pay the annual fee in advance during the time the license remains in force shall, ipso facto, work a forfeiture of said license after a period of sixty days from the first day of January of each year, subject, however, to reinstatement under such rules and regulations as the department may make therefor.

E. All fees set under this title shall be collected by and paid to the Board. All such moneys shall be deposited by the Board in the general fund in the state treasury.

Section VII. Denial, revocation, and suspension of licenses and permits

A. Licenses issued by the Board may be revoked or suspended after notice and hearing for each of the following reasons:

1) Conduct involving moral turpitude or dishonest reporting of tests.

2) Violation of any of the rules and regulations of the Board applicable to this title.

3) Permitting a licensed clinical laboratory technician intern to perform tests, procure specimens, or act for the director in the absence of a duly licensed clinical laboratory technician or technologist.

4) Violation of any provision of law governing the practice of medicine and surgery.

5) Proof that the holder has made false statements in material regard on his application for licensure or that he has used any degree or certificate as a means of qualifying for licensure which has been purchased or procured by barter or by any unlawful means or obtained from any institution which at the time said degree or certificate was obtained was not recognized or accredited by the Board of Education of the state where said institution is or was located to give training in the field of study in which the degree or certificate is claimed.

6) The advertising of clinical laboratory procedures to the lay public in magazines, newspapers, directories, circulars, or signs.

7) Knowingly accepting an assignment for clinical laboratory tests or specimens from and the rendering a report thereon to persons not licensed by law to submit such specimens or assignments.

8) Rendering a report on clinical laboratory work actually performed in another clinical laboratory without designating the laboratory in which the test was performed.

B. The licenses or permits may be denied for any reason applicable to revocation and suspension of licenses or permits.

APPROPRIATIONS

The sum of _____ dollars, or so much thereof as may be necessary, is hereby appropriated out of any moneys in the state treasury in the general fund to the credit of the state purposes fund not otherwise appropriated and made

immediately available for use by the Board of _____, including expenses of maintenance and operation and personnel service of employees in carrying out the provisions of title five of article five of the public health law, as added by this act. Such moneys shall be payable on the certificate of the commissioner of _____ after audit by and upon the warrant of the comptroller in the manner provided by law.

This act shall take effect _____, nineteen hundred sixty _____.

Mr. ROGERS. Thank you very much.

Did you have a statement to make, Mr. Vander Zee?

Mr. VANDER ZEE. No thank you, Mr. Chairman.

Mr. ROGERS. Mr. Stuckey?

Mr. STUCKEY. I have no questions, Mr. Chairman. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I am going to refer to lines 21 and 23 on page 14, and lines 1 and 2 on page 15, concerning positions of osteopaths, dentists, or podiatrists who perform laboratory tests solely as an adjunct for the treatment of their own patients.

You don't want the physicians to have the right to do that?

Mr. ROBINSON. Our question was that, since it was merely for their own patients, would this be interstate commerce, and would it be necessary to leave it in, since it would not be interstate commerce.

Mr. CARTER. But it is not interstate commerce, is it?

Mr. ROBINSON. I wouldn't think so.

Mr. CARTER. But leaving it in is just a safeguard to see that they do have this right, is that not true?

Mr. ROBINSON. I don't know, sir. I wouldn't be able to answer that.

Mr. CARTER. I feel like they should have that safeguard. There are few practicing physicians, as I understand it, who do work for others, those who have laboratories and do laboratory work.

Mr. VANDER ZEE. I think our problem, sir, was just in understanding how this would be in interstate commerce. We didn't see how it would be applicable and, therefore, question the reasons for its presence in the act.

Mr. CARTER. I certainly don't think it would be in interstate commerce. Of course, it is beyond the scope of the Congress to legislate concerning private clinics within States, but it can only legislate on those in interstate commerce.

Mr. VANDER ZEE. In other words, we wondered if it was some kind of a sleeper that we didn't, frankly, understand. We can see no reason for any exemptions whatever.

Mr. STUCKEY (presiding). Mr. Kyros.

Mr. KYROS. On page 4 of your testimony, you say that you noticed an exemption from the bill provided in lines 21 through 23 on page 14.

Mr. VANDER ZEE. If the House bill has different page numbering from the Senate bill, there may be an error there.

Mr. KYROS. I think it is an error.

Mr. VANDER ZEE. It was drafted on the assumption that they were identical.

Mr. KYROS. Secondly, as my colleague just brought out, your sole objection to the licensing of laboratories for physicians who treat their own patients, licensed physicians, osteopaths and dentists, is a question of it not being interstate commerce?

Mr. ROBINSON. Where it says that the laboratories are solely as an adjunct to the treatment of his own patients, they would be exempt

since this was not interstate commerce. We wondered why they would be exempted since they wouldn't be affected in the first place.

Mr. KYROS. Suppose there is a doctor in a State which has a large number of summer vacationists who come from out of State whom he treats. It could well be that that could be interstate commerce. Isn't that a fact?

Mr. ROBINSON. I am not qualified to answer that.

Mr. KYROS. But you have no other grounds for objection to that?

Mr. ROBINSON. No, sir.

Mr. KYROS. No further questions, Mr. Chairman.

Mr. ROGERS (presiding). How many States, if you know, have laws that license the laboratories and also the personnel?

Mr. ROBINSON. There are approximately 11 States now that have some type of licensure, that presently have some types of licensure for personnel.

Mr. ROGERS. Then you feel that this committee should pass the legislation?

Mr. ROBINSON. Not necessarily. I think the preferable thing would be that all States have some type of licensure which would answer the problem.

Mr. ROGERS. But if they don't, should this committee wait until all the States enact their licensing statutes?

Mr. ROBINSON. No, sir.

Mr. ROGERS. We have to consider that as an alternative.

Mr. VANDER ZEE. If I may add a word, we think it would certainly be an encouraging factor to the States to pass acts as quickly as possible if the Congress did that, providing an exemption for States that had an act that was equal to it or better.

Mr. ROGERS. Thank you very much. Your testimony has been most helpful.

Mr. Carter?

Mr. CARTER. You are in favor of Federal licensure in the case of States that don't have the laws at the present time, do I understand correctly? You are in favor of Federal legislation concerning licensure for States which don't have State laws for licensing laboratories and so on?

Mr. ROBINSON. Yes, sir.

Mr. CARTER. I think that is a pretty far-reaching thing. I think it should apply only to laboratories which are in interstate commerce.

Mr. VANDER ZEE. Only within the scope of this act, sir, yes.

Mr. ROGERS. Are there any other questions?

If not, thank you very much. We appreciate your presence here.

Mr. ROBINSON. Thank you.

Mr. ROGERS. The next witness is Mr. L. Davis Michel, United Medical Laboratories, Portland, Oreg., who, I understand, could not be here, but Mr. Garrett Fuller is here to present his statement to the committee.

STATEMENT OF L. DAVIS MICHEL, EXECUTIVE VICE PRESIDENT, UNITED MEDICAL LABORATORIES, INC.

Mr. FULLER. Thank you, Mr. Chairman.

With the committee's permission, I would like to enter this statement for the record. Should there be any questions that I might be helpful on, I would be willing to try to answer them.

Mr. ROGERS. We are willing to accept the statement for the record. Thank you very much for your appearance here today.

Mr. FULLER. Thank you, Mr. Chairman.

(Mr. Michel's prepared statement follows:)

STATEMENT OF L. DAVIS MICHEL, EXECUTIVE VICE PRESIDENT, UNITED MEDICAL LABORATORIES, INC.

Mr. Chairman and members of the Committee, my name is L. Davis Michel. I am Executive Vice President of United Medical Laboratories, Inc., of Portland, Oregon. In addition the laboratories identified below have authorized me to advise the Committee that they agree in principle with the following statement concerning the "Clinical Laboratories Improvement" section of H.R. 6418. We are among the larger laboratories in the country and employ over 1,000 technical and supporting personnel. Each of us has been approved for Coverage of Services of Independent Laboratories under Section 1861(s)(11) of the Social Security Act.

We support the idea of Federal licensing of clinical laboratories since it appears as the most immediate and practicable means of assuring continued high quality laboratory work among laboratories engaged in interstate commerce. Furthermore, Federal licensure should also have a salutary effect on the quality of work performed by intrastate laboratories and laboratories that are excepted from the licensing requirement, since the quality and proficiency of their work will come to be measured by and compared with the federally licensed laboratory. We therefore support H.R. 6418 but wtih certain amendments which we feel are most necessary in the interest of equity and workability.

Before discussing the proposed amendments, I wish to mention that we are all aware of the testimony recently given before the Senate Subcommittee on Antitrust and Monopoly to the effect that there is a need to upgrade the quality of laboratory testing throughout the United States. This need was seen to exist only as to independent laboratories but as to hospital laboratories, clinics, and laboratories in physicians' offices.

Since a Federal laboratory licensing program could serve to allay the fears of the public over what has been reported in regard to poor laboratory practices, we feel that a vital part of this bill is that which brings within its purview any laboratory that reports the result of any of its tests across state lines. The fact is that most laboratories report at one time or another over state lines. We submit that none of them should be excepted from the provisions of the bill, since the minimum standards should be uniformly maintained among all laboratories that do business in interstate commerce. If exceptions were to be made, the public interest to that extent would be sacrified and the excepted laboratories would be left free to follow practices which could bring discredit to the entire industry.

The clinical laboratory industry provides some of the best examples of small business with one to five employees being (with few exceptions) the size laboratory to be found everywhere. However, the advent of space age automation and computer control, combined with the use of jet airmail in transporting specimens and reports, have brought about a revolution in laboratory procedure which is adding new dimension to Medicine. Dozens of tests can be offered to the physician today which were virtually unheard of ten years ago. In fact, some laboratories find that the physician must be instructed and advised in the use and significance of new developments in laboratory testing much as the detail man for the pharmaceutical company must explain his company's new products. Not only is a broad spectrum of testing available today, but the use of sophisticated equipment, meticulously controlled by mechanical and electronic means, has made for a consistent accuracy often unobtainable in older hand-crafted methods of laboratory practice. Further, the coupling together of various items of equipment using micro-quantities of specimen material has resulted in a testing technique in which numerous reactions or results can be produced from one biological specimen within minutes. "Chemistry profile." "Screen testing." These are part of the jargon of the new Medicine which is learning about the importance of chemical imbalance to the present and future health of the patient and the value of the annual complete laboratory analysis for comparison with past and future profiles.

This type of laboratory, new to the medical scene, has resulted in a degree of laboratory specialization on the part of supervisors, technologists and technicians unforeseen even a few years ago. In the large highly automated laboratory, technical personnel are employed to perform in one laboratory specialty—for example, hematology, the study of blood. Technical personnel in hematology will have no occasion to venture into other departments of the laboratory, such as exfoliative cytology (the study of cells) or microbiology (the study of microorganisms). The degree of specialization may be even greater. The technical person may be a reader of "differentials"—one who makes a comparative analysis of certain blood components, or he may be the operator of an automatic device that counts blood cells and produces a report each 15 seconds. Such a machine can report to the computer-dominated "quality control" system as well as produce a printed tape showing the results. Personnel with such a degree of specialization become enormously expert at their task and the possibility of laboratory error becomes ever more remote.

Such a testing facility as I have briefly described requires a volume of material far in excess of that needed by the laboratory which sticks with the old methods, and volume work has resulted in substantial economies.

So we find in the industry that greater accuracy, greater speed, and greater economy has resulted in a vastly increased demand for laboratory work, more tests at prices people can afford to pay, and a broader spectrum of data for the inquiring physician.

But this is a delicately balanced business. If such a laboratory, receiving and reporting on hundreds of specimens each day, were to be shut down for even a few days the business would be greatly jeopardized both financially and its relationship with its clientele.

SEC. 353(C). CATEGORIES

We therefore look to the proceedings before the Committee for assurance that those administering the proposed law will issue licenses by category of laboratory procedure as Section 353(c) seems to contemplate, so that if a license were to be suspended or revoked, it would not result in the laboratory's having to shut down all of its activity but only as to the procedure under question. As we view it, this does not require an amendment to the bill, but we trust these hearings will make it clear that this is what is intended under the proposed law.

SEC. 353(f). SUSPENSION

We are equally—if not more—concerned with Section 353(f) which provides that the license of a laboratory may be temporarily suspended without a hearing for as much as 60 days if the Secretary of Health, Education and Welfare decides that the public safety or welfare would otherwise be in imminent danger. I have previously pointed out that the business of a large, modern laboratory would be greatly jeopardized if it were to be shut down for even a few days. It could very well be out of business if the days stretched into a week or two. That such a situation could be brought about as a consequence of a statute that makes no provision for prompt notice to the licensee, without opportunity for an expedited hearing, and under delegated authority is unequitable to say the least. Yet, that is what Section 353(f) permits. I know of no parallel in administrative law. On the contrary, the Federal Food, Drug and Cosmetic Act, for example, specifically guarantees persons in these circumstances the right of prompt notice and an expedited hearing. Similarly, the authority to suspend the application or license may not be delegated by the Secretary as the bill now before the Committee would permit. In the interest of fairness and justice we therefore strongly urge adoption of an amendment to H.R. 6418 which would assure similar guarantees for the licensed laboratory.

SEC. 353(d). STANDARDS

There are also two basic objections to be noted with regard to Section 353(d) which authorizes the Secretary to prescribe standards that must be met by a laboratory as a conditoin to its being licensed.

First, as Congressman Dignell observed earlier in these hearings, the provisions of Section 353(d) would give the Secretary unrestricted authority to

issue standards for laboratories without any guidelines from the Congress at all. The danger here is that unrealistic and uncompromising standards may be promulgated which would put an unnecessary and unwarranted burden on even the best qualified laboratory. In order to minimize the possibility of this occurring, we respectfully urge that precise guidelines be incorporated in the bill delimiting the Secretary's authority in this respect. As a legislative precedent, we invite attention to Section 401 of the Federal Food, Drug and Cosmetic Act in which the Congress has established guidelines for the Secretary to follow in prescribing standards for food products. Surely laboratories could be dealt with similarly in this important area.

Our second objection with respect to standards has to do with the fact that the Secretary already has prescribed standards for independent laboratories as authorized under Section 1861(s)(11) of the Social Security Act. We see no reason why a laboratory should be required to meet two sets of Federal standards, particularly when both supervisory activities are to be administered in the same Government department. Nor should standards applicable to services for those 65 years of age and older be materially different from those prescribed for the benefit of the general public under a licensure statute. In our opinion, a laboratory that qualifies under the Medicare Program should *prima facie* be eligible for license under the provisions of H.R. 6418 and be exempt from fees, inspections and other evidences of licensure qualification and enforcement. Such exemption would be in keeping with the fact that the laboratory had already qualified for a license and additional tests of qualification would constitute harassment.

SEC. 353(d)(3). FEES

We also are very much concerned with Section 353(d)(3) which authorizes the Secretary to require payment of fees for the issuance and renewal of licenses sufficient "to provide, maintain, and equip an adequate service for the purpose * * *." The quoted language may seem innocuous at first, but on further inquiry one will find that as a practical matter the Secretary may—and most likely he will—impose fees upon laboratories sufficient to cover the multitude of costs incident to the administration of the licensure program. We are advised the estimated cost of these activities during the first year alone will amount to $1.5 million. It also is estimated by the Department of Health, Education, and Welfare that approximately 1,000 laboratories will be required to secure licenses under the propsed law. On the basis, the average annual cost of a license would amount to $1,500. An aportionment of the cost among the affected laboratories obviously would lessen the amount of fees to be paid by some but, by the same token, it would greatly increase the burden imposed upon the others. If this section of the bill were allowed to stand as written, I can foresee that some laboratories may be required to pay annual fees in excess of $5,000. Despite the title "Clinical Laboratories Improvement Act of 1967", this is strictly a licensure statute. The licensee is not to be directly benefited under the act as though it had a product to sell requiring testing and approval by the Government, such as in the case of foods, drugs, color additives and pesticides. Unless fees are reasonably related to benefits received for services, they in effect become a tax. If benefits are indeed to be received by the laboratories in the administration of the program, let us wait to see what the benefits are and not, in the meantime, permit taxation in the guise of fees. Congressman Devine, in discussing the subject earlier in the hearings asked this question:

"Since the licensing of the laboratories is in the public welfare, should the Government pay the cost of the activity and the amount of license fee be set by statute as customary?"

To which Under Secretary Cohen replied in part as follows:

"* * * I want to stress very strongly that I consider this whole area of laboratory performance an important public health service rather than one in which the consumer should necessarily pay for it."

We thoroughly agree that this would be a public health service and respectfully urge therefore that Section 353(d)(3) be stricken from the bill.

Other independent laboratories that agree in principle in the above views and suggested amendments to H.R. 6418 are:

Bio-Chemical Procedures, Inc., North Hollywood, California;
King County Research Laboratories, Inc., New York, New York;
Laboratory Procedures, Inc., Culver City, California.

Thank you for giving us this opportunity to state our views.

Mr. ROGERS. The next witness is the Honorable Paul H. Todd, chief executive officer, Planned Parenthood-World Population, accompanied by Dr. Bruce Jessup, California State Health Department.

STATEMENT OF PAUL H. TODD, JR., CHIEF EXECUTIVE OFFICER, PLANNED PARENTHOOD-WORLD POPULATION; ACCOMPANIED BY DR. BRUCE JESSUP, BUREAU OF MATERNAL AND CHILD HEALTH, CALIFORNIA STATE DEPARTMENT OF HEALTH

Mr. TODD. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Todd, it is a pleasure to have you with us today.

Mr. TODD. I am delighted to be here, Mr. Chairman, and to see some old friends.

I realize it is very late in your schedule and that you have activities on the House floor. I wonder if I might submit my statement for the record and summarize it.

Mr. ROGERS. That will be helpful to the committee. Your statement will be made a part of the record at the conclusion of your remarks.

Mr. TODD. Might I also submit at this point for the record a resolution adopted by the board of directors of Planned Parenthood-World Population, dated May 6, and a statement by Dr. Edward O'Rourke, commissioner of health of New York City, who asked me to present his statement to you.

Mr. ROGERS. They will be accepted for the record.

Mr. TODD. Thank you, Mr. Chairman.

Let me say that I represent an organization of some 150 affiliates throughout the United States which is currently providing birth control services to some 350,000 women. We provide birth control services to approximately half of the individuals who are supplied by public and private agencies.

Our interest in this legislation is concerned with the provision of such services through the sections in the bill which have to do with comprehensive health programs for the various communities. Our organization feels that if birth control information and services are to be provided for indigent women in the United States, this must be done so through a number of pieces of legislation, including the type of legislation which members of your committee, such as Dr. Carter, have introduced.

We believe that the Carter proposal, essentially the same as the proposal of Mr. Moss and the proposal of Mr. Friedel, would be preferable to having a limited authorization for family planning services in the partnership for health bill, but short of that type of legislation we believe that earmarking of some $20 million in the partnership for health proposal would be required to assist in providing family planning services to those in the United States who now do not have access to them.

We believe that unless such services are provided, neither personal, maternal, child, nor family health in this country can be assisted in a reasonable manner, and that in terms of not only human welfare and human dignity but in terms of budget dollars this program should be one of highest priority.

Let me further say that at this point there are many in the State, Federal, and local governments who have advocated the rapid expansion of such programs. In our opinion, the expansion is proceeding at a very, very reluctant pace. I think Dr. Jessup can testify to this.

We have appended to my testimony an estimate of the unfilled need in various selected communities in the United States. I think this will be of particular interest to the members of the committee because it does indicate the numbers of low-income patients not now served in various communities represented by members of this committee.

I think if the members of this committee can interpret the impact of providing services to these individuals in their communities, upon the well-being of their communities, they will see that the proposals we are talking about have considerable merit.

Thank you, Mr. Chairman.

(Mr. Todd's statement and appended material follow:)

STATEMENT OF PAUL H. TODD, JR., CHIEF EXECUTIVE OFFICER, PLANNED PARENTHOOD-WORLD POPULATION

Mr. Chairman, members of the Committee, I am delighted to be with you this morning and to see again the many friends with whom I spent some very happy days. I particularly appreciate the opportunity to present to you some thoughts of Planned Parenthood-World Population on a matter which may seem minor—and perhaps non-controversial—compared with such subjects as the railroad dispute which is under the jurisdiction of your Committee. I well identify with your problem of sifting from the many points of view and many needs those which are most appropriate for your time, attention, and action.

Although the subject to which we devote our time and energies as an organization is now only a very small part of governmental concern, and especially support, I believe no subject is more fundamental to family health and well-being, and through these, to the well-being of the social fabric of our great nation.

As most of you know, the organization I represent is a non-profit national organization which has during the past 50 years provided high quality medical service in the area of family planning to literally millions of American couples. Today our organization is providing family planning services to approximately 315,000 women a year through 450 clinics established in 150 communities throughout the United States.

In spite of massive efforts in the past few years to expand our services in as many places as possible, we cannot—indeed, we should not—be expected to reach all medically indigent families with a service they cannot normally afford. It has become clear to most Americans, as many members of this Congress well known, that Federal, state and local health agencies must increasingly become involved in the provision of family planning services, with special emphasis on providing those services to families living in poverty.

It is because Planned Parenthood-World Population shares with this Congress, this Administration and the vast majority of American people, concern for the extent and the quality of health services available to this nation's impoverished families, that I am here today. Family planning is a health service which has too long been denied to poor families. By making this service available to those who could not afford private medical care, our organization has for many years acted to make health care more comprehensive. We thus associate ourselves with the Public Health Service's concern to develop better and more comprehensive health services.

At the community level, there are five major channels available for delivery of family planning services: local hospitals, health departments, community action organizations, private physicians and voluntary health agencies. Some of these resources exist in almost all communities, but the pattern varies widely from one community to the next, and these different agencies do not all reach the same patients. To deliver family planning services to all impoverished families who need and want them will require coordinated efforts to encourage each of these channels to undertake active programs in this field.

We estimate that there are approximately 5 million medically dependent women in their childbearing years who are not seeking a desired pregnancy and are potential patients for subsidized family planning services. Of these, only about 700,000 are currently being served by all public and private agencies concerned. Thus, 85 percent of those who need these services do not currently have access to them.

To extend family planning to the remaining 85 percent, greatly intensified short- and long-term efforts are required. Far from duplicating services at the local level, a flexible program involving all the relevant Federal agencies is essential in order to accomplish the job. For example, hospital services would be stimulated best through the Children's Bureau Maternity and Infant Care program, and would be geared mainly to helping pregnant and recently delivered mothers. Couples who are newly married and wish to space their children—or who have already had the number of children they want—would best be reached through health department services, assisted by grants from the Public Health Service, and through community action and voluntary agency programs, aided by Office of Economic Opportunity grants, which permit greater flexibility in bringing services close to the population in need. Private physicians are likely to become more involved, in the long run, through the development of the Medical Assistance Program.

Not only are these varied programs not mutually exclusive, but they actually complement each other. Only through a multi-faceted program such as this will local communities receive the level of assistance they need.

I would like to submit for your study a table representing preliminary estimates of the need for family planning services in 25 selected communities and states, many of which the members of this Committee represent. In these 25 areas alone, a minimum of 545,000 families are not currently receiving family planning services, out of an estimated total of 708,000 who need and want them. The financial requirements for these services are estimated at between $11 and $14 million. Most of you will concur with the repeated statements of local officials that these communities do not have surplus budget funds of this magnitude available to finance this new and vital field of health care.

To reach the 4,300,000 medically indigent women throughout the country who *are not now being served*, we believe it is necessary for Congress to act simultaneously on several pending proposals. If enacted, these proposals would allocate funds to all relevant Federal agencies for expansion of family planning services. These proposals were endorsed by the Board of Directors of Planned Parenthood-World Population last month, and I would like to submit their resolution for the record.

Briefly, these proposed complementary efforts include:

1. Dr. Alan Guttmacher, President of our organization, in testifying before the Ways and Means Committee last March 22, suggested that in view of the minimal increase in authorization requested for the Maternity and Infant Care program which would do no more than offset rising medical costs, the Committee should give serious consideration to earmarking additional funds for family planning services through this program.

2. Representative Scheuer has introduced a bill, now before the Committee on Education and Labor, that would earmark funds for family planning services through the OEO's War on Poverty.

3. Proposals to allocate funds for family planning to be administered by either the Public Health Service or the Children's Bureau, at the discretion of the Secretary, have been introduced in this Committee by Representative Carter (H.R. 355); by Representative Hawkins (H.R. 6858 and H.R. 9743); by Representative Friedel (H.R. 8461); and by Representative Moss (H.R. 9045).

Our experience convinces us that for a *limited period of time* necessary to launch this new program, funds need to be allocated specifically, because:

Family planning is a relatively new service to most Federal, state and local governmental health agencies;

Family planning is an area unprotected by existing and entrenched professional staffs at all levels of government;

Family planning has a long history of neglect by health agencies; and

When many health programs must contend for appropriations from a very limited budget, the changes for expansion of family planning services are extremely remote.

In our opinion this special allocation of family planning funds can be provided by this Committee in one of two ways: The bills introduced by Representatives Friedel, Carter, Hawkins and Moss could be reported out favorably, or the allocation of specific sums for family planning in the Partnership for Health Act could be considered.

Let us look for one moment at H.R. 6418, the Partnership for Health Amendments of 1947. The emphasis of this legislation is on the development of a comprehensive approach to health needs on a state-wide basis. The states are encouraged to take stock and to determine what needs to be done and how to do it most expeditiously, using existing resources and, presumably, developing new ones. By establishing a system of block grants to the states, the legislation, at least formally, does away with the old categorical approach to illness and disease. I say at least formally, for this is more theoretical than real.

In fact, the current bill calls for an increase of only $7.2 million each in state formula grants and in project grants over the present level of funding. We can only guess how much of this increase would be absorbed by the rising cost of health care, but certainly a substantial amount would be diverted in this manner. Under these conditions, it seems most likely that the states will continue, at perhaps a slightly expanded level, the programs of TB and venereal disease control, cancer control, etc., which they are now conducting. And this is probably as it should be, for these programs are needed and should not be terminated.

Theoretically again, some reallocation of priorities and perhaps some economies can be realized under a comprehensive state program. It certainly cannot be expected, however, that the funds released in this fashion will be sufficient to finance new endeavors in anything but a minimal manner. We do not feel, therefore, that any sizable extension of family planning services can be realistically be expected through the proposed Partnership for Health bill.

Should the sums authorized for the program be greatly increased as we believe they should be if the legislation is to fulfill its goal, we are still doubtful that funds in sufficient amounts would become available for broad extension of family planing programs. Considerable interest exists at the State and local level, as Dr. Venable of the Association of State and Territorial Health Offices noted in reporting to you the results of the survey undertaken by the Association which indicated that at least 30 states listed family planning among their first ten priorities. But state and local health departments must choose among many unmet health needs, and even several large states such as California, New York or Maryland, where sizable beginnings have already been made in the family planning field, indicated in response to this survey that they did not expect to be able to devote sizable funds to family planning under the Partnership for Health program. Dr. Venable indicated that the State of Georgia would need roughly $1.4 million to reach 70% of its potential case load. You will hear shortly from Dr. Jessup who will report on the level of accomplishment and the level of need in the State of California, and I call your attention to the testimony of Dr. O'Rourke, Health Commissioner for the City of New York, which we would like to submit for the record. The State of Florida has a county-by-county plan and a specially trained staff of professional personnel at all levels ready to do the job—but there are no existing resources. The interest is there, the cost is relatively moderate, but we realize that as long as funds are limited, as they always are, programs which are older and better established, which have carefully cultivated administrative and political support, and which are "glamorous" will fare better in the allocation of funds.

To summarize, Mr. Chairman, family planning services are urgently needed. They are of high benefit to the individual, the family and the community at a relatively low cost. We urge that you and the Committee give consideration to providing financial support to initiate a broad program. The legislation introduced by four members of this Committee, Representatives Friedel, Carter, Hawkins and Moss, would provide the necessary funds. Alternatively, we submit that the authorization for Partnership for Health should be greatly increased if the legislation is to be effective, and that within this increase a sum of $20 million for Fiscal 1968 should be reserved for family planning services.

Closing the gap in family planning services in selected counties, SMSA's, and States

County, SMSA, or State	Estimated minimum need for family planning services [1]	Estimated number of low-income patients now served by all public and private agencies [2]	Estimated number of low-income patients not now served	Financial resources needed to extend family planning to all low-income patients not now served [3]
Sacramento County, Calif.	8,100	1,000	7,100	$142,000–$177,500
San Diego County, Calif.	22,900	3,000	19,900	398,000–497,500
San Mateo County, Calif.	5,000	1,000	4,000	80,000–100,000
Denver (SMSA), Colo.	19,700	6,000	13,700	274,000–342,500
Broward County, Fla.	13,200	1,000	12,200	244,000–305,000
Champaign (SMSA), Ill.	2,700	500	2,200	44,000–55,000
Chicago (SMSA), Ill.	93,200	19,000	74,200	1,484,000–1,855,000
Baltimore (SMSA), Md.	36,400	9,000	27,400	548,000–685,000
Boston (SMSA), Mass.	46,400	[4] 10,000	36,400	728,000–910,000
Detroit (SMSA), Mich.	71,800	9,000	62,800	1,256,000–1,570,000
Saginaw (SMSA), Mich.	3,700	300	3,400	68,000–85,000
Omaha (SMSA), Nebr.	9,100	500	8,600	172,000–215,000
New York City, N.Y.	166,300	85,000	81,300	1,626,000–2,032,500
Westchester County, N.Y.	8,800	2,400	6,400	128,000–160,000
Greensboro (SMSA), N.C.	12,800	800	12,000	240,000–300,000
Dayton (SMSA), Ohio	13,900	500	13,400	268,000–335,000
Franklin County, Ohio	14,800	5,500	9,300	186,000–232,500
Oklahoma City (SMSA), Okla.	14,000	2,500	11,500	230,000–287,500
Allentown (SMSA), Pa.	9,100	200	8,900	178,000–222,500
Columbia (SMSA), S.C.	11,700	700	11,000	220,000–275,000
Memphis (SMSA), Tenn.	26,100	1,000	25,100	502,000–627,500
Austin (SMSA), Tex.	7,800	800	7,000	140,000–175,000
Richmond City, Va.	6,100	1,000	5,100	102,000–127,500
King County, Wash.	13,400	1,200	12,200	244,000–305,000
West Virginia, State	71,000	1,100	69,900	1,398,000–1,747,500
Total	708,000	163,000	545,000	10,900,000–13,625,000

[1] Estimates of need for subsidized family planning services calculated by Nancy Van Vleck of PPWP Research Department, employing the Dryfoos-Polgar formula and Bureau of the Census Population Estimates, p. 25, No. 347, Aug. 31, 1966. Figure denotes minimum number of fertile, medically dependent women who are not pregnant or seeking a pregnancy at any given time.

[2] Low-income patients currently served by all public and private agencies are approximated on the basis of (where applicable) (*a*) patients with incomes below $75 weekly in 1966 at planned parenthood affiliated clinics; (*b*) patient loads reported in the 1966 American Public Health Association Survey of State and Local Health Department Family Planning Activities; (*c*) patient loads reported for 1966 by the California and Florida State Departments of Health.

[3] Estimated, based on an average of $20 to $25 per year per patient, including the cost of medical examination and prescription, Pap smear and continuing supplies.

[4] Boston service levels are estimated on basis of number of hospitals and clinics reporting current availability of services, since specific information is unavailable.

RESOLUTION ADOPTED BY THE BOARD OF DIRECTORS OF PLANNED PARENTHOOD-WORLD POPULATION, DENVER, COLO., MAY 6, 1967

A year ago this Board stated its considered judgment that in the family planning field, "neither the problems of the developing areas overseas nor in poverty areas of our own country will be solved with timid, hesitating efforts. The time has come for our nation to move beyond token programs and to allocate resources to this field comensurate with its worldwide urgency."

In the last year, there has been some progress in the programs of *some* Federal agencies, but, in others, the efforts thus far are still token, timid and unimaginative.

We salute the increased vitality displayed in the last two months by the Office of Economic Opportunity and the Agency for International Development in the encouragement of voluntary family planning services.

On March 20, following an extensive survey by PPWP of the funding status of anti-poverty family planning projects, the OEO announced that special emergency funds would be made available to insure the continuation of all existing family planning programs supported by the War on Poverty. This action—the first administrative allocation of high priority funds for family planning by a Federal agency—prevented a serious setback in approximately 25 communities where family planning services were threatened with closure or sharp reductions in funds.

A major shift in U.S. foreign policy emerged on April 5 when AID announced that it would now entertain requests from developing nations for funds to purchase contraceptive supplies and equipment for their manufacture. This new policy removed a serious restriction that previously hampered AID officials and missions in helping other countries develop national voluntary family planning programs.

We welcome these two developments and congratulate the agencies involved. They are indicative of the kind of administrative initiative which could bring about rapid progress in this field, if it were carried out energetically in *all* the relevant Federal agencies and adequately supported by the allocation of sufficient funds for family planning program development.

We are encouraged, therefore, by the substantial efforts already under way in the 90th Congress to authorize and appropriate significantly larger earmarked funds for both domestic and overseas programs.

Senator Tydings and 17 of his colleagues in the Senate, joined by Representatives Friedel, Moss, Hawkins, and Carter in the House, have introduced measures to provide specific funds, up to $75 million, for domestic family planning services to be provided by both public and voluntary agencies.

Representative Scheuer has stated that he will shortly introduce a measure which would create a national emphasis program on family planning, similar to Operation Head Start, within the War on Poverty, and would also allocate up to $75 million for this effort.

Senator Fulbright and 18 Senators have sponsored a bill to earmark $50 million annually for family planning programs as part of foreign aid to developing nations.

The experience of the last two years has clearly demonstrated the need for these kinds of measures, as well as for Senator Gruening's bill to create an administrative framework in both the Departments of State and Health, Education and Welfare to provide the leadership and direction necessary.

The assignment of top-level administrative responsibility, coupled with adequate financial resources and a flexible funding program, such as is envisioned in the above measures, will stimulate family planning efforts by a variety of public and private agencies, and will insure the rapid and orderly expansion of family planning services at home and abroad.

STATEMENT OF DR. EDWARD O'ROURKE, COMMISSIONER OF HEALTH, NEW YORK CITY

Mr. Chairman, I am pleased to join with the representatives of Planned Parenthood-World Population to discuss with you the likely impact of the Partnership for Health Amendments of 1967, H.R. 6418, on the expansion of family planning services. My views have been shaped by my experiences both as Special Assistant to the Surgeon General in the family planning field, and more recently, as the Health Commissioner of a large metropolitan area.

All of us in the health field are in basic agreement with the long-term purpose of this legislation which is to enable us to make our health services more comprehensive both in delivery and scope, and to use our limited health resources wisely in furthering this objective. We therefore supported PL 89-749 last year and we support H.R. 6418 this year.

Yet I believe we must be clear as to what this program is likely to be able to accomplish in the near future. It is a step toward giving our state and local health agencies the capability to plan more effectively and to coordinate health resources. This is a very important step and should not be minimized. But it is only a first step on a course which will take many years. Certainly the funds requested for Fiscal 1968 are not sufficient to guarantee that the health services we can actually deliver can be greatly expanded. As Under Secretary Cohen stated in his testimony before you on May 2:

"A large proportion of the funds authorized under the Partnership for Health Amendments for fiscal 1968 are likely to be committed by the States to programs approved and begun in earlier years. The $70 million authorization for fiscal 1968 will thus allow for only a modest expansion in these activities * * *."

This factor is especially important when it comes to a field like family planning which, as far as most health agencies are concerned, is essentially a new service. Agencies which have well-established programs in control of tuberculosis,

venereal diseases, chronic diseases and other health fields will not dismantle these programs in order to embark on a new service such as family planning, nor should they. Only if the funds allocated are considerably higher than have previously been available is it possible to expect some development of new services.

A further difficulty, however, is that new health services have rarely been initiated without the protection provided by special funds, at least for a limited period of time. It is very difficult for a new service to compete successfully with long-established programs for funds from a general budget.

Thus I would urge you to consider both increasing the overall authorizations for the Partnership for Health Program and within this increase, allocating at least $20 million specifically for family planning services. This would permit the Public Health Service to become actively involved, as it should, in this field which is so vital to total family health and well-being, including the proper care of mothers and the reduction of infant mortality, prematurity and such associated problems as mental retardation. The delivery of family planning services at the local level must be accomplished through a variety of health resources: hospitals, health departments, voluntary health agencies, community action agencies and private physicians. State and local health departments have an important contribution to make to this total effort, as does the PHS.

New York currently has one of the best developed networks of family planning facilities under both public and private auspices of any city in the country. The resources available to finance these services have come mostly from local tax funds and private contributions, augmented in the last two years by Office of Economic Opportunity and Children's Bureau grants. These services complement and reinforce each other, and we believe that about half the population in need is currently receiving family planning guidance. To complete the job—to make services available to the other half—will require additional funds of between $1.5–3 million annually for the next several years until the programs are established enough to be integrated into the city's ongoing health services. We do not expect that sums of this magnitude will be available from our local budget—or from the funds that will come to us under current Federal health programs. The additional funds we are suggesting under the Partnership for Health program could be decisive in enabling us realistically to make competent family planning services available to every low-income New Yorker who needs and wants them.

Mr. ROGERS. Thank you very much. We appreciate your statement.

Dr. Jessup, have you a statement to make?

Dr. JESSUP. I am pleased, Mr. Chairman, to have this opportunity to present the needs of the people of California for essential Federal assistance in proceeding with the State's private-public partnership effort in relation to family planning. Our objectives in our California plan are to within 4 years, by 1971, make it possible for every newborn child in California to be wanted child and for families to really have the choice.

I have been charged today with presenting the case for this additional Federal assistance by representatives of the State administration of government in Sacramento, by the California Legislature Public Health Committee and the Assembly Public Health Committee, and by the professional groups. Representatives of all these groups have joined together in a partnership interagency family planning council, which I have appended to my statement, the leaders, and so on, who back us in this effort.

California's history in family planning has been one of concern and one of leadership in the Nation over the past decade. Important strides have been taken. The goal has always been, and is today, to make every child a wanted child and thus improve the health and strengthen the integrity of California families.

Among the important steps that have been taken over the past 10 years are: Senate Concurrent Resolution Nos. 19 and 47, policy

statements favoring family planning program extension by representatives of the executive branch of State government, the California Medical Association, County Boards of Supervisors, the California State Board of Public Health, and the California Congress of Parents and Teachers.

Forty of California's fifty-eight counties now have publicly supported family planning services, woefully insufficient though they are. There are also 16 privately supported planned parenthood world population programs, and the important services provided by dedicated private physicians in their own offices.

Today, despite California's leadership and the progress that private and public groups have made, there remain wide gaps in the availability of both family planning information and services. One conspicuous gap lies in the paucity of information available to young people. In California there is now general recognition of the fact that "we cannot ask or expect young people to exercise responsibility over procreative powers without information."

Sixty percent of the population growth rate of California is the fact that 1,500 newcomers come from your State over the border into our State, at the rate of a half million new citizens every year.

Mr. ROGERS. I might say that we in Florida are also getting some people from California.

Dr. JESSUP. Yes, sir, we are trading off.

The proposed extension of freedom of choice in family planning will have but a secondary effect on your State, Mr. Rogers, or our State population, where the growth rate is well recognized.

The primary effect and essential purpose of the family planning program is to extend to all persons the option of planning their families and sharing the benefits of the latest scientific advances in the field. The advantages of such a recent information in family planning services is clearly not available to all Californians or available equally today. A canvass which I have included in my testimony shows that only one in about seven families in California, of low income, really have any chance or information or services to plan their families if they want to. There are some 350,000 medically indigent women of childbearing age in California who simply do not have the services available today. If you take $5,000, their annual family income, it goes up to 750,000 women. A recent canvass we did in just the last 2 months, in preparation for this testimony, indicated that we would need some $2 million of Federal funds in order to realistically get our California program underway.

We have called on the Children's Bureau, the existing maternal and infant care funds, we have used all we can of our maternal and child health allotments from Public Health Service, we have four or five neighborhood health centers coming up, we hope. But we have exhausted these funds. Existing programs will simply not do the job. We have exhausted our State and local resources and our private funding. It comes down to the fact that unless we get some $1.8 to $2 million, about 100,000 mothers in California who would like this service are simply not going to get it in the next fiscal year.

So we are appealing to the Congress this year, and we are supporting strongly 749. California took leadership in the idea of comprehensive planning. What we really feel is that unless we get adequate

funding earmarked in some way out of one of the funds from the Congress this year, we will not be able to carry out the charge of the Congress and of the Secretary of Health, Education, and Welfare, and of the President, given on many occasions.

Unless we get these funds we simply cannot carry out a plan which we have worked out. We don't need planning. We are ready to go. I have submitted the plan with my statement, the plan which all of us in California are in agreement upon.

We in California agree that we need Federal funds at this time and we appeal to the committee to give an increased appropriation which will make possible appropriations to the State.

Mr. ROGERS. Thank you very much.

Are there any questions, Mr. Stuckey?

Mr. STUCKEY. No questions, Mr. Chairman.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. I have certainly enjoyed your presentation, and I thank you for the mention made of the bill which I introduced for family planning. I regret to say that when we mention these bills so many times, particularly in the full committee, there is a great silence that is almost palpable. I regret this. Certainly I would like to see that you get the money for family planning in California, and all the States of the United States. They need it very badly. It would result in the saving of dollars and in the health of mothers, improvement in the health and the lives of the children. I am very interested in this.

I have visited birth control clinics as far away as India. I find that some of them are quite successful. Certainly I wonder about our different forms of foreign aid. It seems that we have supplied military aid in billions of dollars for some of these countries to fight among themselves, as they have just been doing with our material. I wonder what would have happened if we had used this money for family planning and birth control. There are not only the lives that we would save in that, but it would be a tremendous help to the countries, too.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Kyros.

Mr. KYROS. I have no questions, Mr. Chairman.

Mr. ROGERS. Thank you very much.

(Dr. Jessup's prepared statement follows:)

STATEMENT OF DR. BRUCE JESSUP, BUREAU OF MATERNAL AND CHILD HEALTH, CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

Mr. Chairman and Members of the Committee, I am pleased to have this opportunity to present the needs of the people of California for essential federal assistance in proceeding with the State's own private-public partnership plan in family planning. The objectives of the plan are to make it possible by 1971 for every newborn child in our State to be a wanted child; and to make freedom of choice in the number and spacing of children a reality for all California parents.

I am today charged with presenting the case for additional federal funds by representatives of the Administration, the California Legislature's Senate and Assembly Public Health Committees, representatives of the California Medical Association, Nurses' Association, Hospital Association, County Supervisors Association, the Congress of Parents and Teachers, State Board of Education, the California State Departments of Public Health and Social Welfare, the California Conference of Local Health Officers, the leaders of religious groups, labor and California industry. Representatives of all of these groups have joined together in a partnership Interagency Family Planning Council to develop a California Family Planning Program which I have distributed with this statement. (List

referred to may be found in committee files.) California is ready to proceed. There is unanimous agreement that federal financial assistance is essential for reaching the stated goal.

California's history in family planning has been one of concern and one of leadership in the nation over the past decade. Important strides have been taken. The goal has always been, and is today, to make every child a wanted child and thus improve the health and strengthen the integrity of California families. Among the important steps that have been taken over the past ten years are: Senate Concurrent Resolutions No. 19 and No. 47, policy statements favoring family planning program extension by representatives of the Executive Branch of State government, the California Medical Association, County Boards of Supervisors, the California State Board of Public Health, and the California Congress of Parents and Teachers. Forty of California's fifty-eight counties now have publicly supported family planning services, woefully insufficient though they are. There are also 16 privately suported Planned Parenthood World Population programs, and the important services provided by dedicated private physicians in their own offices. Today, despite California's leadership and the progress that private and public groups have made, there remain wide gaps in the availability of both family planning information and services. One conspicuous gap lies in the paucity of information available to young people. In California there is now general recognition of the fact that "we cannot ask or expect young people to excerise responsibility over procreative powers without information".

Recent scientific information on family planning is lacking in California professional training programs, especially for young men and women seeking careers in such helping professions as medicine, nursing, health education, law, social work, teaching. Information and programs are limited for men and for women in the general public, particularly for the young. These deficiencies are particularly felt by those segments of the population dependent on tax-supported health services. It is currently estimated, that in California, only one woman in seven of child-bearing age and of low income has information and services in the family planning field really available to her.

It is well known that California, with a population larger than 100 individual nations, an area larger than 68 separate countries, has by far the highest population growth rate of any great society in the world. California's population growth rate is over 60% from in-migration of about 1500 persons a day—a total of over one-half million new citizens moving across the borders into the state each year. California's projected population in 1980 is 28 million. "The density of population in the state (119 per square mile at present) is already nearly double that in the coterminous United States. As yet, the California population is not so densely settled as that of Japan, but at the rate of growth of the population between 1950 and 1965, it will reach that density (675 per square mile) in 35 years." [1]

That the proposed extension of freedom of choice in family planning will have but a secondary effect on California's population growth is well recognized. The primary effect and essential purpose of the family planning program is to extend to all persons the option of planning their families, and sharing benefits of the latest scientific advances in this field. The advantage of such information and services is clearly not available to all Californians today.

A canvass in the last two months of just the tax-supported family planning services and needs in the state which leaders of public health departments and public hospitals showed that there are an estimated 340,000 women who are medically indigent in the child-bearing age groups with annual family incomes under $3,000 and some 718,000 with family incomes below $5,000, of which only some 50,000 in 1966 received tax-supported family planning services. Local health officials estimated that an amount in excess of some $2,000,000, if it becomes available from the federal government, can be effectively invested in providing women from low income families with needed family planning services in the coming fiscal year. Mr. Chairman, I should like to submit with my statement documentation of this recent canvass of California's family planning service needs.

I should also like to call attention to the study recently made by the Children's Bureau, published on March 12, 1967 which stated that 56 large metropolitan counties in the United States "hold the key to any successful effort to sharply reduce the nation's infant mortality rate" because these counties account for

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[1] Davis, Dr. Kingsley, in the "Population Study Commission. Report to the Governor." December 1966. p. 47.

more than one-third of the nation's excess infant deaths. Four of these urban counties, Los Angeles, San Bernardino, San Diego and San Francisco are in California. Besides these selected areas, we have dozens of Califronia census tracts in which the infant mortality rate exceeds 30 deaths per 1,000 live births, a level which California as a state improved on over a generation ago.

I stated that California is concerned. The recent actions and the draft California Family Planning Program which I am submitting for the record, demonstrate the readiness, given federal fiscal support, for California to reach it family planning goal within four years. The elements of the four year program proposed are (1) public information; (2) education and training for the primary and secondary schools, colleges, and universities, professional schools and the staffs of private and public agencies; (3) family planning services extension through program development, manpower mobilization and effective utilization; (4) the mobilization of adequate funds from private as well as from local, state, and federal tax supported agencies; (5) evaluation and research; and (6) the creation of a permanent California Population Commission.

California has consistently utilized all available family planning funds to the maximum. These include the use of Maternal and Child Health Allotment funds over the past ten years; more recently Office of Economic Opportunity Neighborhood Health Center Projects—we will have four, and we hope five, of these operating within the next six months; and the Maternal and Infant Care funds of the Children's Bureau. These existing funding mechaisms though helpful are not and will not be sufficient to meet the need. For California to move realistically toward our four year goal the availability of some $2 million of additional federal funds will be required in the next fiscal year. We estimate that this amount would bring freedom of choice in family planning to some 100,000 California mothers who otherwise will not be able to have these services, and this right, in a very real sense. The program proposed will not be limited to provision of services or the influencing of the birth rate among any particular group or class. California seeks to have all families have available the information and services they desire.

California has vastly different problems in the provision of health services in different parts of the state. These differences in economic status, in geography and distance, in the distribution of health manpower and schools, make for marked differences also in the availability of family planning information and services. These are reflected in the data being submitted with this statement. I would be glad to discuss specifics if time allows. Suffice it to say that California's population, her health service and family planning problems are not just one-tenth of the nations, they are a cross-section of the problems of the people of the United States. California has been and will continue to provide models of health service programs to meet various representative problems which will be useful to other states and communities.

We in California are frank to admit the gross deficiencies of our state's family planning programs despite great private and public effort. What is today holding the program back, and I speak for the physicians conducting the private and public programs, as well as the full Interagency Council membership, is the lack of sufficient funds. Significant progress in the next year is absolutely and finally dependent on funding assistance from the Congress. With this assistance California can implement it's own family planning plan which is well developed and ready to move.

We strongly urge the appropriation of additional funds to make possible expansion of family planning programs. We support the partnership effort in comprehensive health planning provided for in P.L. 89-749.

Thank you for this opportunity to present California's case.

SENATE CONCURRENT RESOLUTION No. —

CHAPTER —

Senate Concurrent Resolution No. — relating to family planning

(Filed with Secretary of State June —, 1967)

Whereas, The California Medical Association by resolution has voiced the opinion that family planning services should be properly included in every adequate medical care program; and

Whereas, The California Legislature through Senate Concurrent Resolution No. 19 in 1965 memorialized the President and the Congress to consider instructing the National Institutes of Health to mount a crash program to perfect a variety of simple means of fertility control widely useful in all cultures and fully acceptable to all religious faiths.

Whereas, The California Legislature through Senate Concurrent Resolution No. 47 in 1965 clearly expressed the intent that all Californians who so desire should have access to family planning information and services;

Whereas, The 1966 California State Population Study Commission and in 1967 the California Interagency Council on Family Planning have proposed the prompt extension of family planning information and services;

Whereas, The California State Board of Health in 1966 adopted regulations requiring all local health departments to take action to meet the needs for family planning services, now, therefore, be it

Resolved by the Senate of the State of California, the Assembly thereof concurring, That the Legislature of the State of California memorialize the President and the Congress of the United States to give due consideration to instructing the Department of Health, Education, and Welfare to provide all possible technical and financial support to private and public agencies in the State which have responsibility in implementing a California Family Planning Program with the objective of within four years developing services to the end that all Californians shall have continuing access to information and services that will make it possible for them to exercise freedom of choice in the number and spacing of their children within the dictates of their own consciences; so that every child in California may be a wanted child, thus improving the health and strengthening the integrity of California families.

ACTION RECOMMENDATIONS OF THE CALIFORNIA INTERAGENCY COUNCIL ON FAMILY PLANNING

The Council recommends:

1. Public information

That a fully staffed Family Planning Information Office should be established in the Planned Parenthood Regional Office and/or the California State Department of Public Health to develop and make available family planning information to California's men and women. Such information should include the broad concept of freedom of choice in family planning, the most recent scientific advances in the field, and sources of service. Newspapers, magazines, periodicals, radio, television and other media should be explored. This should be a positive public information service to strengthen the family and the quality of family life. It should not be limited simply to conception control. It should provide information to families with involuntary sterility problems; it should stress family planning in the context of comprehensive health services, particularly maternal and child health information; it should disseminate information on the strictly voluntary quality of family planning, specifying that no coercion, direct or implied is attached to the seeking of family planning services. Public information should be directed to all individuals who are interested and should not be regarded or conducted as a means of influencing the birth rate among any particular group or class.

2. Education and training

A. That the State Board of Education and the State Department of Education foster and encourage inclusion of family life education courses in California's public schools at the elementary and secondary school levels. This material should be incorporated in existing courses where possible, and in new courses. The State Department of Education should assist interested school districts in development of appropriate curricula and teaching materials; in strengthening existing family life teaching programs; and in mobilizing assistive resources from the U.S. Department of Health, Education, and Welfare's Office of Education. The State Department of Education Office should, when requested, provide technical and fiscal assistance for teacher training programs and workshops in family life education.

The State Department of Education should provide close liaison with junior college, college and university family life education programs, particularly with schools of education.

B. The deans and obstetric department chairmen of schools of medicine, and deans of schools of public health, schools of nursing, social work, theology and law should be petitioned and assisted in developing courses which stress the importance of responsible parenthood, the importance of children being wanted and planned for, and the consideration of individual conscience in family planning programs.

C. Private and Public Agency Staff Education:

1. The State Department of Social Welfare should develop and distribute a policy statement to all local welfare departments on the right of all families to have access to appropriate family planning information and services.

2. The staffs of the California State Departments of Education, Mental Hygiene, Corrections, Public Health, and Social Welfare, and the staffs of local health departments and welfare departments should be provided with training programs in family planning information. These departments may wish to utilize existing in-service training programs for this purpose where possible.

3. Family planning services

A. Program Development:

1. The Western Region Planned Parenthood World Population Office should be assisted in developing additional staff to implement the California Family Planning Program.

2. The California State Department of Public Health should employ an appropriate full-time staff to meet Department responsibility in California's private-public family planning program.

3. Family planning services should be available to all low income Californians desiring assistance. Medical programs should be broadened to include family planning services for all low income Californians who desire such services. The categorical requirements of the program should be eased to make this possible.

4. Each major obstetrical hospital service in the State should develop a full-time family planning nurse, and social worker to make daily family planning rounds a part of nursing programs for all post-partum patients so desiring, in both inpatient and outpatient services, and to provide liaison with community family planning service programs.

5. Family planning aides should be trained to assist in provision of paraprofessional health personnel in staffing the California Family Planning Program through a partnership effort of the junior college, college, and university programs, California Medical Association, California Nurses' Association, the State Department of Public Health, and selected Planned Parenthood affiliates.

B. Manpower Mobilization and Professional Training:

1. The California Medical Association, through the mechanism of its existing Committee on Maternal and Child Care, should explore with the California Hospital Association, California Nurses' Association, and the State Department of Public Health, opportunities for extending family planning services particularly through public and private hospital obstetric services. These organizations should look to the extension of family planning services by expanding or developing new services through Planned Parenthood organizations, local health departments, and private physicians' offices. Educational courses for practicing physicians, nurses, and other professional and nonprofessional personnel should be developed and carried out on a continuing basis through the California Medical Association Scientific Board and appropriate committees.

4. Funding from private sources and from local, State, and Federal tax-supported agencies

A. All concerned California groups should petition the United States Congress, and the Department of Health, Education, and Welfare to assist in promptly obtaining necessary federal funds to implement the California Family Planning Program. May 1967 discussions with family planning program directors in over forty California counties yielded information indicating that some $2,000,000 of federal funds is urgently needed and could be effectively invested in California Family Planning Programs during the next fiscal year.

B. Through a private-public partnership, efforts should be made to obtain private funds to extend family planning services to anyone desiring them in California.

5. Evaluation and research

A. Support should be sought for scientific research in new methods of fertility control and in the correction of infertility. Appropriate social science research efforts should be undertaken to assist in program development to make it possible for everyone to have freedom of choice.

B. Appropriate evaluation procedures should be incorporated in all elements of the California Family Planning Program.

6. Permanent California Population Commission

A. Legislation should be adopted to establish and fund a California Population Study Commission. This Commission would be advisory to the Governor and the Legislature.

REPORT AND RECOMMENDATIONS OF THE CALIFORNIA INTERAGENCY ON FAMILY PLANNING

INTRODUCTION

California's history in family planning over the past decade is one of concern and leadership. Progress has been made toward achievement of complete freedom of choice in the number and spacing of their children for every family in the State. The ultimate goal is to make every California child a wanted child, and to thus improve the health, and strengthen the integrity of California families.

The newly formed California Interagency Council on Family Planning, the first statewide private-public partnership of its kind in the United States, has been charged with reviewing the nature and extent of family planning services in the State, evaluating the problem areas, and assisting in the development of appropriate programs of action.

Policy decisions strongly favoring extension of family planning information and services have been made in California by representative public and private groups. Among the important steps have been: Senate Concurrent Resolutions #19 and #47 (1965), statements by representatives of the executive branch of state government, the California Medical Association, various county Boards of Supervisors, the California State Board of Public Health, and the California Congress of Parents and Teachers. In 1966, the California Population Study Commission, the first such state body, developed its report and recommendations.

Forty California counties now have some publicly supported family planning services, as well as those services provided by private groups and private physicians in their own offices. There are sixteen privately supported Planned Parenthood World Population programs in the state.

In California, there is now a concensus among all groups that adequate medical programs should include family planning information and services. Through a private-public partnership effort, it should be possible, with appropriate federal fiscal support, to extend information and services—so that within four years every newborn child in California may be a "wanted" child.

Today, despite the remarkable recent progress that private and public agencies have made toward this objective, there are wide gaps in the availability of both information and services. One conspicuous gap lies in the paucity of information available to young people, despite the truth of the statement that "we cannot ask or expect children to exercise responsibility over procreative powers without information".[1] Professional training programs which include adequate family planning information are lacking especially for persons seeking careers in the helping professions such as medicine, nursing, health education, law, social work,

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[1] Beaseley, Dr. Joseph, Prof. of Pediatrics, Tulane University, Personal Communication, May 12, 1967.

teaching. Information and programs are limited for both men and women in the general public, particularly for the young, leading to gaps in the availability and acceptability of family planning services, commensurate with present knowledge. These deficiencies are felt particularly by those segments of the population dependent on tax-supported health services. It is currently estimated that, in California, only one woman in seven of child-bearing age and of lower income has information and services in the family planning field really available to her.

It is well known that California, with a population larger than 100 individual nations, an area larger than 68 separate countries, has by far the highest population growth rate of any great society in the world. California's population growth rate over the last decade has varied between 4 and 5% per year. India now averages 2.8% per year, Pakistan 3.0%, Colombia 3.2%. Over 60% of California's population growth rate is from in-migration of about 1500 persons a day—a total of over one-half million new citizens moving across the borders into the state each year. California's projected population in 1980 is 28 million. "The density of popuiation in the state (119 per square mile at present) is already nearly double that in the cotermonius United States. As yet, the California population is not so densely settled as that of Japan, but at the rate of growth of the population between 1950 and 1965, it will reach that density (675 per square miles) in 35 years." [2]

That the proposed extension of freedom of choice in family planning will have but a secondary effect on California's population growth is well recognized. The primary effect and essential purpose of the family planning program is to extend to all persons the option of planning their families, sharing benefits of the latest scientific advances in this field. The advantage of such information and services is clearly not available to all Californians today.

From materials assembled and distributed to the members of the California Interagency Council on Family Planning, discussions at the first Council meeting on May 12, 1967 in San Francisco, and subsequent discussions with Council members, the following recommendations for a California Family Planning Program have been developed.

CALIFORNIA FAMILY PLANNING PROGRAM

Proposed goal

Through mobilization of local, state and federal resources, guided by a private-public partnership:

Development of California family planning services on a continuing basis, so that by 1971

(1) all Californians may have true freedom of choice in the number and spacing of their children within the dictates of their own consciences

(2) every child will be a wanted child—

thereby improving the health and strengthening the integrity of California families.

Program elements

1. *Public information.*

2. *Education and training.*—(*a*) Public elementary and secondary schools, colleges, and universities; (*b*) Professional schools; (*c*) Private and public agencies.

3. *Family planning services.*—(*a*) Program development; (*b*) Manpower mobilization and effective utilization; (*c*) Funding from private sources, and from local, state and federal tax-supported agencies.

4. *Evaluation and research.*

5. *Permanent California Population Commission.*

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[2] Davis, Dr. Kingsley, in the "Population Study Commission. Report to the Governor." December, 1966, p. 47.

Summary of estimated family planning needs for California counties, fiscal year 1968

County	Estimated population (1964)	Number of medically indigent women in need of family planning services		Number of new patients attending tax-supported clinic (1966)	Outside funds needed to provide expanded family planning services (fiscal year 1968)
		Family income under $3,000	Family income under $5,000		
California	18,234,000	334,400	718,100	40,035	$1,897,806
Alameda	1,000,100	17,700	37,300	1,690	50,000
Alpine	500	(1)	(1)		
Amador	10,500	300	500		
Berkeley City				1,280	15,000
Butte	95,500	2,800	5,500	364	18,000
Calaveras	11,500	300	600		
Colusa	12,700	300	700		
Contra Costa	493,200	6,600	13,900	806	240,000
Del Norte	19,000	300	800		
El Dorado	38,800	700	1,600	49	3,500
Fresno	405,300	11,400	22,400	1,280	32,750
Glenn	18,800	600	1,100	24	
Humboldt	107,100	1,900	4,500		1,000
Imperial	84,100	2,300	4,800	288	
Inyo	12,500	300	600	24	
Kern	320,900	7,800	16,100	946	
Kings	60,500	2,000	4,000	112	18,000
Lake	17,000	700	1,200		
Lassen	13,800	300	600		
Los Angeles	6,737,300	110,600	240,600	16,260	400,000
Madera	42,400	1,600	3,000	104	1,000
Marin	182,000	2,100	4,800	292	
Mariposa	5,300	200	400		
Mendocino	50,900	1,200	2,600		26,000
Merced	102,100	3,500	7,000	206	30,000
Modoc	7,800	200	400		
Mono	2,600	(1)	100		
Monterey	220,600	4,900	11,700	746	15,000
Napa	74,400	1,400	3,100		5,000
Nevada	24,600	700	1,400	76	3,700
Orange	1,056,900	15,200	33,700	1,786	30,000
Placer	68,800	1,500	3,200	236	
Plumas	11,600	200	600	4	12,000
Riverside	402,000	10,800	21,800	822	71,851
Sacramento	602,500	8,100	19,500	954	100,000
San Benito	16,800	400	1,000	22	1,000
San Bernardino	622,600	13,900	29,600	1,928	29,000
San Diego	1,165,800	22,900	49,100	1,030	50,000
San Francisco	755,700	13,300	30,100	1,086	250,000
San Joaquin	265,700	6,600	13,400	776	35,000
San Luis Obispo	95,700	2,600	5,300	544	20,500
San Mateo	528,600	5,000	11,700	998	50,000
Santa Barbara	231,000	3,900	8,900	246	63,500
Santa Clara	853,500	11,300	25,200	592	99,000
Santa Cruz	100,300	3,400	6,000	128	20,000
Shasta	72,800	1,600	3,400	64	2,000
Sierra	2,400	100	100		
Siskiyou	35,300	800	1,900		
Solano	157,300	3,300	7,400	424	10,005
Sonoma	171,600	4,900	9,300	304	50,00
Stanislaus	172,100	5,500	10,500		30,000
Sutter	35,500	900	1,900	836	7,500
Tehama	27,800	700	1,500	42	
Trinity	9,300	200	400		
Tulare	182,700	6,400	12,400	1,128	28,000
Tuolumne	16,300	400	900	24	
Ventura	283,300	5,400	12,000	1,024	56,000
Yolo	77,500	1,400	3,400	414	13,000
Yuba	40,800	1,100	2,600	76	500

[1] Less than 100.

Source: State of California Department of Finance, Financial and Population Research Section, California Population—1964, State of California Department of Public Health, Bureau of Maternal and Child Health Records. Planned Parenthood World Population, "Estimating the Minimum Number of Medically Indigent Women Requiring Family Planning Services During the Year," September 1965.

Mr. ROGERS. We shall hear next from Mr. Ralph Haskins, president of American Medical Technologists, accompanied by counsel. You may proceed Mr. Haskins.

STATEMENT OF RALPH S. HASKINS, NATIONAL PRESIDENT, AMERICAN MEDICAL TECHNOLOGISTS; ACCOMPANIED BY ROBERT L. McCARTY AND BILLY DWIGHT PERRY, SPECIAL COUNSEL

Mr. HASKINS. Mr. Chairman, at the outset let me explain that I am accompanied by Mr. Robert L. McCarty and Mr. Billy Dwight Perry, our special counsel. Also I will summarize my statement in the interests of your time, and I ask that my full statement given the clerk be put in the record.

Mr. Chairman, let me say that our concern is with the people who actually perform tests in clinical laboratories—the medical technologists. Thousands of fully qualified medical technologists throughout the country are presently threatened with loss of job, demotion, or a severe limitation on employment opportunities because of the unnecessary and unrealistic standards already set up by the Secretary of Health, Education, and Welfare on independent laboratories under medicare.

Since the Secretary has stated that the regulations he would issue under section 5 of the bill before you would parallel the medicare laboratory regulations, enactment of this bill would mean that these technologists could not work in any laboratory doing any interstate business.

We oppose section 5 for two reasons. First, we seriously question the need for comprehensive Federal regulation; second, even assuming some form of Federal regulation to be required, we strongly oppose the approach taken by this bill. If Congress gives the Secretary the authority to regulate, that authority should be limited under strict legislative standards. This bill contains no such standards, and every indication is that if it becomes law, the Secretary will not exercise his power with restraint.

The Medicare Act, passed less than 2 years ago, contains sections which give the Secretary authority to prescribe conditions necessary to health and safety on laboratories participating in the medicare program. After careful consideration Congress expressly limited the Secretary's power to impose conditions on hospital laboratories to the standards of the Joint Commission on Accreditation of Hospitals. As the joint commission leaves the qualifications of technologists to the laboratory director, the Secretary's hospital regulations follow suit. However, the statute does not expressly so limit the authority to prescribe conditions for independent laboratories, and the laboratory regulations require a minimum of 3 years of college or, until 1971, 10 years experience before a person can work as a technologist. The strange and unhappy result is that there are thousands of competent medical technologists who are not academically qualified to work in independent laboratories, but who are fully qualified for and indeed, actively recruited by the Nation's accredited hospitals.

The medicare regulations will affect most of the Nation's clinical laboratories. They have been in effect only a few months and their

impact cannot be evaluated from this brief experience. The Secretary is apparently dissatisfied with the limitations medicare places on him or he would not be asking for the virtually limitless grant of power this bill would give him. However, in that legislation Congress carefully considered exactly how much Federal control was needed. We think that before more Federal control is exercised over an area traditionally left to the State and to the profession, Congress should know what effect the medicare regulations will have.

Certainly, much study needs to be done before an informed judgment can be made on whether Federal regulation is needed. In February, Dr. Sencer testified before a Senate subcommittee on the problems he saw in the Nation's clinical laboratories. In listing those problems he stated that there was a great lack of information—real knowledge about the laboratories and their personnel. Many of the problems he listed were directly related to the critical shortage of medical technologists.

We already have regulations that disqualify thousands of technologists from employment in the independent laboratories. If regulations at least as restrictive as those set for independent laboratories under medicare are imposed on all interstate laboratories, it will certainly aggravate those problems which Dr. Sencer traced to this personnel shortage.

There has been much said lately about the poor quality of laboratory work. In fact, Dr. Sencer has stated that more than 25 percent of all laboratory tests may be in error. Quite frankly, I think his data should be critically examined. I have been a medical technologist for 17 years and have worked in a laboratory in a supervisory capacity and as an instructor for over 13 years. Both as president of AMT and as a technologist, I have worked closely with laboratory directors, pathologists, and technologists from all over the country. It has been my experience that for the most part, the Nation's clinical laboratories perform tests competently and report their results accurately. There may be exceptions but these should not be used as a blanket indictment of all laboratories, nor used to impose unnecessary and unrealistic personnel standards upon all medical technologists.

There has also been a good deal of publicity about the ease with which unqualified persons can become registered as medical technologists. In one obviously trumped-up case a dog, Straybourne Betts, was able to purchase credentials purporting to certify him as a technologist. This is unfortunate, more unfortunate however, is the way in which the incident has been distorted. Reports of the incident—which, by the way, happened over 4 years ago—at least imply that any technologist not registered by the American Society of Clinical Pathologists is a threat to human health and safety if allowed in a laboratory. This is absolutely false. AMT, which incidentally rejected the application made for Straybourne Betts, can assure this committee that it registers only adequately trained, competent medical technologists. The entire story of Straybourne Betts is, in any event, worthless as an indicator of the qualifications of technologists actually working in laboratories. Most laboratories are directed by highly educated, professional persons who recognize worthless credentials when they see them. It is one thing to be able to purchase regis-

tration papers—it is quite another to be able to obtain a position as a technologist based on them.

Even assuming that some Federal control over clinical laboratories is necessary, AMT strongly believes that the Secretary's power should be limited under strict legislative standards to the minimum necessary to effectively assure laboratory proficiency. The current medicare regulations for independent laboratories illustrate the necessity for this approach. In a time of critical technologist shortage they are unnecessarily and unrealistically high. Let me illustrate my point with an example. A friend of mine, and an AMT registrant, is a laboratory supervisor in a State hospital. He has 27 years experience, 16 as a laboratory supervisor. He was trained in both the vocational and in the Armed Forces schools. He has lectured on testing procedures at a famous State college. Yet, under the medicare regulations, he can only work in an independent laboratory until 1971. After that he is out, simply because he does not have 3 years of college education.

The point is that individual ability, not the number of college degrees or credits, is the important thing. We believe that good vocational school, Armed Forces school, or junior college training, a period of internship under qualified supervision, and the successful completion of a comprehensive examination—the AMT criteria for admission to the registry—amply qualify a person for employment as a technologist. The facts are that thousands of persons with exactly this kind of training are fully qualified technologists and are presently working in this capacity. If there is to be regulation the question is how can it operate so as not to bar qualified personnel from employment.

We suggest to you that this can be done by setting only qualifications for the laboratory director. He is responsible for hiring and assignment of jobs within the laboratory. If he is properly qualified he can be trusted to employ only competent people and to assure that they perform only those tests which are within their ability. This is the approach of the Joint Commission on Accreditation of Hospitals, adopted by Congress when it passed the Medicare Act.

If further assurances are believed necessary, the laboratory could be required to demonstrate proficiency in the tests it performs. Periodic testing of the performance of the laboratory as a unit coupled with qualifications of the director would fully assure accuracy in testing and would not discriminate against any qualified laboratory worker. Comprehensive regulation of clinical laboratory personnel is unwarranted.

On behalf of AMT and its 10,000 registrants, let me again thank you for the opportunity to present these views.

(Mr. Haskins' full statement follows:)

STATEMENT OF RALPH S. HASKINS, NATIONAL PRESIDENT, AMERICAN MEDICAL TECHNOLOGISTS

Mr. Chairman, members of the committee, on behalf of American Medical Technologists (AMT), I wish to thank you for the opportunity of presenting this statement in opposition to the provisions of Section 5 of H.R. 6418 relating to the licensure of clinical laboratories, entitled "The Clinical Laboratory Improvement Act of 1967." We are here because this proposed legislation makes it clear that not only laboratories, but laboratory personnel would come under the total control of the Secretary of Health, Education, and Welfare.

To identify our organization, AMT is a national registry of medical technologists, founded in 1939 and headquartered at 710 Higgins Road, Park Ridge, Illinois. Current registration is in excess of 10,000 persons and includes college and vocational school graduates as well as several thousand veterans, most of whom were trained in Armed Forces schools of medical technology.

AMT's standards assure that only qualified medical technologists gain admission to the registry. Present minimum standards require formal training in an approved school and internship, for a total of at least two years, plus successful completion of a difficult and comprehensive examination. The formal training must be taken at either a technical school accredited by the Accrediting Bureau of Medical Technology Schools, and which requires a minimum of 1500 clock hours of instruction in all necessary laboratory subjects; an accredited college or junior college (60 semester hours); or an Armed Forces school of medical technology (1 year). The standards which accredited technical schools must maintain are high and are rigidly enforced. The quality of training in the Armed Forces schools is unquestionably high. Their graduates staff laboratories in military hospitals throughout the world, and in many cases serve as the noncommissioned officers in charge of laboratories.

One indicator of the adequacy of AMT's requirements is the fact that accredited hospitals, pathologists, physicians, and quality independent laboratories throughout the country aggressively recruit technologists registered by AMT. A recent survey showed that some 22% of our registrants are currently employed as technologists or higher in accredited hospitals; some 30% are employed in pathologists' offices; some 30% are employed by physicians' offices; and some 10% are employed in independent laboratories. Many hospitals in the Washington area employ AMT registrants as technologists, including Bethesda Naval Hospital and Walter Reed Army Hospital.

AMT opposes the Clinical Laboratory Improvement Act on two basic grounds. First, we seriously question the need for comprehensive federal regulation. Second, even assuming some form of federal regulation to be required, we strongly oppose the approach taken by this bill. The grant of authority to the Secretary of Health, Education and Welfare is entirely too broad and without any guiding legislative standards. Based on recent experience, we question whether this power would be exercised wisely and with the restraint which is the hallmark of effective regulation. We, therefore, believe it dangerous to simply turn the nation's interstate laboratories over to the Secretary to regulate as he sees fit. The power to regulate commerce is given to the Congress alone; and we think that when that power is delegated to an officer of the Executive Branch, Congress should tell that officer how it is to be used.

One would think from this bill that there is no federal control in the laboratory field. This, of course, is incorrect. The Medicare Act which became law less than two years ago contains sections authorizing the Secretary of Health, Education and Welfare to establish conditions necessary to the health and safety of Medicare beneficiaries which hospital laboratories, nursing home laboratories, and independent laboratories must meet in order to qualify for Medicare funds. Regulations issued pursuant to this Act have been in effect only a few months. While it is too early to evaluate the experience gained under them, it appears clear that they will affect most of the nation's clinical laboratories.

At least so far as hospitals are concerned, it is undeniable that Congress carefully considered the extent to which their facilities should be subject to federal regulation when it passed the Medicare Act. Congress then decided that the maximum standards the government should impose were the standards of the medical profession itself, as laid down by the prestigious Joint Commission on Accreditation of Hospitals. Under the statute the Secretary is to adhere to these standards, which in the course of the Medicare legislation throughout the Congress the Secretary endorsed.

Independent laboratories, however, are being treated differently, and we think not in a fashion intended by Congress. The legislative history of Medicare shows that on May 17, 1965, after the Medicare bill had passed the House, and shortly before the Senate hearings closed, the Secretary proposed that the bill be amended to give him power to establish conditions necessary to health and safety on independent laboratories. In making his proposal, The Secretary represented to the Senate Finance Committee that it "* * * would assure that the [independent] laboratories meet the same standards essential to health and safety of beneficiaries as hospital laboratories."

This amendment was adopted by the Senate without debate and agreed to by the House, also without debate, by its approval of the Conference Report. Despite his representations to Congress that the same standards relating to hospital laboratories were intended, the Secretary, on December 16, 1966, promulgated detailed regulations which are radically more stringent than the standards which he applies in the case of hospitals.

The bill now before you proposes a comprehensive scheme of regulation far broader than that established in the Medicare Act. It is a complete grant of power to the Secretary to impose upon *all* interstate clinical laboratories, including those in hospitals, such standards as he may find necessary to carry out the purposes of the Section, which purposes are nowhere stated. If this becomes law, the Secretary will be free to impose his own notions of wisdom upon virtually every laboratory operating in the United States. Underlying this proposal, we presume, is the conclusion that present standards imposed by the Medicare Act are inadequate, a conclusion reached without any significant period of experience to determine what the effects of that regulation will be. It is in any event clear that passage of the bill before you would provide a sharp conflict with what the Congress has already provided in the Medicare Act. If repeal of the parallel portions of Medicare is intended, Congress should be provided clear justification for such action. In short, AMT believes that if an increased dosage of federal regulation is to be prescribed, Congress should be told where existing regulation—in effect for such a short time—has proved adequate.

Testimony given to a Senate Committee in February by Dr. David J. Sencer, Director, National Communicable Disease Center, indicates that much needs to be done before an informed judgment can be made on this matter. For example, in cataloging what he thought were "major problems" in this field, he started with "lack of information"—real knowledge about laboratories and their personnel. The next problems he indicated to be "Shortage of Educated, Trained, and Experienced Personnel," and "Obsolescence of Personnel." He stated "Hospital laboratories employ 59,200 medical technologists and require many more to meet current urgent needs. The demand for medical technologists is increasing faster than they are being trained." Will not the proposed licensing only aggravate this situation? We think it will.

Much has been said in the past few months about the poor quality of laboratory work. Quite frankly, AMT believes these reports misleading. We do not know how the estimates that more than 25% of laboratory tests are erroneous were derived, but we find it inconceivable that these estimates are generally applicable. It has been our experience that for the most part the nation's clinical laboratories perform tests competently and report their results accurately. Exceptions do, of course, exist, as they do in any business or profession. However, these exceptions should not be used for a blanket indictment of all laboratories. May I remind the Committee that about half the nation's clinical laboratories are in hospitals and therefore subject to the general supervision of the hospital's governing body. Most of the others are directed either by medical doctors or highly trained biochemists, many of whom have a doctorate. All specimens are sent to the laboratory by a doctor of medicine, who presumably has an interest in accurate results and selects a laboratory that will produce them. These factors all argue against the validity of a high percentage of serious errors in laboratory tests. AMT believes the studies upon which these estimates are based should be critically examined before they are accepted as evidence of a need for additional federal controls in this area.

There has also been a good deal of publicity about the ease with which unqualified persons (and in one case a dog) can become registered as medical technologists. These reports at least imply that any technologist not registered by the American Association of Clinical Pathologists (ASCP) is a threat to human health and safety if allowed in a laboratory. This is absolutely false. The fact that the dog, Strayhourne Betts, was able to purchase credentials from a registry is unfortunate. More unfortunate, however, is the way this incident has been distorted. AMT—which, incidentally, refused to register Strayhourne Betts—can assure this Committee that it registers only adequately trained, competent medical technologists. Laboratory directors, pathologists, and medical doctors recognize this by actively recruiting for registrants. There are other qualified technologists who belong to no registry. Most laboratories are directed by highly educated, professional people, who recognize worthless credentials when they

see them. It is one thing to be able to purchase registration papers, but it is quite another to be able to obtain a position as a technologist based on them. Consequently, while Straybourne Betts may sell newspapers, he is largely irrelevant as an indicator of the qualifications of technologists actually working in the laboratories.

Arguments based on selected case histories, statistics derived from admittedly incomplete information, and spurious publicity are of limited value in determining the degree of regulation, if any, which Congress should authorize. Thirteen States and the City of New York now regulate clinical laboratories in degrees varying from regulation of the laboratory director only (Connecticut, Illinois, New Hampshire, New Jersey, New York and Rhode Island) to detailed regulation of all laboratory personnel. AMT believes that Congress should carefully consider the effect of these varying degrees of regulation upon clinical laboratory performance before it gives the Secretary of HEW the power to regulate at his pleasure. This requires further study and more complete information. Should this show federal regulation of all laboratories to be necessary (their methods, their prodecures, their use of materials, their use of equipment, and their personnel), whatever legislation is enacted should limit that regulation under strict legislative standards to the minimum necessary to effectively solve the problem.

The Secretary's action in the Medicare regulations governing independent laboratories demonstrates the necessity for a limited grant of authority with clearly stated standards in any regulatory legislation that may eventually be enacted. As mentioned earlier, in requesting authority to regulate independent laboratories, the Secretary represented to Congress that the statutory language he proposed would enable him to do no more than assure that independent laboratories met the same standards as hospital laboratories. However, once this authority was given, he promulgated regulations far more repressive than those he could legally issue for hospitals. He completely ignored the critical shortage of laboratory personnel as well as the standards of the Joint Commission on Accreditation of Hospitals, and established minimum personnel qualifications which disqualify thousands of competent medical technologists from holding their present positions in independent laboratories. These regulations absolutely bar any graduate of a technical school or an Armed Forces school, or any other person with less than three years of college, from holding the position of technologist unless the person has 10 years of laboratory experience. And after 1971 no amount of laboratory experience will qualify. Under these regulations, an AMT registrant who has completed an intensive 18 month training program in all relevant laboratory subjects at a closely supervised technical school, who has interned for 6 months, who has passed the rigorous AMT registration examination, and who has worked as a technologist for less than 10 years must be fired or demoted.

In our discussions with HEW we called their attention to an AMT registrant who is only one example of the absurdity of these regulations. He presently holds a State rating as a laboratory supervisor and is working as a supervisor in a large State Hospital. He was trained in a vocational school and in the Armed Forces. He has taught in an Armed Forces school of medical technology, and he has lectured on medical testing procedures at a famous college. Yet, under the Secretary's regulations, he absolutely cannot qualify as a technologist after 1971.

Only three months ago the President told Congress, "The United States is facing a serious shortage of health personnel." According to figures furnished this Committee last year, there is a present demand for between 70,000 and 100,000 technologists in the United States. The supply is far less. As noted above, in his testimony before the Senate Committee in February, Dr. Sencer stated that hospital laboratories need many more technologists than they now employ "to meet current urgent needs," and he called this shortage a "major problem" contributing to substandard laboratory performance. In view of this shortage, the country can ill-afford the disqualification of any competent technologist. Yet, this bill will permit the Secretary to apply the standards of his existing laboratory regulations to all clinical laboratories doing any interstate business. The result will be that many thousands of competent medical technologists will lose their jobs. Costs of laboratory tests will increase and, if the shortage of personnel already contributes to inaccurate testing, as Dr. Sencer says, then a Secretarial induced shortage can only increase the number of inaccurate test results.

Significantly, this bill would make it possible for a technologist to be barred from his job by regulations without a hearing at which to establish that he is, in fact, qualified by experience or training other than that which the Secretary chooses to recognize.

AMT learned from experience the futility of attempting to persuade HEW to exercise reasonable restraint in regulation. Beginning in December, 1965, when AMT first learned that the Medicare laboratory regulations were in the drafting stage, it offered the Department complete cooperation in developing realistic standards that would not discriminate against any qualified laboratory worker. In the beginning our letters were not acknowledged. When we were able to arrange conferences we found HEW officials already predisposed against any approach that did not pattern the current requirements of the American Society of Clinical Pathologists (ASCP), which owns its own registry of technologists. In fact, the regulations formally proposed on June 22, 1966 (31 Fed. Reg. 8668) disqualified all technologists not having a college degree or registered by the ASCP. The regulations finally adopted are not substantially improved, although ASCP is not mentioned by name. As the Committee may know, the Department of Justice filed an anti-trust suit against the College of American Pathologists in July, 1966, charging a monopoly by this group on laboratory testing.

AMT requested HEW to at least inspect accredited schools which administer the AMT registration examination before issuing regulations that would discredit AMT and disqualify its registrants. No such inspection was ever conducted. AMT requested HEW to evaluate its examination and furnished copies of past examinations for that purpose. We were never able to persuade HEW to discuss with us the results of that evaluation, if, in fact, one was conducted, or any deficiencies found in the examination. We requested a hearing and made a formal proffer that we would show that the quality of work performed by AMT registrants is equal, or superior, to that of ASCP registrants in similar positions. HEW denied this request. In short, HEW consistently refused to make any good faith inquiry into the quality of training or the ability of AMT registrants to competently perform the normal duties of medical technologists. Yet, AMT is the second largest source of registered medical technologists in the nation and full utilization of its registrants, as technologists, is absolutely necessary in view of the critical shortage of trained laboratory personnel. On the basis of this experience, which may well be mild if the Secretary is given the unqualified breadth of authority contained in the bill over all interstate laboratories and their people, we think Congress should reject this proposed legislation.

As the Committee realizes, our major concern is with people to get the job done properly, rather than with buildings, facilities, and equipment. As far as people are concerned, if Congress feels that some authority should be given the Secretary in the laboratory field, we strongly recommend limiting this authority to regulations governing the qualifications of the laboratory director. AMT has consistently argued that competent, well-trained, and ethical directors provide the best possible assurance that laboratory testing will be adequately performed and reported. Such a director can and should be trusted to select properly qualified personnel and to limit each laboratory worker to those tasks within the limits of his individual competence, demonstrated to and known by the director. No amount of detailed regulation can ever assure the competence of a laboratory worker as well as can a qualified director having firsthand knowledge of his own employees. The Joint Commission on Accreditation of Hospitals expressed a similar view by stating that the "responsibility for determining the training, experience, and competence of [technologists and technicians], registered or not" is in the hands of the pathologist in charge of the laboratory. By adopting the standards of the Joint Commission as a restriction on the Secretary's power to regulate hospital laboratories under the Medicare Act, the Congress only two years ago expressed its confidence in the Joint Commission and its considered judgment that only limited federal regulation should be imposed. Significantly, the limits of this regulation coincide with those established by the six States which also set qualifications for the laboratory director only. Significantly, Dr. Sencer, in his testimony before the Senate Antitrust and Monopoly Subcommittee last February, stated that "studies have shown that there is a strong positive correlation between the education of the [laboratory] supervisor and the quality of laboratory performance."

If further assurances are needed, the statute could also require the laboratory itself to demonstrate proficiency in the types of tests it is licensed to perform. The end sought, after all, is accuracy in the performance and reporting of lab-

oratory tests. If a laboratory can demonstrate its ability to do this through the successful completion of a proficiency testing program, its lower and middle echelon personnel should not be forced from their jobs simply because they lack a college degree or a predetermined number of college credits.

In summary, AMT believes that comprehensive regulation of clinical laboratory personnel is unwarranted. Congress should not expand federal control over the nation's clinical laboratories without additional information showing a real need. Should further study show the need for additional regulation, Congress should carefully limit the authority it grants the Secretary to the minimum necessary to cope with the problem. Upon a convincing showing that federal regulation is necessary, AMT would not oppose a statute which confines the power to set detailed personnel qualifications to those relating to the laboratory director. A proficiency testing program for the laboratories would likewise not be opposed.

On behalf of AMT and its 10,000 registrants, let me again thank you for the opportunity to present these views.

Mr. ROGERS. Thank you very much, Mr. Haskins.

Are there any questions? Dr. Carter?

Mr. CARTER. I have worked with medical technologists for many years. I have not found many errors. I want to assure you of that. As a group they are usually proficient and industrious, doing their jobs well. That is the usual thing. Of course, the physician has to work closely with and trust the people with whom he works.

You mentioned that medicare regulations will rule out some of your technicians by the year 1971. Could you tell me what that regulation is?

Mr. PERRY. These are the independent laboratory regulations that were promulgated in December, I believe, 1966. I can give you the Federal Register citation to them in just a minute. Briefly, what they do is to prescribe minimum standards for technologists.

The minimum standard is 3 years of college education. However, until 1971 there is an exception for people who have had 10 years of experience. After 1971, to be qualified as a technologist under these regulations, the person must have the minimum 3 years of college in specified subjects. I will give you that citation.

Mr. CARTER. That is quite all right. That will not be necessary. But with 10 years of experience they will be qualified to go on until 1971 and then they will be cut off.

Mr. PERRY. That is correct.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Kyros?

Mr. KYROS. I have no questions, Mr. Chairman.

Mr. ROGERS. It might be helpful to the committee if you would submit suggested language which you feel should be included in the bill to take care of the objections you have. I assume you would prefer to continue a person with 10 years' experience, qualified to serve as a medical technologist?

Mr. HASKINS. We feel that a person who can adequately pass proficiency testing through experience and merit should be qualified to go on working, and not be legislated out of a job because 10 years are up.

Mr. ROGERS. Would you submit that language to us?

Mr. HASKINS. Yes.

(The material requested was not available at time of printing.)

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I think these people should have the benefit of a test before ruling them out arbitrarily.

Mr. ROGERS. Thank you very much.

Mr. HASKINS. Thank you.

Mr. ROGERS. Our next witness is Mr. Leslie Lee, of Orlando, Fla., representing the Certified Laboratory Assistants Board of the American Society of Clinical Pathology.

STATEMENT OF LESLIE LEE, REPRESENTING THE CERTIFIED LABORATORY ASSISTANTS BOARD OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGY

Mr. LEE. Mr. Chairman, I would like to submit my statement for the record and add a few words of summation on some of the comments that have been made during the day.

Mr. ROGERS. That will be fine.

Mr. LEE. We have heard a lot about medical expenses and the increasing cost of hospitalization during the day, and during the entire testimony before this committee. It is rather important to note that about 75 or 80 percent of all of the costs of hospitals is payroll. So it is extremely important that personnel be adequate and be efficient. I have been in medical technology now for about 27 years, and during about 20 years of this I have been concerned with training of medical technologists and assistants. So this is not a new area to me at all.

I am extremely interested in some of the testimony that has been going on in the last few hours here. Until we have some sort of better standards for proficiency and hospital performance, I believe we will do very well to stick with the standards that have been set up and approved by the medical profession. Certainly the care of patients is medicine. Certainly the performance of laboratory tests is of prime importance in their care. I believe it is the prerogative of the medical profession to set the standards that are going to govern the laboratory work that is involved here.

I personally rather doubt that a licensing bill, a national licensing bill, is going to increase the number of people who are available. That is, indeed, I think the crux of the problem. It may do something to straighten out some of the questionable practices that are going on. But I believe the primary problem is the shortage of personnel.

Of course, this is the interests of the CLA board, which I represent. We feel that there are many laboratory tests that can be done by people who have less training than a college degree. They do, however, need to be adequately trained in a clinical situation under competent medical supervision. When they are working, they need still to be under competent supervision.

The CLA board has been set up to establish the standards and criteria for personnel in this particular echelon of laboratory work.

I would like to thank you very much for the opportunity to appear here. I have enjoyed the testimony very much. It has been very educational.

(Mr. Lee's prepared statement follows:)

STATEMENT OF LESLIE LEE, MT (ASCP), REPRESENTING THE BOARD OF CERTIFIED LABORATORY ASSISTANTS OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGY

I am Leslie Lee, a Medical Technologist and Assistant Director of Laboratories of Orange Memorial Hospital in Orlando, Florida. I have been concerned with the training of medical laboratory presonnel for the past 20 years and am author of the Laboratory textbook, "Elementary Principles of Instruments". I am a member of the Board of Certified Laboratory Assistants of the American Society of Clinical Pathologists, which sets standards for the certification of medical laboratory assistants and for the approval of the schools in which they are trained. These workers are at the post-high school level and are being trained in programs from twelve to eighteen months.

To qualify for admission to such an approved training program, the student must be a high school graduate with some aptitude in science and math and students are encouraged, in most schools, to take additional courses in biology, chemistry and math. The Board requires that the course be at least twelve months in duration, that it cover a minimum required curriculum, and that it includes extensive practical clinical training in a hospital laboratory under the supervision of pathologists and technologists. The minimum curriculum for this program has been outlined in a training manual developed by the National Committee for Careers in Medical Technology for the United States Office of Education entitled "A Suggested Guide for a Training Program—Medical Laboratory Assistant". The Board is particularly concerned that the training include exposure to a wide variety of clinical material and adequate patient contact in an actual clinical laboratory situation.

Upon completion of this program, graduates are eligible to take a national examination conducted by the Board, which, if successfully completed, leads to certification as a Laboratory Assistant or CLA. Graduates of the two year junior college programs would also receive an associate degree.

Certified Laboratory Assistants work under the supervision of Pathologists or other Physicians and professional Medical Technologists who are trained at the baccalaureate level and who are in a position to take final responsibility for the tests performed. Laboratory Assistants, on the other hand, perform important though not critical tasks, thus relieving the hard-pressed Medical Technologists for the more complex and automated tests.

The Board of Certified Laboratory Assistants was organized in 1963 by the American Society of Clinical Pathologists working with the American Society of Medical Technologists to provide an adequately trained second level of laboratory worker. In the past four years 150 schools have been approved for training, including 21 financed under the Manpower Development and Training Act and 14 through provisions in the Vocational Education Acts. The rest are financed by hospitals or other private sources with no tuition or a minimal charge to cover the cost of books, uniforms and so forth. The capacity of the existing schools is 1,300 and is increasing each month. The schools are over 80% filled at the present time and many report a waiting list of applicants.

Since the first national examination was conducted in the Fall of 1964, 2,300 laboratory assistants have been certified, including those who took the certifying examination on the basis of previous training or experience. Many technicians with military lab training and experience have been certified in this way, for example.

A vital element of training at this level is the impression on the student of the importance of recognizing his limitations. The danger to the patient of improperly trained laboratory help whose reach exceeds their grasp cannot be overemphasized. This is one reason why training in proprietary schools without adequate medical supervision and patient contact is dangerous. Anyone presenting himself as a Medical Technologist and taking responsibility for tests affecting life and health of patients should have at least three years of science oriented college training and at least a year of actual hospital training under competent medical direction. The poorly prepared worker who tries and fails can kill the patient.

Junior colleges are beginning to express considerable interest in the Certified Laboratory Assistant program and the Board has been very interested in this development. In my own state of Florida a two year CLA program is beginning this Fall at Polk Junior College in Bartow. Part of the training will be given in the class rooms and part in the affiliated hospital laboratories. The students will be eligible to take the national certifying exam and will receive

an Associate in Science degree. The program meets the requirements of the college system as well as those of the profession. It has been reviewed by the Medical Technologist Consultant to the State Department of Education as well as the Advisory Committee for Laboratory Assistant Programs. Everyone is pleased with this arrangement and we feel it is an excellent framework which will be used in other community and junior colleges in Florida and elsewhere. Some of these are already in the planning stages at Lake Sumpter Junior College in Leesburg, Broward Junior College in Fort Lauderdale and Miami-Dade Junior College in Miami.

I wish to thank you for the opportunity of appearing before you. If you have any questions I will be glad to try to answer them.

Mr. ROGERS. Thank you for your presence here today.

Mr. Stuckey?

Mr. STUCKEY. I have no questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I think you have made a very good witness and have been very sensible in your observations.

Mr. LEE. Thank you.

Mr. ROGERS. Mr. Kyros?

Mr. KYROS. I have no questions, Mr. Chairman.

Mr. ROGERS. Thank you very much for your presence today, Mr. Lee.

That concludes the list of witnesses. The committee stands adjourned subject to call of the Chair.

(The following material was submitted for the record:)

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the committee, the American Medical Association appreciates this opportunity to present its views concerning H.R. 6418, the "Partnership for Health Amendments of 1967."

This bill would (1) extend for four years and expand Public Law 89-749, "Comprehensive Health Planning and Public Health Services Amendments of 1966," (2) require certain medical laboratories to be licensed by the Secretary of HEW, and (3) make other amendments to the Public Health Service Act. Our statement will be limited to items (1) and (2).

Last year, we appeared before this Committee and presented our views on S. 3008 and H.R. 13197, the predecessor bills from which Public Law 89-749 evolved. In enacting the law, the 89th Congress did not accept the six-year program for planning grants and the five-year health services program, but instead, while adopting the essential substance of the administration proposal, limited it to a two-year planning program and one-year program of formula and project health services grants, and reduced the appropriation authority originally sought.

At last year's hearings we stated a measure of approval of the legislative proposal—and a measure of disapproval. At that time we also suggested certain amendments which we considered would be beneficial and necessary to the program.

Briefly, the AMA offered endorsement of the concept of comprehensive health planning, noting that for some years the Association had played an active role encouraging such planning on a voluntary basis, local and areawide. At the same time, we voiced objection to the provisions of the law which would permit the furnishing of "public health services" and "health services" without *any* expressed limitation by this Congress as to the kind or scope of the services intended. (Attached as an appendix to our statement is a brief summary of our position stated at the hearings October 11, 1966, on S. 3008 and H.R. 13197, together with certain amendments we then recommended.)

We will now direct our comments to the provisions of H.R. 6418.

PROGRAM PLANNING—H.R. 6418

For many years the AMA has supported voluntary efforts in health planning—state, local and areawide. Planning is an inherent requirement if the desired program is to be properly organized and implemented in a manner that will

recognize the need for coordination and avoidance of unnecessary duplication of related programs. Many voluntary planning agencies—on a local and regional basis—are effectively operating presently throughout our nation. Accordingly, the AMA supports the principle of health planning embodied in the legislation.

Our support for health planning under P.L. 89–749 is conditioned upon the incorporation of the recommendations we made in our testimony before this Committee on October 11, 1966.

Alternate proposal for section 314(a)

There are, however, considerations which we believe warrant a complete reevaluation of the program under Section 314(a) under Public Law 89–749.

One of the underlying reasons for Public Law 89–749 was that it should avoid duplication of existing programs. From an analysis of this legislation, however, it is becoming apparent that this program cannot directly alter or remove duplication in existing federally supported programs where such duplication may exist. No authority exists in the law concerning modification of other programs.

We believe that a different mechanism to avoid duplication, and at the same time provide coordination of the various programs existing within a state, would be more effective for this purpose. Therefore, we suggest that a State Commission be created in lieu of the planning agency. This Commission would be empowered to inquire into the operation of all government supported health programs and make periodic reports to the Governor, containing recommendations for improving existing programs and for the establishment of new progams. The Commission's functions would include responsibility for reviewing, evaluating and coordinating all government supported health programs in the State.

Public Law 89–749 states that the attainment of its goal depends on close intergovernmental collaboration. We believe that the coordinating commission referred to would be more effective in accomplishing coordination among the various programs.

Planning amendment under H.R. 6418

An amendment contained in H.R. 6418 would require that a state's plan under section 314(a), as amended by P.L. 89–749, provide for the State agency to assist *each* health care facility within the state to develop a plan for capital expenditures for replacement, modernization and expansion consistent with the plan developed in accordance with criteria of the Secretary of HEW. The state agency will also be required to periodically review the program of the health care facility and recommend modifications.

The State agency under section 314(a) has a broad planning authority in all sectors encompassing the whole scope of health within the state—services, facilities and manpower, both public and private.

H.R. 6418 does not define "health care facilities." Such a broad term could conceivably include, among others, such facilities as a group practice establishment, a clinic, the nursing home, the public health station, the private or community hospital, the medical school and teaching hospital. Is it to be intended that all facilities—whether public or private, for profit or not for profit—must have their plans for replacement, modernization or expansion fit in with the state agency's conception of priority This State agency will be charged with jurisdiction over facilities serving not only its State exclusively, but others serving multi-state areas. Will its effect fall on facilities whether they are recipients of federal funds for construction or merely receiving payments for services?

An extension of the authority of the State agency to include replacement, modernization and expansion of hospitals—whether public or private and whether for profit or not for profit—is not idle conjecture. The proposed amendment to H.R. 6418 must be read in conjunction with the proposed amendment in H.R. 5710 relating to medicare, which would cut off depreciation allowances to hospitals under its reasonable medicare cost formula where the hospital attempts rehabilitation, construction, or expansion without the approval of the appropriate state agency. Under the medicare amendment, the only agency specifically identified is the state planning agency under Public Law 89–749.

It thus appears, for instance, that a hospital desiring expansion may become stymied as to its planning for expansion or modernization. Whereas approval of the Hill-Burton planning agency was sufficient where such funds were desired, under the Medicare Amendment it would be required to secure (in order not to lose the medicare depreciation allowance), in addition to approval of the Hill-Burton agency, the approval of the state planning agency. And even

where the hospital did not require Hill-Burton funds, the state planning agency's approval would still be required lest the hospital risk losing the medicare depreciation allowance. Thus a health care facility is controlled because it provides health care services, payment for which services (as distinguished from construction grants) is supported by the government.

It was our belief that the planning effected on a voluntary basis for hospitals, coupled with the approval required under the Hill-Burton program, was a satisfactorily working program. It had apparently worked so well that a witness for the administration, stated in his testimony last year in advocating the present "partnership for health" program: "We must extend and improve the kind of partnership in a dynamic Federal-State system that has been demonstrated so effectively in the Hill-Burton hospital construction program." The AMA supports the Hill-Burton program. We do not believe that the amendments proposed in H.R. 6418 and H.R. 5710 augur well for hospitals and other facilities covered thereunder and the voluntary system of planning which has developed under the Hill-Burton program.

AREAWIDE PLANNING

H.R. 6418 would extend the program under Public Law 89–749 of grants to provide for the development of comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services. The AMA has supported voluntary areawide planning. Accordingly, we support a continuation of this program, restating our hope that the grants, available to various groups, will stimulate voluntary private agencies to play a substantial role in planning activities.

COMPREHENSIVE "PUBLIC HEALTH SERVICES"

The AMA has supported, and continues to support, the furnishing of public health services. Our relationship with the U.S. Public Health Service has been one of longstanding support and cooperation. Our basic concern with this legislation is not that it would continue the provision of public health services—as such programs are unquestionably meritorious—nor is a basic concern the fact that proper public health services may now be expanded.

Apprehension fundamentally stems from the fact that the language of Public Law 89–749 contains no congressional expression concerning its intent as to the kind or scope of the services to be furnished. We recognize there is a supportable advantage in removing strict categorization of grant funds. To the other extreme, however, the categorical identification having been removed, there no longer appears any limitations on the health care which may be provided.

From testimony on this legislation by government officials, it would appear that there will be little limitation, if any.

Is it the intent that the Congress is authorizing a program of *individual treatment* for *unidentified patients* for *unspecified conditions* for *unlimited services?* As we read this bill, while the services are furnished under the auspices of "public health," the only required relationship to public health in furnishing services will be the relationship of the individual as a member of the public! It is clear that the lack of definition of "public health services" is, in effect, an invitation from Congress to unlimited expansion of "public health" beyond its traditional role in the community. With the purpose of the law stated as "marshaling of all health resources—national, State, and local—to assure comprehensive health services of high quality for every person" and there being no formal limitation on the scope of public health services funded under this law, there is an obvious potentiality for the State health agency to provide the medical treatment of individual patients, without limitation.

The American Medical Association has strongly supported flexibility of operation within the State and local health departments, as an effective tool for community health. We feel, however, that the distinction between the public and the private health sectors should be delineated by this Congress in more positive terms than a mere prohibition of interference with existing patterns of private professional practice.

In our testimony before this Committee in October 1966, we stated: "The American Medical Association cannot endorse an undefined program . . . 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."

These strictures remain unchanged, and the Association accordingly finds itself unable to support this portion of the legislation for comprehensive public health services as presently constituted.

Alternate proposal to provide flexibility

We believe that the flexibility which is sought through the elimination of categorical grants can be achieved by either a block grant for support of stated programs identified in the law, or by a continuation of grants for the separate programs but with authority in the States to transfer, with the approval of the Surgeon General, funds from one program to another to provide emphasis in any category as needed within the particular State.

PROJECT GRANTS FOR "HEALTH SERVICES"

Under our discussion of the provision for grants for comprehensive public health services, we stated there is no restriction as to the type of services which may be permitted.

Under Public Law 89-749, in section 314 (a) of the Public Health Service Act, where "health services" are provided, it seems clear there is authorized under this section a type of "health service" different from "public health services." That this is so is evident, not from any distinction stated through definition, but by the difference in terminology and from the language in the subsection which states that only insofar as projects under clause (1) of the subsection involve the furnishing of public health services must these services conform to the state plans of the State Planning Agency. Thus any limitation on services which may be advanced by implication from the term "public health services" is now swept away under the project grant provision. Apparently then, services other than "public health services" are to be provided, and these need not conform to the State's plan. Aside from the difficulty which may well arise under this subsection in trying to determine when services are "public health services" and must comply with the State's plan, there arises a more basic consideration. The intention of the legislation, which originally was to eliminate categorical grants, is thus negated. The provision for project grants perpetuates the categorical grants. Moreover, under HEW projected appropriations, categorical grants will not only continue but will more likely flourish to a greater degree than before.

We do not believe that it is the intention of this Congress to have provide unrestricted health services for our population. It is incumbent that some limitation be stated clarifying the Act. Section 314 (e) should be changed to a program relating to public health services properly defined under subsection (d). As the law stands, the Association cannot support this vague section providing undefined services for unidentified persons. Accordingly, that portion of H.R. 6418 extending and expanding section 314 (e) cannot be supported.

GRANTS TO SCHOOLS OF PUBLIC HEALTH

We support an extension of the program of grants to schools of public health.

LICENSING OF CLINICAL LABORATORIES

This bill would also require federal licensing of clinical laboratories engaged in interstate commerce. The licensing of laboratories within a State has traditionally been a matter within the purview of state legislation. Standards for the operation of clinical laboratories have been promulgated by HEW in order for a laboratory to be certified for participation under the medicare program.

We believe that these requirements will do much to raise the standards of laboratories where this is necessary to participate in the medicare program. A reasonable period of time should now elapse to determine the effectiveness of these new requirements. Accordingly, we do not support that portion of the bill which would require federal licensure, and we recommend the deletion of this section.

SUMMARY

In testimony before this Committee last year we stated our support of the planning grant program under section 314 (a) if amendments which we sug-

gested were incorporated. Notwithstanding this, we believe that a coordinating commission would be more effective to accomplish the objectives of avoiding duplication of programs and would most effectively utilize facilities and manpower. Accordingly, we recommend that a coordinating commission within the State be established to replace the planning grant program.

As to the program for comprehensive public health services under section 314 (d), we believe that the services to be supported should be identified, and, accordingly, we recommend that the Congress provide either for a block grant for support of stated programs identified under the law, or for a continuation of grants for the separate programs, but with authority in the State to transfer, with the approval of the Surgeon General, funds from one program to another program to provide emphasis in any category as needed within the particular State.

The program of project grants, as provided under section 314 (e) should be related to the public health services which we have recommended be identified under subsection (d).

Other amendments to Public Law 89–749, given in our testimony before this Committee October 11, 1966 (set out in the Appendix attached hereto), including the creation of a National Advisory Council, should be incorporated into the law. (The amendments relating to the planning grants (section 314 (a)) would not be necessary upon the adoption of the program establishing the State Coordinating Commission.)

We support those provisions of the bill continuing the grants for areawide planning and grants supporting public health schools. We oppose the provisions requiring certain medical laboratories to be licensed by the Secretary of HEW.

We further recommend that a continuation of Public Law 89–749 should be limited to a one-year extension with appropriation authorizations being specifically stated in the legislation. We believe that this program is of such significance that it warrants a further evaluation by this Committee and the Congress after another year.

APPENDIX

Summary of position of American Medical Association presented on October 11, 1966 on S. 3008 and H.R. 13197, 89th Congress—the "Comprehensive Health Planning and Public Health Services Amendments of 1966."

The AMA supported the concept of comprehensive health planning, recommending stated changes, and supported the program for areawide planning. It did not support the program for formula grants for comprehensive undefined "public health services" and project grants for undefined "health services" as contained in the bill, again proposing certain recommendations, and indicating support of programs for appropriate public health programs. The Association also supported other provisions of the legislation, including the training of public health personnel and grants to schools of public health. As to the formula and project grants, it recommended a continuation of the then existing categorical programs with flexibility in the States to shift funds from one category to another to meet special needs within the State. In voicing these positions, the Association advocated certain amendments should be made.

In brief, the recommendations for amendments to the program were as follows:

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.

Formula and project grants

(a) clarify the scope of any health services to be provided by:

(1) adding a definition of "public health services";

(2) identifying the program of project grants for health services development by changing it to one relating to public health, as defined;

(b) delete the provision that standards for comprehensive public health services, including scope and quality of services, shall be set by regulations.

General

(a) provide for the creation of a National Advisory Council to the Surgeon General of the Public Health Service, with authority to approve grants to the States and changes in State plans, and with representation from the national organizations whose state affiliates are represented on the State planning councils;

(b) insert a provision indicating there shall be no interference with the private practice of medicine.

STATEMENT OF THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN

The National Association for Retarded Children has a continuing interest in the Partnership for Health legislation, since health and health related services for the mentally retarded are still inadequately developed. Between 1963 and 1966 mental retardation was looked on by the Public Health Service as a concern of the Division of Chronic Diseases. Although not specifically mentioned in the old law, a "categorical" program of project grants in mental retardation had been initiated. Within the Division it was administered by the Mental Retardation Branch, now the Mental Retardation Division of the Bureau of Health Services. We can only assume, in the absence of positive responses to recent inquiries, that the vital training and service needs to which these funds had been so successfully directed in that brief three years will continue to receive support.

Among the mental retardation activities which deserve attention are the Student Work Experience and Training Program, planning funds for universities which are contemplating development of university affiliated facilities for the mentally retarded, and information and referral services.

Of even greater concern to us at this time is the fate of mental retardation within the programs administered by the state health and mental health authorities. In fiscal 1966 the formula grant appropriation for Chronic Diseases and Health of the Aging was increased by $2.5 million to enable the state health departments to initiate activities affecting the health of the retarded, especially the adult retarded. There was, however, no requirement that they do so, and most states gave higher priority to other on-going activities. Clearly action on behalf of the mentally retarded at the state level cannot be realistically anticipated unless federal appropriations are substantially increased. Therefore, we urge the Committee to authorize amounts which are realistic in view of the enormous task before us.

In some states (e.g., Ohio and Virginia) the state mental health authority has a significant responsibility for community programs for the retarded (exclusive of education and vocational rehabilitation). In others (e.g., Oklahoma and Florida) responsibility lies elsewhere. Thus, there is no protection for the interests of the retarded in the earmarking of 15% of formula grant funds for the state mental health authorities.

We do not ask for earmarking at this time but would urge the Committee to reaffirm its intent, as explicitly expressed in its report of last year, that formula grant funds be used to improve health services to the mentally retarded.

Finally, we wish to express support for the new opportunities which would be opened up under Section 3 of H.R. 6418. There is much interest in the application of experimental approaches and use of new materials and functional designs in facilities for the mentally retarded; therefore, we welcome the inclusion of mental retardation facilities among those with respect to which grants and contracts may be awarded.

STATEMENT OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

The National Association for Mental Health is a national voluntary citizens organization directing its efforts to improved care and treatment of the mentally ill and the prevention and reduction of the incidence of mental illness or disability.

We strongly support H.R. 6418, amending the Public Health Service Act by extending and expanding the authorizations for grants for comprehensive health planning and services, and for other purposes.

We subscribe fully to the Congress' findings and declaration of purpose set forth in PL 89–749, the "Comprehensive Health Planning and Public Health Services Amendments of 1966", to be extended and expanded by H.R. 6418. We sincerely believe that "to assure comprehensive health services of high quality for every person, . . . 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 to people in their communities should be broadened and made more flexible".

It was therefore our privilege to testify last year before this Committee in favor of the bills which were later enacted as PL 89–749, although we did at that time express some reservations about the adequacy of the authorizations and the term thereof. We are indeed grateful that we now have this opportunity to support H.R. 6418, which increases those authorizations and extends the term of the program through fiscal year 1972.

We favor the proposed amendment of subsection (7) of Section 314 (d) which would require that at least 70 per centum of the amount reserved for mental health services 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 the State plan of services in communities of the State.

Through this amendment, funds will be made available on a realistic basis compared with known needs, for the development of mental health services in communities.

We regard it as particularly significant that subsection (7) of Section 314 (d) 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. As was stated by the Office of Comprehensive Health Planning and Development:

"Comprehensive health planning neither negates or diminishes the need for continued or expanded functional or specialized planning. Operating State and local agencies and private and voluntary organizations should continue to plan for specialized programs—the construction of health facilities, the development and expansion of community mental health programs, regional medical programs, programs in environmental control, services for the mentally retarded, etc.—and to plan for increasing the supply and effective utilization of trained manpower. Comprehensive State health planning provides a framework for strengthening such efforts by relating objectives in these specialized areas to each other and to the overall needs and resources of the State."

"Information and Policies on Grants to States for Comprehensive State Health Planning under Section 314 (a), Public Health Service Act as Amended" (draft dated April 11, 1967), issued by the Office of Comprehensive Health Planning and Development, H.E.W.

In summary, we urge passage of H.R. 6418 because, with respect to comprehensive planning, it provides adequate funds to the States, for a reasonable period of time, to continue the vital planning now just beginning; and with respect to comprehensive public health services, because the bill makes 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.

STATEMENT OF KAISER FOUNDATION HOSPITAL PLAN, INC.

We appreciate the opportunity to present our views on the important subject of comprehensive planning for health facilities and services as embodied in the "Partnership for Health Amendments of 1967." In our opinion this legislation has significant constructive aspects including Section 5 dealing with improvement of clinical laboratories engaged in interstate activities, Section 7 authorizing the Public Health Service to enter into cooperative arrangements, and particularly Section 3 which will provide affirmative encouragement for innovation in the health care field. We wish to express our support for these provisions.

A persuasive case has been made for the benefits of comprehensive health planning and the proposed legislation is a responsibly supported effort to deal with the very difficult problems posed by uncoordinated development of health care facilities and related services. Nonetheless, on the basis of considerable experience and study of both governmental and voluntary planning efforts in the

health care field we have deep reservations as to whether or not the benefits claimed for governmentally supported health facility planning will in fact be realized to a substantial degree. In this connection and in the interest of the brevity of this record we would like to refer to our statement made before the Ways and Means Committee of the House of Representatives during public hearings on H.R. 5710, the "Social Security Amendments of 1967."[1]

More important than the lack of effectiveness which we anticipate is the serious potential inherent in governmentally supported health facility planning for perpetuating the status quo and stifling useful innovation. We urge this committee to give careful attention to the establishment of federal standards which will assure, insofar as realistically possible, that the health facility planning effort contemplated by H.R. 6418 does not become primarily a tool for preserving traditional methods of organizing health facilities and services and precluding or hampering the development of useful or potentially useful alternatives under which the stimulus of competition and the expression of consumer preference may contribute toward improving the efficiency and economy of our health care system.

There is one proven alternative repeatedly endorsed by the Federal Government and other responsible sources which deserves particular attention—namely prepaid group practice health care.[2]

Because the group practice prepayment approach to the provision of health care services is both effective and non-traditional, it tends to be viewed as a threat or at least with skepticism and concern by many traditionally minded persons and organizations. These forces play key roles in the health care field and are certain to exert considerable influence on the development of state and local health facility plans such as those contemplated by H.R. 6418. Unless special attention is given to this problem, the frequently declared policy and intention of the Federal Government to encourage the development of prepaid group practice health care programs will be frustrated in the planning process.

The essential characteristic of group practice prepayment plans, and a likely characteristic of possible variations and innovations not yet clearly formulated or recognized, lies in the concept of assuming responsibility for comprehensive health services for a defined population consisting of individuals and families wishing to avail themselves of an organized approach to the provision of health care.

The traditional and dominant health care system in the United States, built around the individual medical practitioner or small group of physicians, involves a strong assumption of responsibility for treating the illnesses of individual patients. Although its full potential is as yet far from achieved, and barely recognized—even by the most advanced thinkers in the field—the group practice prepayment approach involves assumption of a much broader more pervasive responsibility:

> Assumption of responsibility not only to treat the illnesses of individual patients but also *to promote the health of a population consisting of all enrolled individuals whether or not they are patients.*

To the end that H.R. 6418 may contribute to the effective planning of health facilities and services by encouraging, not inhibiting, assumption of broad responsibility for health rather than narrow responsibility for treatment of illness, we urge that this concept be expressly embodied in federal standards guiding the planning process. A suggested amendment representing one method of including such concept in the legislation is attached as Exhibit A to this statement.

We wish to offer another suggestion of a more technical nature. The planning unit dealt with in H.R. 6418 is the *individual health care facility*. Thus on page 2 lines 17 through 21, the bill requires state plans to "provide for assisting *each health care facility* in the state to develop a program for capital expenditure . . . which is consistent with an overall state plan" (emphasis added). A basic point made in the opening session of the National Conference on Medical Costs on Tuesday, June 27, 1967, in Washington, D.C., was the potential value of recognizing and encouraging *systems of health care facilities* rather than individual units. We suggest that H.R. 6418 should further this useful concept by deleting the

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[1] Report of hearings before the Ways and Means Committee of the House of Representatives, 90th Congress, 1st Session, on H.R. 5710: Part 2, pages 780 through 786.

[2] See, for example, "Medical Care Prices," a report to the President by Health, Education, and Welfare, published February 1967, pages 4 and 5. See also: "Building America's Health" (A Report to the President by the President's Commission on the Health Needs of the Nation), 1952, Vol. 1, pages 33–34; "Health Care for California" (The Report of the Governor's Committee on Medical Aid and Health), December, 1960, page 16; "Health of the Nation" (Message from President Lyndon B. Johnson to Congress), February 10, 1964.

language "each health care facility" on line 2, page 18 and substituting language along the following lines: "*each health care facility or group of health care facilities under common control or coordinated direction.*" A similar amendment should also be made on page 3 at line 4.

In conclusion we urge this committee and the Congress that even at best the advantages claimed for health facility planning are apt to be of trifling significance compared to the social, technological, and organizational changes and innovations realizable in the health care field in an atmosphere of freedom and flexibility; thus protection of innovation and development in the planning process is a major public responsibility.

Respectfully submitted.

SCOTT FLEMING,
Vice President and Associate Manager.

EXHIBIT A.—SUGGESTED AMENDMENTS TO H.R. 6418, PLANNING TO ENCOURAGE ORGANIZATIONS WHICH ASSUME RESPONSIBILITY FOR HEALTH CARE FOR AN ENROLLED POPULATION

Insert at the end of section 2 of subsection (a)(2)(I) following line 5, page 3 of H.R. 6418, dated March 1, 1967, the following: "; and (iii) in developing criteria to guide the development of state plans, the Secretary shall give particular attention to provisions for the encouragement of innovation and proven or promising alternatives to prevailing patterns for the organization and delivery of health care services, including alternatives under which a qualified sponsor or sponsors may assume responsibility to provide or arrange reasonably comprehensive health care services on behalf of a population comprised of individuals and families choosing to obtain health care services primarily as provided or arrange by such sponsor or sponsors."

[Telegram]

ATLANTA, GA., *May 2, 1967.*

Hon. HARLEY O. STAGGERS,
Chairman, House Interstate and Foreign Commerce Committee,
House Office Building, Washington, D.C.:

I heartily support extension authority for grants for comprehensive health planning and Public Health Service as contained in H.R. 6418. Also strongly support adequate appropriation ceilings to at least $500 million level by fiscal year 1971.

GOV. LESTER MADDOX.

[Telegram]

BERKELEY, CALIF., *April 29, 1967.*

Hon. HARLEY O. STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

Urge your support of principles involved in S. 1131 with particular reference to proposed section 353 regulating clinical laboratories in interstate commerce. Certain amendments for improvement of bill have been transmitted to Secretary Gardener. Copy being forwarded to you. If these changes are incorporated in bill we would find it entirely satisfactory. Urge your strong support.

LESTER BRESLOW, M.D.,
California Director of Public Health.

[Telegram]

JEFFERSON CITY, MO., *May 4, 1967.*

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

With increased emphasis on licensing of clinical laboratories by each of the 50 States, it is apparent that licensing at the Federal level of clinical laboratories

engaged in interstate commerce is desirable. The Missouri Division of Health is favorable to enactment of the "Clinical Laboratory Improvement Act of 1967" as contained in H.R. 6418.

L. M. GARNER, M.D.,
Acting Director, Missouri Division of Health.
By J. P. RUSSELL, M.D.

[Telegram]

TOPEKA, KANS., *April 27, 1967.*

Hon. HARLEY STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.:

As director of health for State of Kansas may I urge your vigorous support for H.R. 6418? Regulatory action for control of medical laboratories involved in interstate commerce has been long overdue. Many of these laboratories are performing a volume business with little regard to quality of standard and frequently with little concern for consequences of responsible diagnostic testing results on medical patient. Accuracy of such laboratory diagnostic studies can often mean difference between life and death. Licensure and periodic inspection of such laboratories by a government agency is imperative if we are to insure a high quality of medical care to citizens of our State.

HUGH DIERKER, M.D.,
Kansas State Health Officer.

[Telegram]

PIERRE, S. DAK., *Apr. 25, 1967.*

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

Urge passage of H.R. 6418 regarding licensure of laboratories working in interstate commerce.

G. J. VAN HEUVELEN, M.D.,
State Health Officer.

[Telegram]

BISMARCK, N. DAK., *April 27, 1967.*

Congressman HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

Strongly encourage favorable support of House bill 6418.

JAMES R. AMOS, M.D.,
State Health Officer.

[Telegram]

BOISE, IDAHO, *April 26, 1967.*

Hon. HARLEY O. STAGGERS,
House of Representatives,
Washington, D.C.:

In 1967 Idaho Department of Health unsuccessfully attempted to enact State legislation on clinical laboratory licensure on the national level. We strongly support H.R. 6418. This is a definite public health need.

A. W. CLOTZ, D.P.H.,
Director of Laboratory Division, Idaho Department of Health.

[Telegram]

BLACKFOOT, IDAHO, *April 27, 1967.*

Representative HARLEY O. STAGGERS,
House of Representatives,
Washington, D.C.:

The Idaho Health Association strongly supports and urges passage of the laboratory licensing bill H.R. 6418. Its passage is a definite health need.

JACK JELKE, *President.*

[Telegram]

MAY 1, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.:

Federal licensing of clinical laboratories engaged in testing specimens shipped interstate is needed. Senate Bill 1131 relating to this activity is endorsed, in principle.

Suggest correction of certain defects in printed bill as follows:

1. Section 353(b) should be modified not to cover laboratories sending only test reports interstate. Otherwise, a laboratory which occasionally sends a report to a physician across a state line may be subject to federal licensure, regardless whether the specimen was shipped interstate.
2. Section 353(d)(1)(B) should be clarified to stipulate basis on which Secretary will establish standards to determine whether laboratory is operating satisfactorily to carry out purposes of Section 353.
3. Section 353(i) should be clarified so that naturopaths and chiropractors are not exempted on the basis that they may be considered "licensed physicians."
4. Section 353(k) should be clarified to permit States having freedom of enacting higher standards than those proposed under federal regulations.

Your consideration of these suggestions appreciated.

NATHAN J. SCHNEIDER, Ph. D.,
President, Association of State and Territorial Public Health Laboratory Directors.

[Telegram]

NEW YORK, N.Y., *May 2, 1967.*

Hon. HARLEY STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

The National Council on Alcoholism urges that your committee approve H.R. 6418 and its authorization to extend and expand the provision of Public Law 89–749. It is our hope that alcoholism and its victims may indeed receive the necessary recognition and services that the farsighted concepts of sound health planning embodied in H.R. 6418 can bring about.

THOMAS P. CARPENTER,
President, National Council on Alcoholism.

HOUSE OF REPRESENTATIVES,
Washington, D.C., May 26, 1967.

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

DEAR MR. CHAIRMAN: I am aware that your Committee is in the process of scheduling hearings on your bill H.R. 6418, the "Partnership for Health Amendments of 1967."

This is a fine bill, which if enacted, will have significantly beneficial effects on the programs of health planning and services of the Commonwealth of Puerto Rico, however, in studying your bill I have noted a problem which I think should specifically call to your attention.

Section 5 of the bill would add a new Section 353 to Part F of Title III of the "Public Health Service Act" (42 U.S.C. 263) to provide for definitions and requirements in the licensing of biological products and clinical laboratories. To this effect, the term "interstate commerce" is so defined as to include and regulate all commercial activities which would be performed wholly within the Commonwealth of Puerto Rico for the purpose of the proposed amendments.

It is apparent, as you know, that the Administration drafters of this proposed obsolete definition were temporarily unaware of our present Commonwealth status and overlooked the solution to the problem presented in the definitions of the "Public Health Service Act."

Section 2(f) of such Act defines the term "State" as meaning Puerto Rico, and Section 2(g) of this same Act defines the term "possession" as including Puerto Rico.

Consequently the drafters of the definition of the term "interstate commerce", proposed in H.R. 6418 as an amendment to the Act, included commerce specifically "*within*" the *Commonwealth of Puerto Rico* on the apparent theory that such imposition upon the internal commerce of the Commonwealth was authorized by the inclusion of Pureto Rico within the term "possession" given in Section 2(g) of the Act.

This problem, of course, could have been ideally resolved by striking out "Puerto Rico" from the term "possession" in Section 2(g) of the "Public Health Service Act", but since H.R. 6418 does not appear to be the instrument for such amendment I must postpone it for the future and, counting with your kind cooperation, avail myself of a practical solution.

As you know, the "Public Health Service Act" was enacted as Public Law 78-410, on July 1, 1944, almost 8 years before the advent of the Commonwealth of Pureto Rico.

In this connection it would seem pertinent not to overlook the present relationship between the United States and the Commonwealth of Puerto Rico, as established by Public Law 81-600. Implicit in the creation of the Commonwealth in 1952, by the mutual agreement of the people of Puerto Rico and the United States Congress, was the understanding that the Commonwealth of Puerto Rico was to be accorded autonomy in the regulations of its internal affairs. As a matter of fact, in 1953, this compact enabled the United States to request and obtain from the United Nations that the Commonwealth of Puerto Rico be removed from their rolls of the non-self governing territories and possessions.

To this effect, on November 27, 1953, the United Nations recognized that the people of the Commonwealth of Puerto Rico, exercising effectively the right of self-determination in a free and democratic way, had achieved a new constitutional status and that, in view of this new status, it was appropriate that the United States should cease the transmission of information with regard to Puerto Rico under Article 73(e) of the Charter U.N. Gen. Ass. Res. 748 (VIII) (1953).

Because of the significance of this constitutional status of the Commonwealth of Puerto Rico President Kennedy issued his memorandum of July 25, 1961 (which has not been superseded) in which he states that:

". . . it is essential that the executive departments and agencies be completely aware of the unique position of the Commonwealth, and that policies, actions, reports on legislation, and other activities affecting the Commonwealth should be consistent with the structure and basic principles of the Commonwealth and.

". . . The Commonwealth structure, and its relationship to the United States which is in the nature of a compact, provide for self-government in respect to internal affairs and administration, subject only to the applicable provisions of the Federal Constitution, the Puerto Rican Federal Relations Act, and the Acts of Congress authorizing and approving the constitution."

Up to the present moment, as you know, Congress has consistently recognized this principle by not extending federal regulations to the internal commerce of Puerto Rico, and all the laws enacted applying in Puerto Rico make specific reference to the "Commonwealth of Puerto Rico" and to this effect they equate the Commonwealth with the States of the Union by including it within the meaning of the definition of the term "State."

Among the many actions taken by the Congress to support this policy, I might take the liberty of mentioning the case of the bill H.R. 13881 approved by Congress last year for the purpose of regulating in interstate commerce the transportation, sale and handling of dog and cats used in research.

During the consideration of the bill by the Senate, Chairman Magnuson stated that the inclusion of the internal commerce of the Commonwealth of Puerto Rico

in the bill did not originate in the House-passed version, that such inclusion made by the Senate Commerce Committee violated the compact and that it should be deleted from the bill. The Magnuson amendment was agreed to and the House ratified the amendment.

I sincerely hope that this situation may be kept present for the purpose of amending the definition of the term "interstate commerce" proposed in Section 5 of H.R. 6418 as follows:

"On page 10, at the end of line 10, after the term the District of Columbia, strike out "the Commonwealth."

"On page 10, beginning on line 11, strike out "of Puerto Rico."

To preclude any possible misinterpretation, it would seem prudent to clarify the legislative history of the bill by adding in the report that the term "possession" including Puerto Rico in Section 2(g) of the "Public Health Service Act" of July 1, 1944 (Public Law 78–410) has become inapplicable to the Commonwealth of Puerto Rico because of the reasons, supra.

Since this is an Administration bill, I have discussed the matter with Mr. Ralph Huit, Assistant Secretary for Legislation, of the Department of Health Education and Welfare, and with Mr. Sidney Saperstein, Deputy Chief of the Legislative Division, in the Office of the General Counsel, in this Department, and I have been informed by them that their Department has no objection to my recommendations.

I would appreciate very much your good office in the sponsoring of this necessary amendment.

Respectfully yours,

SANTIAGO POLANCO-ABREU,
Resident Commissioner of the Commonwealth of Puerto Rico.

HOUSE OF REPRESENTATIVES,
Washington, D.C., May 5, 1967.

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

DEAR MR. CHAIRMAN: I enclose for your consideration a copy of a letter from The Honorable John A. Burns, Governor of Hawaii, emphasizing the importance of passage of H.R. 6418 to my State. May I underscore the Governor's comments in requesting the earliest possible favorable action on this legislation.

The Hawaii Department of Health has completed planning for community health programs authorized by Public Law 89–749 and is anxiously awaiting extension of the Act so that its early progress in qualifying for these important Federal-State health programs will not be disrupted.

May I respectfully request that every consideration be given to Governor Burns' letter and that it be made an official part of the hearings on H.R. 6418 when they are resumed.

Your kind attention to this inquiry will be most appreciated.

Very truly yours,

PATSY T. MINK,
Member of Congress.

EXECUTIVE CHAMBERS,
Honolulu, Hawaii, May 1, 1967.

Hon. PATSY T. MINK,
House of Representatives, Longworth Building, Washington, D.C.

DEAR REPRESENTATIVE MINK: We have been informed in a special letter from the Association of State and Territorial Health Officers that hearings on H.R. 6418 (the bill to extend Public Law 89–749) are to be held on May 2, 3 and 4, 1967 by the House Committee on Interstate and Foreign Commerce.

As you no doubt know, the threefold intent of this bill is to increase the ceiling for State Health Planning grants, to increase the ceiling for formula grants, and to increase the ceiling for project grants under the Comprehensive Health Planning and Public Health Services Amendments of 1966. These increases represent a substantial amount and could means a considerable expansion of services available to the citizens of Hawaii when our State Comprehensive Health Plan is finally promulgated. In addition to this, it is the intent of this bill to extend the life of Public Law 89–749 up to a total of five years.

Your interest in this important piece of legislation is appreciated, and I will be grateful for anything that you might be able to do to expedite the passage of it. Our Department of Health is well on the way to implementing its provisions, and any additional effort you might lend toward the passage of this bill will greatly help us in the period of transition concerning Federal health programs that will be occurring next year.

With warm personal regards. May the Almighty be with you and yours always.

Sincerely,

JOHN A. BURNS, *Governor.*

EXECUTIVE DEPARTMENT,
Annapolis, Md., May 12, 1967.

Hon. HARLEY O. STAGGERS,
House Interstate and Foreign Commerce Committee,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: My staff has examined Bill H.R. 6418 which you recently introduced.

I am fully in agreement with the provisions of this Bill. I particularly am in favor of the proposal which provides an increase of ceiling for comprehensive health planning and grants to the States. Maryland now receives no funds for comprehensive health planning and, in all categories of grants, only receives about ten per cent more than the amount authorized in Public Law 89-749.

This Bill moreover would provide for licensure of laboratories which conduct business on an interstate basis. Maryland at the present time has to certify out-of-state laboratories which receive specimens from Maryland patients.

May I wish you every success as this Bill is debated in the House.

Sincerely,

SPIRO T. AGNEW, *Governor.*

OFFICE OF THE GOVERNOR,
Springfield, Ill., May 8, 1967.

Re: H.R. 6418.

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

DEAR CONGRESSMAN STAGGERS: I understand that additional legislation is needed in this session to extend the concepts of flexible health grants in combination with money needed to implement the Comprehensive Planning under Public Law 89-749, which I previously supported.

I would like to place myself on record in support of this additional legislation. It will bring not only more flexible health grants and planning programs to the states but will place more leadership responsibility in the several states, thus making them more effective partners with the federal govenment.

Sincerely,

OTTO KERNER, *Governor.*

STATE OF WEST VIRGINIA,
DEPARTMENT OF HEALTH,
Charleston, W. Va., May 9, 1967.

Hon. HARLEY O. STAGGERS,
Member of Congress,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: In answer to your letter of May 3, 1967, referring to the Health Referral and Counseling Service for armed forces examining station medical rejectee program in West Virginia, we would like to first thank you for the information which you supplied us.

Regarding your question concerning the method of financing, we feel that plans currently being formulated under section 314 (c) will be sufficient providing funds are available to the extent of that level of operation which is now being carried on. It is the intentions of our department to extend counseling and refer-

ral to those young men that have been rejected at the draft board level, funds being available. In West Virginia in the fiscal year of July 1, 1965, through June 30, 1966, 871 men were eliminated at the draft board level before reaching the armed forces examining station at which point we would normally intercept them. Also, many more young men of our state and nation have been accepted by the armed forces and after having served for a period less than ninety days were discharged for a defect discovered after entry into the services. This group, it is planned, will also be served by our Health Referral Program. In addition studies are being made toward possibilities of a referral and counseling program for eighth grade level boys and girls in our elementary or junior high schools in West Virginia. The inclusion of the above program into our present operation of the Health Referral and Counseling Service will be a big step to be taken for future planning in the comprehensive health of the future.

Item IV, "Grants for Studies and Demonstrations," *Project Grants for Studies and Demonstrations in Comprehensive Health Planning*, we refer to Item I—*Development and Testing of New Methods of Obtaining and Analyzing Information Pertinent to Health Planning.* It is our impression that the experiences which we are having in the Health Referral Program in West Virginia will be invaluable in this particular category. We are enclosing statistics (attachment A) showing West Virginia activities in comparison with the national average for the months of July, 1966, through February, 1967. Also, a chart (attachment B) to point out the areas which we feel are in the greatest need. This is covered in our graph showing number of defects and diseases discovered in rejectees during the period of fiscal year 1965–1966.

If you would convey to your committee the above information and the enclosed statistics it will be greatly appreciated. We would like to point out to you that it is very important that some action be taken relative to our program in this state and in other states throughout the nation at the very earliest date. We are required to give notice to our personnel and to our lessors thirty days prior to termination should this be necessary. West Virginia Law and Civil Service Regulations require this.

Your work in comprehensive health is well known and the services rendered by you in the interest of West Virginia is common knowledge. Your assistance in advancing this program into another fiscal year will be in line with your continued fine service to West Virginia.

Sincerely,

N. H. DYER, M.D., M.P.H.,
State Director of Health.

ATTACHMENT A

Statistical chart comparing West Virginia with the national average

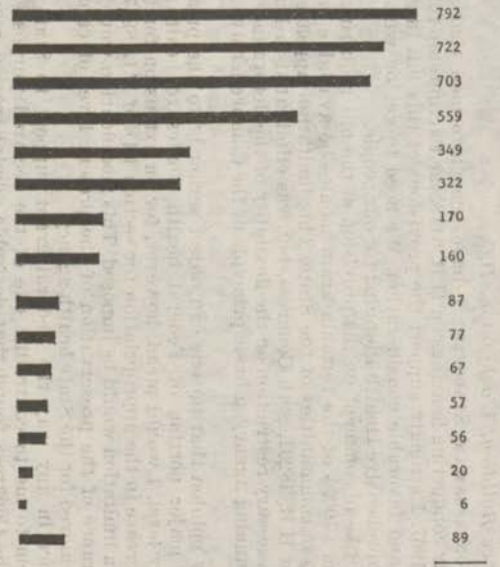
Month	Rejectees processed		Rejectees interviewed		Percent interviewed		Forwarded to designated community agency [1]		Percent forwarded to designated community agency		Number of cases receiving care		Number of cases referred	
	National	West Virginia	National	West Virginia	National	West Virginia	National	West Virginia	National	West Virginia	National	West Virginia	National	West Virginia
July	25,093	137	22,153	116	88.3	84.7	10,240	97	40.8	83.6	2,376	142	4,846	116
August	29,126	282	26,388	232	90.6	82.3	11,791	205	40.5	88.4	2,218	31	5,608	97
September	29,461	251	26,890	224	91.3	89.2	12,063	182	40.9	81.3	2,755	66	5,894	102
October	32,214	306	29,592	290	91.9	94.8	13,200	185	41.0	63.8	2,695	46	6,395	122
November	32,577	307	29,987	284	92.0	92.5	13,289	208	40.8	73.2	2,535	46	6,806	184
December														
January	25,368	134	23,717	121	93.5	90.3	10,211	77	40.3	63.6	2,872	78	6,057	128
February	9,889	49	9,057	36	91.6	73.5	3,937	31	39.8	86.1	2,998	67	4,521	99
Total	183,728	1,466	167,784	1,303	91.3	88.9	74,731	985	44.5	75.6	18,449	476	40,127	848

NOTE.—In comparing West Virginia with the national average of those rejectees receiving care through the period of July 1966 through February 1967, West Virginia's percent receiving care was 56.1 as compared with the national percent of 46 over this same time period.

Attachment B

REASONS FOR MEDICAL DISQUALIFICATIONS*

at
Armed Forces Examining Station
State of WEST VIRGINIA
August 1965 - July 1966



*Based on 3,064 Disqualified Youth

ARIZONA STATE DEPARTMENT OF HEALTH,
Phoenix, Ariz., May 1, 1967.

Hon. HARLEY O. STAGGERS,
House of Representatives,
House Office Building, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: I have been informed that your Committee is currently conducting hearings on H.R. 6418, the Partnership for Health Amendments of 1967. I strongly support the provisions of this bill in general and hope for early and favorable consideration. We need to get on with the challenging job of Comprehensive Health Planning for our people.

I would like to comment on the provision of the bill requiring that at least 70 per centum (70%) of the formula grant monies be available only for provision of services in communities of the State. This limitation appeared in the original wording of H.R. 18231, 89th Congress, but was eliminated in Public Law 89-749 as an unnecessary restriction on the flexibility of the determinations of the State Health Planning Agency, a basic principle of the Comprehensive Health Planning concept.

It is my opinion that no one can object seriously to the principle of subvention of a major portion of Federal health monies to health services at the community level. I would plead, however, for an extension for at least one year and an increase in the appropriation for section (d) of P.L. 89-749 before the 70 per centum limitation would be imposed. This modification would provide reasonable assurance of the preservation of the present level of capability and competence achieved for the State health agency.

To reduce in any way the Federal grant support to State health agencies would seem to me to contradict one of the declared purposes of P.L. 89-749, wherein the Congress found that desirable administration requires strengthening of the leadership capacities of State health agencies.

Sincerely,

GEORGE SPENDLOVE, M.D., M.P.H.,
Commissioner.

STATE OF NEW MEXICO,
DEPARTMENT OF PUBLIC HEALTH,
Santa Fe, April 26, 1967.

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

DEAR CONGRESSMAN STAGGERS: This Department, and I as a long-time laboratorian, are much interested in the objectives of H.R. 6418 which will shortly come before you. I express to you our unqualified support of the bill and I solicit your assistance in gaining the understanding of Congress that it may become law.

Sincerely,

EDWIN O. WICKS, M.D., D.P.H.,
Director.

THE AMERICAN REHABILITATION FOUNDATION,
Minneapolis, Minn., June 21, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
Rayburn House Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: The American Rehabilitation Foundation respectfully submits the following views and recommendations concerning the proposals for health services research contained in H.R. 6418.

The most significant aspect of this proposal is the underlying assumption that the organization and delivery of health services has now become a subject of inquiry that must be pursued with the same scientific rigor and urgency of purpose as biomedical research. The scale of the Government's present and probable future subsidies for the payment of health services is by itself ample justification for exerting systematic efforts to realize the maximum return on this investment in the Nation's health. In addition, however, the development of

models and systems for increasing the efficiency, availability and quality of medical care will also increase the cost-effectiveness of private health expenditures.

The proposal before the Committee may be said to be a natural and necessary development in the evolving pattern of Government health programs. Each preceding phase—the establishment of the Public Health Service, the creation of the National Institutes of Health, and the enactment of the Hill-Burton legislation—can be identified with a corresponding demand for increased manpower, the pursuit of new standards of excellence, heightened educational and administrative demands and increased need for expanding programs in keeping with intelligent decision-making and assignment of priorities.

Now that grants and payments for health care services in non-governmental institutions comprise the largest and fastest-growing category of Government expenditures for health, it is natural to expect similar corollary effects. H.R. 6418 anticipates this eventuality by proposing programs that will aid health professions and institutions in the private sector to adjust to the impact of this intensified concentration of Government funds on health care services.

The sudden and mounting influx of these funds is placing a severe strain on the existing framework of health facilities. There is a danger that the stress may impair the operation of the system and the quality of its services, thereby defeating, rather tha naccomplishing the purposes of these programs.

Length of hospital stays, as the *Report to the President on Medical Costs* clearly indicates, is a critical factor in rising costs. Health services research could contribute to the solution of this problem and at the same time help ease the tension created by arbitrary utilization review requirements. For example, the present legislative proposal could provide assistance to the medical profession in establishing objective criteria for determining optimum discharge status. It could also aid in the further development of progressive patient care programs. Lack of facilities for subsequent stages of care after the need for acute hospitalization has ended is one of the chief factors contributing to lengthy hospital stays.

Of utmost importance, health services research proposes to seek creative and positive methods of reducing costs and maximizing benefits through voluntary efforts on the part of health professions and institutions. In the absence of such efforts, actions, impelled by a natural and responsible concern, could be taken to curb excessive costs by imposing controls and restrictions. While curtailing costs, such actions, by themselves, might also inhibit the free exercise of profesional responsibility, imperil the quality of care and lead to dissension that could endanger the future of Medicare and related programs. In the meantime, large sums could be dissipated in the attempt to channel funds for these programs though the medium of an obsolescent system. Health services research, as envisioned in H.R. 6418, is an attempt to eliminate waste, while at the same time preserving the quality of care and stimulating voluntary solutions by the health professions and health care institutions.

The scope of health services research extends beyond problems related to Medicare. It is also directed at basic and persistent problems of maldistribution of health manpower and malformations in the structure of services.

The improvisatory and illogical character of present responses to health needs is dramatically illustrated by the spectacle of the emergency room of the metropolitan hospital. Demands for service come not only from patients suffering severe trauma requiring emergency care, but also from patients seeking services because they are without a personal physician or because their doctors' offices do not have the advanced diagnostic equipment which is available in hospitals. Straining emergency facilities to the limits of their capacity, this situation makes it extremely questionable whether either emergency cases or other patients receive adequate attention. Health services research could be directed at making advanced diagnostic facilities available in each doctor's office through the mode of modern communications technology as has recently been demonstrated by transmitting electrocardiograms over the telephone for diagnosis by a computer.

Clearly, health services research should be directed toward increasing the productivity of physicians. It has been conceded that there is little hope of increasing the number of physicians in practice to a level that will even maintain the present ratio of physicians to population. Means must therefore be found to increase their productivity and concentrate more of their attention on the intrinsi-

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cally professional aspects of practice. Such means include, of course, the frequently proposed delegation of some tasks to appropriately trained assistants and the increased utilization of advanced technological adjuncts to medical care, such as the autoanalyzer and computerized multiphasic screening.

Since such research represents a new and highly complex field of study, there is little or no previous experience to draw upon. For this reason, the search for models and systems must be multifaceted and far-ranging. Imaginative and diversified approaches must be pursued to determine the effectiveness and potential of various alternatives. While such studies should deal with focused research, in the sense that they are aimed at specific objectives and problems, they should be speculative in terms of freedom to pursue a variety of avenues in attaining the objectives.

I strongly urge passage of this legislation.

Sincerely,

PAUL M. ELLWOOD, Jr., M.D.,
Executive Director.

PIMA COUNTY HEALTH DEPARTMENT,
Tucson, Ariz., April 14, 1967.

Hon. HARLEY O. STAGGERS,
House of Representatives, House Office Building,
Washington, D.C.

DEAR MR. STAGGERS: I would like to comment on the proposed Partnership for Health Amendments of 1967 (S. 1131). These amendments would improve the Public Health Service Act including those portions which were included as comprehensive health planning in Public Law 89-749.

I will comment on some of the more important and desirable features of the proposed amendments.

1. *Continuity of planning and grants.*—The authority in the existing legislation expires in 1968; the proposed amendment would extend the authorization to 1972. From experience, I can attest to the waste and inefficiency that occur in health programs that do not have a promise of stability for some years. Quality personnel can not be obtained and long term projects can not be planned.

2. *Authorized funding.*—The proposed amendment would increase the funding authorized for planning, grants to states, and project grants. The increases are not great and what may be allowed is still subject to the appropriations actually made. I have felt that the original bill was too conservative in the grant area.

I would like to illustrate this with the provisions for Comprehensive Health Services. The grants called "block grants" to States supplant the present system of "formula grants" to States. They have been thought of as giving the State Health Department a degree of flexibility in meeting needs not provided for under formula grants. The presently authorized $62,500,000 would permit Arizona practically no increase over its present formula grants. And yet in Arizona there should be a preventive program in many fields where nothing now exists, yet preventive measures are known to save people from pain and suffering and premature death.

3. *Community services.*—The proposed amendment would put back the provision that 70% must go for services in communities of the State. This provision had been dropped out of PL 89-749 for reasons unknown to me.

This provision helps to insure services reach the people, as is the intent of Congress. It helps guard against a cumbersome machinery which can eat up a disproportionate amount of funds.

4. *Licensing of laboratories.*—The proposed amendment would provide Federal controls of laboratories engaged in interstate commerce.

An erroneous laboratory finding can be as fatal as prescribing a wrong drug. Thus controls for incompetent laboratories are required. Further there is the growing problem of mail order diagnosis which can be a vicious type of quackery.

From the above, Mr. Staggers, you can understand my interest in this bill. I have some insight in the problems with 33 years of public health experience encompassing international, national, and local positions.

Sincerely,

FREDERICK J. BRADY, M.D.,
Director.

NATIONAL CYSTIC FIBROSIS RESEARCH FOUNDATION,
New York, N.Y., June 19, 1967.

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

DEAR MR. CHAIRMAN: The National Cystic Fibrosis Research Foundation would like to convey to your Committee our complete support of the objectives of Public Law 89-749, Partnership for Health Act of 1966, and H.R. 6418 (S. 1131), the Partnership for Health Amendments of 1967. We feel that Public Law 89-749 was a significant step in creating a more effective partnership among the Federal and State and local units of government in the field.

One important provision of Public Law 89-749 was the authorization of project grants for studies to develop new methods or improve existing methods of providing health services (section 314e, clause 3). There is an urgent need for the development of new methods to improve the existing methods for the prevention and control of chronic diseases. Of particular concern to our Foundation, is the problem of chronic respiratory diseases of children, including the pulmonary manifestations of cystic fibrosis. It is our feeling that developmental project grants can make a significant contribution to the solution of these grave health problems.

We note that, by the terms of H.R. 6418 (S. 1131), this clause is stricken from Section 314e and transferred to a new Section 304 of the Public Health Service Act. It would be our interpretation that the new language dealing with "development of new methods or improvement of existing methods of organization, delivery, or financing of health services," is intended to cover developmental projects related to the prevention and control of chronic diseases. However, we are concerned that this language may not be sufficiently explicit to assure the availability of project grants for this important developmental work.

We therefore recommend that the language of the New Section 304 be made more explicit in this regard, or at least that this meaning be spelled out by the Committee in its report accompanying the Bill.

We also note that the new Section 304 established a ceiling of $20 million on funds to be appropriated to carry out projects under this authority. It appears that this ceiling might make less money available for necessary developmental projects than might have been available under Clause 3 of Section 314e. In view of the urgency of the problems of the prevention and control of chronic respiratory diseases in children and other chronic diseases, we earnestly recommend that the Committee raise this ceiling.

We would appreciate it if you would make this letter part of the hearing you are holding on the legislation.

Thank you for your kind consideration.

Sincerely yours,

MILTON GRAUB, M.D., *President.*

LOUISIANA TUBERCULOSIS &
RESPIRATORY DISEASE ASSOCIATION,
New Orleans, La., May 15, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, House Interstate and Foreign Commerce Committee, House Office Building, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: We would like to add our voice to that of the National Tuberculosis Association, for whom Dr. Joseph B. Stocklen testified before your Committee on May 4, 1967, regarding the need for increased authorizations for project and formula grants for comprehensive health services. We understand that H.R. 6418 provides for an increase in authorization for each of the grant programs from $62.5 million to $70 million for fiscal 1968.

In our opinion, the proposed increase in authorizations is not sufficiently large to assure the amount of support needed for maintenance of accelerated tuberculosis control—in accordance with the Surgeon General's TB Task Force recommendations of a couple years ago—and for increasing the number and scope of chronic respiratory disease programs, truly a serious need throughout the United States.

We urge you and your committee members to give these programs the priority and attention they need.

With many thanks for your interest and consideration, I remain,

Respectfully,

W. FINDLEY RAYMOND,
Executive Director.

CENTRAL FLORIDA TUBERCULOSIS &
RESPIRATORY DISEASE ASSOCIATION,
Orlando, Fla., May 15, 1967.

Hon. EDWARD J. GURNEY,
U.S. House of Representatives,
House Office Building, Washington, D.C.

SIR: We strongly feel that the proposed increased authorizations for the Public Health Service grants programs, from 62.5 millions to 70 millions under H.R. 6418, are not sufficiently large to assure the support needed for maintenance of accelerated tuberculosis control and for increasing the number and scope of chronic respiratory disease programs.

Our views are based on the recommendations of the Surgeon General's Task Force Report on Tuberculosis. We are in support of these recommendations for funds and believe they are consistent with the goals of our organization and are vitally needed to implement programs and maintain progress.

Increased federal financial is also urgently needed for the initiation and expansion of activities to control other chronic respiratory diseases. We are in accord with the testimony presented by Dr. Joseph B. Stocklen on May 4, 1967.

We request that our views be transmitted to members of the House Interstate and Foreign Commerce Committee.

Sincerely yours,

JOHN W. COLLINS,
Managing Director.

FLORIDA TUBERCULOSIS &
RESPIRATORY DISEASE ASSOCIATION,
Jacksonville, Fla., May 23, 1967.

Hon. DANTE B. FASCELL,
House of Representatives, House Office Building,
Washington, D.C.

DEAR MR. FASCELL: H.R. 6418 is currently being considered by the House Interstate and Foreign Commerce Committee. This legislation would provide for an increase in formula and project funds under the Comprehensive Health Planning Act (89–749) from $62.5 million to $70 million for fiscal 1968.

If Florida is to continue with its intensive tuberculosis eradication program and initiate new programs for the control of other respiratory diseases, then it is vital that sufficient funds be authorized by Congress. As pointed out to you in earlier correspondence, the Florida State Board of Health has Special Tuberculosis Project Grants pending in the amount of $745,000 for fiscal 1967–68 and a $836,000 project for fiscal 1968–69. Tuberculosis is still a very serious problem in our state and it would be most unfortunate if the Federal support for these eradication efforts was cut at this time.

By supporting an increase from $62.5 million to $70 million as requested in H.R. 6418, you would also be supporting the initiation and expansion of programs to control chronic emphysema and other respiratory diseases which are beginning to take a terrible toll among Florida's citizens, particularly among men in their most productive years. Emphysema has risen from the 15th cause of death in Florida in 1956 to the 7th cause in 1966. The number of deaths in 1966 in Florida was 1,257, and for every death that is directly attributed to emphysema it is reliably estimated that this disease is the secondary cause of two other deaths.

Members of this association would be most grateful if you would contact your fellow Congressmen on the House Interstate and Foreign Commerce Committee and urge their support of this legislation which will mean so much to the health and welfare of Florida.

Sincerely,

R. A. CARUTHERS, *President.*

HARVARD MEDICAL SCHOOL,
DEPARTMENT OF PSYCHIATRY,
Boston, Mass., May 2, 1967.

Re: H.R. 6418.

Hon. HARLEY O. STAGGERS,
Chairman, Interstate and Foreign Commerce Committee, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN STAGGERS: I understand that you will be considering in your Committee the above noted bill. I sincerely hope and urge that in your consideration of Comprehensive Health Planning you will include a consideration of patients suffering from alcohol problems.

As becomes increasingly evident the ramification of the serious complications deriving from unrecognized and untreated alcoholism, continues to multiply and increase in severity. Therefore, I believe no real Comprehensive Health Planning can take place until and unless alcoholism efforts are incorporated in this planning.

Sincerely,

MORRIS E. CHAFETZ, M.D.,
Director, Alcoholic Clinic and Acute Psychiatric Service; Assistant Clinical Professor in Psychiatry.

HEALTH FACILITIES PLANNING
COUNCIL FOR NEW JERSEY,
Princeton, N.J., May 1, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, House Interstate and Foreign Commerce Committee,
Congress of the United States, Washington, D.C.

DEAR SIR: We understand that the House Interstate and Foreign Commerce Committee is considering amendments to the Comprehensive Health Planning Legislation, P.L. 89-749.

Our purpose in writing is to invite your attention to the fact that there are some areawide planning councils operating on a statewide basis. Public Law 89-749 makes specific reference to metropolitan and regional planning councils but does not specifically refer to statewide planning councils. We believe that this is an oversight which should be corrected.

We are enclosing a copy of our 1966 Annual Report for reference. It points out that one of the major efforts of the Health Facilities Planning Council for New Jersey, which is non-profit, has been directed toward the establishment of twelve regional planning councils. Ten of these councils are already incorporated and there is an active interest in the remaining two regions to form their own councils.

If planning grants are to be made to metropolitan and regional planning councils only, to the exclusion of statewide planning councils, where they exist, it appears that this would be a disservice to the planning problem. For example, the twelve regional planning councils in New Jersey which we will soon have developed ostensibly could apply for and obtain planning grants under the Comprehensive Health Planning Legislation. This would, in our opinion, create duplication and the unwarranted expenditure of unnecessary funds.

It is our intention in New Jersey to provide sufficient staffing on a statewide basis to make it possible to do the staff work for all or most of the regional planning councils, leaving the Boards of the regional planning councils to operate primarily on a policy level. This would make it possible to coordinate at one level sufficient staff, both in depth and professionally oriented, to do a commendable job. On the other hand, if twelve regional planning councils are to be supported by federal funds in New Jersey and if each of them applies for a grant-in-aid, it is conceivable to expect that they could not raise sufficient funds to provide adequate in depth staffing to effectively carry out satisfactory planning programs.

Our suggestion is intended to direct your attention to the desirability of including statewide planning programs by name in the legislation. Statewide planning councils plan for every portion of the state, whereas metropolitan and regional planning councils are geographically limited in their planning and, in many instances, will leave large geographic areas of states completely unplanned

for. This cannot happen under a statewide planning council as it is being developed in this state.

We feel sure that you will recognize the desirability of our approach. Your consideration of this policy is earnestly recommended.

Sincerely,

EDWARD A. MOONEY,
Executive Director.

GROUP HEALTH ASSOCIATION OF AMERICA, INC.,
Washington, D.C., May 22, 1967.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing to express to your Committee the support of Group Health Association of America for HR 6418, the "Partnership for Health Amendments of 1967", now being considered by the Committee on Interstate and Foreign Commerce. We support this bill in the broad context of Public Law 89–749, as interpreted through regulations and policies now being developed by the Public Health Service. We trust that you will incorporate this communication in the record of your hearings on HR 6418.

I should also like to take this opportunity to record our Association's full support of the broad, systematic approach to comprehensive health planning which was initiated in Public Law 89–749, the Comprehensive Health Planning and Public Health Service Amendments of 1966. The rapidity of your Committee's response to the urgency of the need when this legislation was considered last year gave us no opportunity to express our endorsement at that time.

To identify our Association and explain our vital concern that the Comprehensive Health Planning Program achieve its full potential, I should state that GHAA is an organization of group practice prepayment plans distributed over the country, which are primarily sponsored by or oriented toward consumers. These plans have their own medical staffs and facilities, with which they provide medical services on a prepaid basis to an enrolled population of more than five million.

In supporting HR 6418, we wish to comment on four aspects of the Bill and the programs it would inaugurate: (1) The need to assure that the planning process lead to effective action in the public interest, rather than to delaying or obstructing action under the influence of some special interest group; (2) The need to assure that planning machinery and processes deal effectively with interstate metropolitan areas and regions, rather than being rigidly segmented and circumscribed by State lines; (3) The need to secure true consumer representation on advisory councils and other planning bodies to ensure that the planning process really serves the consumer interest; (4) The need for Federal licensing of clinical laboratories operating in interstate commerce.

Our first concern is that the new partnership for comprehensive health planning should result in action that improves the availability, efficiency, and quality of total health services to the people of the community. Planning also must give due scope to experimentation and innovation in ways of providing health services, and to evaluating traditional as well as new operations.

Most essential is constant vigilance to prevent planning from becoming a substitute for action. There have been times when planning has been so used, particularly when action is opposed by a special interest group. The history of opposition to prepaid group practice facilities as a result of medical society influence in state Hill-Burton planning bodies is a familiar example.

Delay through a multiplicity of overlapping or layered planning bodies can actually have the effect of a veto on introduction or expansion in a community of new or better methods of organizing health services, such as group practice prepayment.

A second matter for concern is the inadequacy of States as the sole geographic units for health services planning for the interstate metropolitan areas that dot the nation. Also, in States with urban and rural areas of opposing political philosophies competing for State and Federal support, a State government of one political character may shortchange its opponents with respect to health resources.

Effective planning for interstate metropolitan area health services, as authorized in Section 314(b), requires vigilance in the Federal administration and particularly on the part of Public Health Service Regional Health Directors to assure that planning resources of the States concerned are appropriately committed for these areas. Guarding against favoritism toward one area over another for political reasons requires that planning be oriented primarily to the health needs of people rather than to the interests of one or another segment of the medical care industry.

We understand that the new partnership for Federally-aided planning complements and builds on such specialized planning as that of the Regional Medical Programs and Area-Wide Facilities planning under the Hill-Burton program. Without appropriate safeguards, however, comprehensive planning through the newly defined Federal-State partnership could carry over all the old problems of planning that is initiated at the State or non-Federal level and that involves conflicting jurisdictional interests.

This leads to our third point that a major safeguard in Public Law 89–749 is the requirement for establishment of a State Health Planning Council, a majority of the membership of which consists of "representatives of consumers of health services." The extent to which this council is wisely selected and effectively used is, in our view, the key to comprehensive health planning and the spur to action in the public interest.

We are therefore particularly concerned with the implementation of this requirement, and specifically with the determination of who may be considered a "consumer representative." Some confusion in resolving questions about consumer interest occurs at times from the use of such aphorisms as "everybody is a consumer," or "the consumer interest is synonymous with the pubic interest," or "anyone who is not a professional (in this case a health professional) is a consumer." Actually, a consumer as an individual may be a banker or an industrialist who might not be considered by informed consumers as their *representative*. Also, the public interest is a composite of the whole range of special interests—industry, services, professions, as well as consumers—which make up our society.

We therefore feel the need for some elaboration, either in legislative history or possibly in the statute, of the nature of consumer representation. The Public Health Service has undertaken some clarification in its draft "Information and Policies on Grants to States for Comprehensive State Health Planning under Section 314(a)" dated April 11, 1967. With respect to consumer representatives, the draft policies state:

"Although State or local public officials may be considered, most consumer representatives should be private citizens. No person whose major occupation is the administration of health activities or performance of health services can be considered as a consumer representative. This requirement also excludes as consumers all persons engaged in research or teaching in health fields. Its intent is best illustrated by several examples:

"1. A member of a voluntary health agency's board who is not in a health-related occupation would qualify as a consumer; an executive of such an agency would not.

"2. A president or other official of a labor union who has only general responsibility for health programs would qualify as a consumer; the director of the union's health and welfare program would not.

"3. An Urban League official or organizer who deals only generally with health concerns would qualify as a consumer; a League official with major responsibility for organizing for health services would not."

This statement will help political leaders and planning officials understand the intent of Congress that comprehensive health services planning be oriented to the consumer who is to be served. We are concerned, however, that the lines drawn may be too rigid and may in fact tend to insulate the consumer from the expert representation he so sorely needs. To exclude teachers and researchers in health fields may deprive the consumer of a representative who is exceptionally well qualified for the very reason that he views the health services system broadly rather than from the orientation of a provider of service or the administrator of an institution or a health agency. The "health program" of most unions consists of purchasing insurance for health benefits for a specific amount of money arrived at through collective bargaining and overseeing the operation

of the insurance program, including dealing with members' reactions as to the acceptability and effectiveness of the benefits provided. The director of such a program might be uniquely qualified to represent the consumer interest.

It is important to avoid the trap of equating consumer representation with ignorance of the health services field. Any planning body or advisory council depends heavily on its staff for information and analysis, but effective council members must have the capacity to assimilate and deal with the data and issues involved.

Former HEW Secretary Marion B. Folsom in the 1964 Michael M. Davis Lecture at the University of Chicago entitled "Responsibility of the Board Member of Voluntary Health Agencies" said: "While most of the administrative staff people are alert to these issues (overlapping and duplicated services, possibility of combining with other agencies in the same field, adjusting programs and services to meet changing needs), it is only natural that they be concerned primarily with their own agency. It is up to the board to exercise a broader, more objective, and more critical analysis of the agency's purposes and services." These comments are fully applicable to the members of planning advisory councils and their relation to staff.

On the whole, we believe the Public Health Service guidance regarding consumer representation should be more affirmative, rather than the rather negative draft of April 11. It would seem appropriate to identify types of clear consumer organizations such as labor unions, consumer cooperatives and other citizens' organizations as examples, and provide as a matter of policy that they have substantial representation on planning councils. It may or may not be feasible to specify other major segments of society which are not engaged in health services operations, because the problem of definition and balance immediately arises. In any event, it is most important that the criteria for council membership not make knowledge of health services operations a disqualification for consumer representatives.

With specific reference to HR 6418, GHAA supports the provisions of Section 5 which are designed to improve clinical laboratories by authorizing the Secretary of Health, Education and Welfare to regulate by licensing those laboratories that operate in interstate commerce. The Communicable Disease Center of the Public Health Service is now offering valuable assistance to group health plan, hospital, health department, and independent laboratories through technical consultation and, on request, through checking a laboratory's test results against carefully controlled standard methods. The proposed legislation would simply require all laboratories engaging in interstate commerce to meet the standards that well-run laboratories have established voluntarily for themselves today. The smaller group health plans are dependent on outside clinical laboratories for the more complicated tests that their members are entitled to under the provisions of the plan. They would therefore welcome regulations to assure that these laboratories meet the same high standards that the group health plan customarily imposes on its own work and facilities.

We recognize that the provisions of Section 5 have encountered considerable opposition. This opposition clearly stems from special interests and ignores the right of the consumer to laboratory tests that are consistent, performed under responsible supervision, and with established clinically sound procedures. We therefore urge the Committee to discount this opposition by acting favorably on the provisions of Section 5.

In conclusion, I should like to repeat that GHAA heartily endorses the comprehensive Health Planning Program, initiated by Public Law 89-749 and extended by HR 6418. We offer these specific comments and suggestions—not to weaken our support—but with the hope that the experience of GHAA and its member plans in promoting better health care, will be useful in the implementation of this important national program.

Sincerely yours,

W. PALMER DEARING, M.D.,
Executive Director.

NATIONAL CONSUMERS LEAGUE,
Washington, D.C., June 7, 1967.

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

DEAR MR. STAGGERS: The National Consumers League wishes to go on record in support of H.R. 6418, the Public Health Service Act Amendments of 1967. The League is particularly concerned with the provisions of Section 5 providing for the improvement of clinical laboratories by authorizing the Secretary of HEW to regulate through licensing those laboratories which operate in interstate commerce. The recent disclosures of the shocking unreliability of tests performed in a sizable proportion of United States laboratories points up the great need for the regulation provided by this bill. It is hardly necessary to cite further examples of the unnecessary human anguish, pain, and even death caused by incorrect laboratory diagnoses. Since regulation of this aspect of medical care has been so largely neglected by the states, the safety of the citizens of our nation demands immediate action by the Congress.

The League is also concerned that in its administration of the Comprehensive Health Planning and PHS Amendments of 1966 and of the provisions of H.R. 6418 when this is enacted, that the Public Health Service give appropriate emphasis to the public interest by providing for adequate consumer representation on advisory councils and planning bodies connected with this program. Comprehensive health services planning should be oriented to the needs of the consumers of the service. It would be highly desirable that your Committee spell out the intent of Congress with respect to the nature of consumer representation in this important national program.

The National Consumers League, therefore, urges that your Committee act favorably on H.R. 6418, and hasten its enactment into law. We respectfully request that this statement be included in the record of the hearings.

Sincerely yours,

SARAH H. NEWMAN,
General Secretary.

(Whereupon, at 4:40 p.m., the hearing was concluded.)

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