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COMPREHENSIVE HEALTH PLANNING AND REGIONAL MEDICAL PROGRAMS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

SECOND SESSION

ON

H.R. 15960

A BILL ENTITLED

"HEALTH SERVICES IMPROVEMENT ACT OF 1970"

(AND SIMILAR BILLS)

AND

H.R. 17570

A BILL ENTITLED

"HEART DISEASE, CANCER, STROKE, AND KIDNEY DISEASE AMENDMENTS OF 1970"

(AND SIMILAR BILLS)

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CONTENTS

	Page
Hearings held on—	
June 1, 1970	1
June 2, 1970	105
June 3, 1970	157
June 4, 1970	221
Text of—	
H.R. 14284	53
H.R. 14486	49
H.R. 15135	53
H.R. 15895	60
H.R. 15960	2
H.R. 16147	2
H.R. 16425	41
H.R. 16798	2
H.R. 17570	41
H.R. 17670	41
H.R. 17932	41
Report of—	
Bureau of the Budget on:	
H.R. 14284, H.R. 15895 and H.R. 15960	65
H.R. 16425	65
H.R. 17570	66
General Accounting Office, Office of the Comptroller General on H.R. 15960	66
Health, Education, and Welfare, Department on H.R. 15960	67
Housing and Urban Development Department on H.R. 15960	69
Office of Economic Opportunity on H.R. 15960	69
Statement by—	
Barrow, Dr. J. Gordon, director, Georgia Regional Medical Program, also representing the regional medical program directors	198
Biester, Hon. Edward G., Jr., a Representative in Congress from the State of Pennsylvania	105
Cannon, Dr. Bland, member, Council on Medical Education, American Medical Association	222
Danielson, John, director, Department of Teaching Hospitals and Health Services, Association of American Medical Colleges	228
Dotter, Dr. B. D., Okeene, Okla	198, 208
Duff, Dr. Ivan F., professor of medicine, University of Michigan Medical School	187
Egeberg, Dr. Roger O., Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare	70
Farber, Dr. Sidney, immediate past president, American Cancer Society	157
Gottlieb, Symond R., president-elect, Association of Areawide Health Planning Agencies	249
Hagan, Hon. G. Elliott, a Representative in Congress from the State of Georgia	236
Hampton, Dr. H. Phillip, Tampa, Fla	198, 206
Herndon, Dr. John F., vice president for medical affairs, National Cystic Fibrosis Research Foundation	163
Hiscock, William Mc., director, Association of Areawide Health Planning Agencies	249
January, Dr. Lewis E., former president, American Heart Association	226
Kimmey, Dr. James R., executive director, Community Health, Inc., New York, N.Y	176
Kuykendall, Hon. Dan, a Representative in Congress from the State of Tennessee	221

Statement by—Continued Page
Lentz, Edward A., president, Association of Areawide Health Planning Agencies 249
Letton, Dr. A. Hamblin, chairman, Medical and Scientific Committee, American Cancer Society 146
Lewis, Irving, Deputy Administrator, Health Services and Mental Health Administration, Department of Health, Education, and Welfare 70
Maxwell, Judge Stephen L., chairman, Regional Advisory Group, Northlands Regional Medical Program, Inc., St. Paul, Minn 198, 202
Merrill, Dr. John P., director, Cardiorenal Laboratory, Peter Bent Brigham Hospital, in behalf of the National Kidney Foundation 108, 118
Metts, Dr. James C., Jr., Savannah, Ga 236
Moscato, John, Acting Assistant Administrator for Legislation, Health Services and Mental Health Administration, Department of Health, Education, and Welfare 70
Moses, Dr. Campbell, medical director, American Heart Association 226
Murtaugh, Joseph S., director, Department of Planning and Policy Development, Association of American Medical Colleges 228
Najarian, Dr. John S., professor and chairman, Department of Surgery, College of Medical Sciences, University of Minnesota, in behalf of the National Kidney Foundation 108, 122
Parry, Dr. William, professor of urology and chairman, Department of Urology, University of Oklahoma, in behalf of the National Kidney Foundation 108
Peterson, Harry N., attorney, Legislative Department, American Medical Association 222
Robison, Hon. Howard W., a Representative in Congress from the State of New York 107
Ruhe, Dr. C. H. William, director, Division of Medical Education, American Medical Association 222
Sanazaro, Dr. Paul, Director, National Center for Health Services Research and Development, Department of Health, Education, and Welfare 70
Schlesinger, Richard, executive vice president, Community Health Information and Planning Service, Inc., Syracuse, N.Y., and also on behalf of American Public Health Association 141
Schreiner, Dr. George E., president, National Kidney Foundation, and professor of medicine, director of renal division, Georgetown University 108, 128
Shanholtz, Dr. Mack I., past president, Association of State and Territorial Health Officers 153
Sieverts, Steven, director, Association of Areawide Health Planning Agencies 249
Van Ness, Edward H., vice chairman, board of directors, American Academy of Comprehensive Health Planning 155
Additional material submitted for the record by—
American Hospital Association, Washington Service Bureau, Kenneth Williamson, deputy director, letter dated June 12, 1970, to Chairman Staggers 285
American Nurses' Association, Inc., Eileen M. Jacobi, R.N., Ed. D., executive director, letter dated June 9, 1970, to Chairman Jarman 287
American Optometric Association, statement 273
Comprehensive Health Planning Council of Western New York, Inc., Mitchell E. Roth, executive director, and John R. F. Ingall, M.D., director, Regional Medical Program of Western New York, letter dated April 15, 1970, to Chairman Staggers 289
DeBakey, Michael E., M.D., Baylor College of Medicine, Texas Medical Center, letter dated May 31, 1970, to Chairman Jarman 298
Duff, Dr. Ivan F., director, Regional Arthritis Control Program in Michigan, letter dated June 4, 1970, to Congressman Paul G. Rogers re estimate of what increase in manpower would be required to meet the challenge of the arthritis problem and its cost 194
Federation of American Hospitals, Sam A. Weems, statement 274
Health, Education, and Welfare Department:
Budget estimates—Fiscal years 1969–73 80
Need for technical amendment to section 314(e) to permit transfer of OEO projects 91
Population in areas receiving 314(b) planning grants 85

Additional material submitted for the record by—Continued Page
Health Insurance Association of America, statement 275
Kansas State Board of Health, Mrs. Norma Satten, coordinator, letter dated June 4, 1970, to Chairman Staggers 284
Lattimer, Dr. John K., professor and chairman, Department of Urology, Columbia University College of Physicians and Surgeons, statement 111
Memorial Hospital for Cancer and Allied Diseases, Edward J. Beattie, M.D., chief medical officer, letter dated June 11, 1970, to Chairman Jarman 293
Mid-Rio Grande Health Planning Council, Joe M. Henry, chairman, letter dated May 29, 1970, to Chairman Staggers 284
National Cystic Fibrosis Research Foundation:
Barbero, Giulio J., M.D., chairman, Department of Pediatrics, Hahnemann Medical College and Hospital, Philadelphia—Congressional testimony on pulmonary disease 174
Petty, Thomas L., M.D., F.C.C.P., associate professor of medicine, director, respiratory care unit, University of Colorado Medical Center, Denver, Colo.—statement entitled "We Need Programs for Chronic Airway Obstruction" 172
Waring, William W., M.D., chief, School of Medicine, Tulane University, New Orleans, La.—letter dated March 16, 1970, to Dr. John F. Herndon re discontinuance of the chronic respiratory diseases control program and the National Center for Chronic Disease Control 171
National Kidney Foundation, computer capabilities in organ retrieval and tissue typing 140
New York State Cancer Programs Association, Inc., George M. Saypol, M.D., president, letter dated June 3, 1970, to Chairman Jarman 288
Nobles, Lewis, president, Mississippi College, letter dated April 30, 1970, to Congressman Charles Griffin, with forwarding letter 296
Phillips, Harry T., M.D., director, Training Program for Health Planners, School of Public Health, University of North Carolina, letter dated June 9, 1970, to Chairman Jarman 300
Regional Medical Program Directors:
Examples of regional medical program activities that have a direct effect upon the availability of patient care, the quality of that care, and the cost of medical care in general 213
Letter dated July 17, 1970, from J. Gordon Barrow, M.D., director, Georgia Regional Medical Program, to Congressman Rogers re Public Health Service physicians serving in areas short of physician services 220b
Letter dated July 17, 1970, from J. Gordon Barrow, M.D., director, Georgia Regional Medical Program, to Congressman Kyros re reasons for opposing H.R. 15960 especially from the standpoint of its alleged capability of better coordinating various Federal health programs thereby lessening duplication and fragmentation 219
United Community Funds and Councils of America, Inc., William Aramony, executive vice president, letter date June 10, 1970, to Chairman Jarman 289
United Steelworkers of America, John J. Sheehan, legislative director, statement 278
Washington/Alaska Regional Medical Program, Donald R. Sparkman, M.D., director, letter dated April 10, 1970, to Congressman Paul G. Rogers 283

ORGANIZATIONS REPRESENTED AT HEARINGS

American Academy of Comprehensive Health Planning, Edward H. Van Ness, vice chairman, board of directors.
American Cancer Society:
Farber, Dr. Sidney, immediate past president.
Letton, Dr. A. Hamblin, chairman, Medical and Scientific Committee.
American Heart Association:
January, Dr. Lewis E., former president.
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ORGANIZATIONS REPRESENTED AT HEARINGS—Continued

American Medical Association:
- Cannon, Dr. Bland, member, Council on Medical Education.
- Peterson, Harry N., attorney, Legislative Department.
- Ruhe, Dr. C. H. William, director, Division of Medical Education.

American Public Health Association, Richard Schlesinger, chairman, Community Health Planning Section.

Association of American Medical Colleges:
- Danielson, John, director, Department of Teaching Hospitals and Health Services.
- Murtaugh, Joseph S., director, Department of Planning and Policy Development.

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- Gottlieb, Symond R., president-elect.
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- Sieverts, Steven, director.

Association of State and Territorial Health Officers, Dr. Mack I. Shanholtz, past president.

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Health, Education, and Welfare Department:
- Egeberg, Dr. Roger O., Assistant Secretary for Health and Scientific Affairs.
- Lewis, Irving, Deputy Administrator, Health Services and Mental Health Administration.
- Moscato, John, Acting Assistant Administrator for Legislation, Health Services and Mental Health Administration.
- Sanazaro, Dr. Paul, Director, National Center for Health Services Research and Development.

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National Kidney Foundation:
- Merrill, Dr. John P., director, Cardiorenal Laboratory, Peter Bent Brigham Hospital.
- Najarian, Dr. John S., professor and chairman, Department of Surgery, College of Medical Sciences, University of Minnesota.
- Parry, Dr. William, professor of urology and chairman, Department of Urology, University of Oklahoma.
- Schreiner, Dr. George E., president, National Kidney Foundation, and professor of medicine, director of renal division, Georgetown University.

Regional Medical Program Directors, Dr. J. Gordon Barrow, director, Georgia Regional Medical Program.

Syracuse (N.Y.) Community Health Information and Planning Service, Inc., Richard Schlesinger, executive vice president.

COMPREHENSIVE HEALTH PLANNING AND REGIONAL MEDICAL PROGRAMS

MONDAY, JUNE 1, 1970

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. John Jarman (chairman) presiding.

Mr. JARMAN. The subcommittee will please be in order.

The hearing today is on bills pending before the committee to extend and modify title IX of the Public Health Act, generally known as Regional Medical Programs and section 314 of the Public Health Services Act authorizing comprehensive health planning and formula and project grants to the States for health services.

The administration has proposed legislation H.R. 15960, which would integrate these two programs as well as the National Center for Health Services, Research, and Development, by placing them in a single title in the Public Health Service Act, giving them a common statement of purpose, a single advisory council, and a single annual report.

The purpose of these hearings will be to explore the alternative proposals for extending and improving these programs, each of which expires June 30, 1970.

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

(The bills and reports referred to follow:)

[H.R. 15960, H.R. 16147, and H.R. 16798, 91st Cong., 2d sess., introduced by Mr. Staggers (for himself and Mr. Springer) on February 17, 1970; Mr. Robison on February 24, 1970; and Mr. Patten on April 7, 1970, respectively, are identical as follows:]

A BILL

To amend and improve the Public Health Service Act to aid in the development of integrated, effective, consumer-oriented health care systems by extending and improving regional medical programs, supporting comprehensive planning of public health services and health services development on a State and areawide level, promoting research and demonstrations relating to health care delivery, encouraging experimentation in the development of cooperative local, State, or regional health care delivery systems, enlarging the scope of the National Health Survey, facilitating the development of comparable health information and statistics at the Federal, State, and local levels, 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 "Health Services Improvement Act of 1970".

AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 2. Title IX of the Public Health Service Act is amended to read as follows:

"TITLE IX—PLANNING, ORGANIZATION AND DELIVERY OF HEALTH SERVICES

"FINDINGS AND PURPOSES

"SEC. 900. (a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful family and individual living; that attainment of this goal depends on an effective partnership among those who provide health and medical care and services, government at all levels, and the consumers of health services; that Federal assistance must be directed to support cooperative efforts aimed at the organization and development of improved systems for the delivery of health care and services of high quality for every person; that the leadership and capacities of those involved in these cooperative efforts must be strengthened; that support of community health services should be continued and strengthened; that these ends should be accomplished through support and encouragement of evolving, innovative patterns, and forms of providing pre-

ventive, diagnostic, therapeutic, and rehabilitative services; that Federal assistance should support cooperative efforts for the organization, development, or establishment of more efficient and effective systems for the delivery of health services, that support of regional and areawide health services programs and comprehensive health planning should be continued; and that support should be given to innovative patterns and methods for delivery of health care services.

"(b) The Congress further declares that in the fulfillment of such general purpose, the purposes of this title are:

"(1) to encourage and assist in the establishment and support of regional medical programs providing regional cooperative arrangements among public or nonprofit private institutions or agencies for improving the quality, distribution, and efficiency of preventive, diagnostic, therapeutic, and rehabilitative services;

"(2) to encourage and assist in the establishment and support of comprehensive health planning agencies at the State and areawide levels which, with involvement of consumers of health services, will examine the relationship between health needs and the distribution and utilization of health resources, and assist in the training of health planners and the development of planning methodologies;

"(3) promote the establishment of more efficient and effective health service systems, assure the coordination of health services programs under this and other titles of this Act with related activities authorized under the Social Security Act and other Federal health programs, as well as with other health related programs and activities, and with particular attention to the relationship between improved organization and delivery of health services and the financing thereof;

"(4) to assist in the support of State programs of public health services, the initial support of new health services, and the support of health services meeting particular needs;

"(5) to provide support for research and development (including demonstrations and training) related to improving the organization, financing, and delivery of health services; and

"(6) to provide support for experiments and demonstrations in the integration and coordination of the programs authorized by this title, and appropriate related programs, leading to the development of improved health systems extending high quality health care to all, improving efficiency in the use of resources, and promoting the effective interrelationship of assistance provided by Federal health programs.

"NATIONAL ADVISORY COUNCIL ON THE PLANNING, ORGANIZATION, AND DELIVERY OF HEALTH SERVICES

"SEC. 901. (a) There is hereby established a National Advisory Council on the Planning, Organization, and Delivery of Health Services, consisting of the Secretary, who shall be Chairman, and twenty-four members, not otherwise in the regular full-time employ of the United States, appointed by the Secretary without regard to the civil service laws. The twenty-four members shall be selected from among persons who are leaders in the fields of the fundamental sciences, the medical sciences, or the organization, delivery, and financing of health care, who are State or local officials, or who are active in consumer affairs, or public or community affairs, or who are representatives of minority groups.

"(b) The Council shall advise and assist the Secretary in the preparation of general regulations to carry out the purposes of this title and on policy matters arising in the administration of this title, including the coordination of programs thereunder with programs authorized under other parts of this Act or under the Social Security Act and other Federal or federally assisted health programs, with particular attention to the relationship between the improved organization and delivery of health services and the financing of such services; and shall, in carrying out such functions, review, not less often than annually, the grants made under

this title to determine their effectiveness in carrying out its purposes.

"(c) The Secretary shall make appropriate provision for consultation between and coordination of the work of the Council, the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, the Medical Assistance Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this title and the coordination of programs under this title with related Federal health programs.

"(d) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, six at the end of the first year, six at the end of the second year, six at the end of the third year, and six at the end of the fourth year after the date of appointment. No member may be reappointed unless at least one year has elapsed since the end of his last full term.

"(e) Members of the Council, who are not in the regular full-time employ of the United States, while attending

meetings of the Council or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS–18 in section 5332 of title 5, United States Code, including travel-time, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 5703 (b)) for persons in the Government service employed intermittently.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 902. (a) There are authorized to be appropriated for the fiscal year ending June 30, 1971, and for each of the next two fiscal years, such sums as may be necessary for grants and contracts under part A of this title. Sums so appropriated for any fiscal year shall remain available for making such grants until the end of the fiscal year following the fiscal year for which the appropriation is made.

"(b) There are authorized to be appropriated for the fiscal year ending June 30, 1971, and for each of the next two fiscal years, such sums as may be necessary, for grants and contracts under part B of this title.

"(c) There are authorized to be appropriated for the fiscal year ending June 30, 1971, and for each of the next

two fiscal years, such sums as may be necessary to carry out the other provisions of this title, including grants to public or nonprofit private agencies and organizations, and contracts with public or private agencies, and technical assistance with respect to cooperative planning and experimentation related to organizing and developing health care systems, including planning for the manpower, services, and facilities necessary therefor, and promotion of effective combination or coordination of public and private methods and systems for the delivery of health services at regional, State, and local levels, including the integration of regional medical programs and comprehensive health planning activities authorized under this title.

"PART A—REGIONAL MEDICAL PROGRAMS

"DEFINITIONS

"SEC. 911. For the purposes of this part—

"(1) The term 'regional medical program' means a cooperative arrangement among a group of public or nonprofit institutions or agencies (i) engaged in planning, research, training, prevention, diagnosis treatment, and rehabilitation relating to such one or more diseases and impairments of man as may be required by regulations and, at the option of the applicant, such other diseases and impairments of man as may be permitted in such regulations, and (ii) engaged in, in appropriate cases (as determined under regulations),

developing and demonstrating systems for organizing and delivering medical care; but only if such group—

"(A) is situated within a geographic area, composed of any part or parts of any one or more States, which the Secretary determines, in accordance with regulations, to be appropriate in carrying out the purposes of this part;

"(B) consists of one or more medical centers, one or more clinical research centers, and one or more hospitals; and

"(C) has in effect cooperative arrangements among its component units which the Secretary finds will be adequate for effectively carrying out the purposes of this part.

"(2) The term 'medical center' means a medical school or other medical institution involved in postgraduate medical training and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes.

"(3) The term 'clinical research center' means an institution (or part of an institution) the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high-quality diagnostic and treatment services for inpatients and outpatients.

"(4) The term 'hospital' means a hospital as defined in section 625(c) or other health facility in which local capability for diagnosis and treatment is supported and augmented by the program established under this part.

"(5) The term 'construction' means alteration, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

"GRANTS FOR PLANNING

"SEC. 912. (a) The Secretary, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist them in planning the development of regional medical programs.

"(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such application for a planning grant may be approved only if it meets the requirements of section 914 and contains or is supported by a satisfactory showing that the applicant has designated an advisory group, to advise the applicant (and the institutions and the agencies participating in the resulting regional medical program) in formulating and carrying out

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the plan for the establishment and operation of such regional medical program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, State or local public or nonprofit private health agencies, health planning agencies established pursuant to section 922, representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program, including the financing or evaluation of such activities, and representatives of consumers of health services (including the poor and minority groups) familiar with the community's needs with respect to the services provided under the program.

"GRANTS FOR ESTABLISHMENT AND OPERATION

"SEC. 913. (a) The Secretary, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist in the establishment and operation of regional medical programs, including construction and equipment of facilities in connection therewith and including training and continuing education.

"(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such

application may be approved only if it is recommended by the advisory group described in section 912(b), meets the requirements of section 914, and contains or is supported by reasonable assurance that—

"(1) satisfactory efforts will be undertaken by the applicant to obtain financing from non-Federal sources, and from Federal sources providing reimbursement for medical care for eligible beneficiaries, to support the program after such period of initial support under this section as may be prescribed by regulations; and

"(2) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"GENERAL CONDITIONS OF GRANTS

"SEC. 914. Grants may not be made under this part unless the applicant also gives reasonable assurance that—

"(1) Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) in the case of an application under section 913, will not supplant funds that are otherwise available for establishment or operation of the regional medical program with respect to which the grant is made;

"(2) the applicant will provide for such fiscal control and fund accounting procedures as are required by the Secretary to assure proper disbursement of and accounting for such Federal funds;

"(3) the applicant will make such reports, in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

"(4) reasonable opportunity has been provided, prior to submission of the application, for review and comment by the appropriate State health planning agency or agencies designated pursuant to section 921 of this title, and by the agency or agencies conducting the comprehensive regional, metropolitan, or other area planning referred to in section 922 of this title or, if there

is no such agency in the area where the project is to be located, such other public or nonprofit private agency or organization performing similar planning functions as may be determined in accordance with criteria prescribed by the Secretary.

"INFORMATION ON SPECIAL TREATMENT AND TRAINING RESOURCES

"SEC. 915. The Secretary shall provide, either directly or through grants or contracts, for the establishment, and maintenance on a current basis, or (1) a list or lists of facilities in the United States equipped and staffed to provide advanced methods and techniques in the prevention, diagnosis, and treatment, of such diseases and impairments of man as may be prescribed by the Secretary for the purposes of this section, and in the rehabilitation of persons suffering from such diseases and impairments, and (2) such related information as trends in equipment, staffing, and services and the distribution of various types of such facilities in the United States, and (3) the availability of advanced specialty training in such facilities.

"PROJECT GRANTS FOR MULTIPROGRAM SERVICES AND CONTRACTS FOR CLINICAL AND FIELD STUDIES

"SEC. 916. Funds appropriated to carry out this part shall also be available for (a) grants to any public or nonprofit private agency or institution for services needed by, or

which will be of substantial use to, any two or more regional medical programs, and (b) contracts with public or private agencies and institutions for the conduct of cooperative clinical and field studies and demonstrations of systems for organizing and delivering medical care and of other activities for which support is authorized pursuant to this part.

"PART B—COMPREHENSIVE STATE AND AREAWIDE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

"GRANTS FOR COMPREHENSIVE STATE HEALTH PLANNING

"State Plans

"SEC. 921. (a) In order to be approved for purposes of assistance under this section, a State plan for comprehensive State health planning must—

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

"(2) provide for a State health planning advisory council which shall include representatives of State and local agencies, and public and private agencies and organizations concerned with health and with the financing of health services (including representation of the regional medical program or programs within the

State established pursuant to part A of this title), and of consumers of health services, and with one member being a representative of the regional medical programs and with a majority of the membership of such council consisting of representatives of consumers of health services (including an appropriate number of representatives of poor and minority groups as determined in accordance with regulations promulgated by the Secretary);

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

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

"(5) contain or be supported by assurances satisfactory to the Secretary that the funds paid under this subsection will be used to supplement and, to the extent

practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

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

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

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

"(9) (A) 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 established by the Secretary after consultation with the States which 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;

"(B) provide that the State agency furnishing such assistance will periodically review the program (developed pursuant to clause (A)) of each health care facility in the State and recommended appropriate modification thereof; and

"(C) provide that in carrying out its functions under this subsection, such State agency shall, in each case, consult with the agency or organization which has developed the applicable comprehensive regional, metropolitan, or other area plan referred to in section 922 of this part, or, where there is no such agency, such other public or nonprofit private agency performing similar planning functions (as determined in accordance with criteria prescribed by the Secretary);

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

"(11) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this section.

"State Allotments

"(b) (1) From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year to carry out the purposes of this section.

"(2) The amount of any allotment to a State under paragraph (1) for any fiscal year which the Secretary determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallotment by the Secretary from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under paragraph (1) for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly

reallotted among the States whose proportionate amounts were not so reduced. Any amount so reallotted to a State from funds appropriated pursuant to this section for a fiscal year shall be deemed part of its allotment under paragraph (1) such fiscal year.

"Payments to States

"(c) From each State's allotment for a fiscal year under this section, the State shall from time to time be paid the Federal share of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this section. Such payments shall be made on the basis of estimates by the Secretary of the sums the State will need in order to perform the planning under its approved State plan under this section, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The 'Federal share' for any State for purposes of this section shall be such percentage as the Secretary may determine, except that it shall in no event exceed 75 per centum.

"PROJECT GRANTS FOR AREAWIDE HEALTH PLANNING

"SEC. 922. (a) The Secretary is authorized—

"(1) to make, with the approval of the State comprehensive health planning agency administering or supervising the administration of the State plan approved under section 921(a), project grants to any other pub-

lic or nonprofit private agency or organization to cover the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for the provision, financing, and coordination of existing and planned health services, including the facilities and persons required for the provision of such services;

"(2) to make project grants to such a State comprehensive health planning agency for provision of assistance in the development (and revision from time to time) of comprehensive plans described in clause (1) with respect to any area or areas of the State with respect to which grants have not been made under paragraph (1).

No such grant for any project may exceed 75 per centum of the cost thereof.

"(b) In order to be approved for purposes of this section, an application must include or be accompanied by assurances that there has been or will be established, an areawide health planning council, to advise the recipient of the grant in carrying out the project referred to in subsection (a), which shall include representatives of public and private agencies and organizations concerned with health and with the financing of health services (including representa-

tion of the interests of local government where the recipient of the grant is not a local government or combination thereof or any agency of such government or combination, and of any regional medical program carrying out activities within the area and established pursuant to part A of this title), and of consumers of health services, and with one member being a representative of the regional medical programs and with a majority of the membership of such council consisting of representatives of consumers of health services (including an appropriate number of representatives of poor and minority groups as determined in accordance with regulations).

"PROJECT GRANTS AND CONTRACTS FOR TRAINING, STUDIES, AND DEMONSTRATIONS

"SEC. 923. The Secretary is also authorized to make grants to any public or nonprofit private agency, institution, or other organization, or to enter into contracts with public or private agencies, institutions, organizations, or individuals, to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation.

"GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

"Availability of Appropriations

"SEC. 924. (a) Sums appropriated to carry out the purposes of this section shall be available for making payments

to States which have submitted, and had approved by the Secretary, State plans for provision of public health services.

"State Plans for Provision of Public Health Services

"(b) In order to be approved under this section, a State plan for provision of public health services must—

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

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

"(3) indicate the relationship of the activities included in the plan to the total health program of the State, including health activities which are the responsibility of State agencies other than the State health and mental health authorities and including programs concerned with the financing of medical care;

"(4) contain or be supported by assurances satisfactory to the Secretary that (A) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions in order to improve the health of the people; (B) such funds will be made available to other public or nonprofit

private agencies, institutions, and organizations, in accordance with criteria which the Secretary determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; and (C) such funds will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds;

"(5) provide for the furnishing of public health services in accordance with such plans as have been developed pursuant to section 921 of this part;

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

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

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

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

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

"(11) be approved by the State agency administering or supervising the administration of the State plan approved under section 921 if the Governor certifies such agency is ready to perform such function; and

"(12) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this section.

"State Allotments and Payments

"(c) (1) From the sums appropriated to carry out the provisions of this section the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States, except that no State's allotment shall be less for any year than the total amounts allotted to such State under formula grants for cancer control, plus other allotments under section 314, for the fiscal year ending June 30, 1967.

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

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

46-566 O - 70 - 3

"Federal Share

"(d) The 'Federal share' for any State for purposes of this section shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than 33⅓ per centum or more than 66⅔ per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, America Samoa, the Trust Territory of the Pacific Islands, and the Virgin Islands shall be 66⅔ per centum.

"Determination of Federal Shares

"(e) The Federal shares shall be determined by the Secretary between July 1 and September 30 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on the next July 1. The populations of the several States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

"Allocation of Funds Within the States

"(f) At least 15 per centum of a State's allotment under this section shall be available only to the State mental health

authority for the provision under the State plan of mental health services. At least 70 per centum of such amount reserved for mental health services and at least 70 per centum of the remainder of a State's allotment under this section shall be available only for the provision under the State plan of services in communities of the State.

"PROJECT GRANTS FOR HEALTH SERVICES DEVELOPMENT

"SEC. 925. The Secretary is authorized to make grants to any public or nonprofit private agency, institution, or organization to cover part of the cost (including amortization of loans on facilities) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Such grants may be made only if the application therefor contains (A) satisfactory evidence that reasonable opportunity has been provided, prior to submission of the application, for review and comment with respect to the application by the agency conducting the comprehensive regional, metropolitan, or other area planning referred to in section 922 or, if there is no such agency in the area where the project is to be located, such other public or nonprofit private agency or organization performing similar planning functions as determined in accordance with criteria prescribed by the Secretary; and

(B) reasonable assurance that efforts will be undertaken by the applicant for a project grant described in clause (2) of the preceding sentence to obtain financing from non-Federal sources, and from Federal sources providing reimbursement for medical care for eligible beneficiaries, to support the project after such period of initial support under this section as may be prescribed by regulations.

"WITHHOLDING OF PAYMENTS

"SEC. 926. Whenever the Secretary after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of a State or a State health planning agency designated or established pursuant to paragraph (1) of subsection (a) of section 921, finds that, with respect to money paid to the State out of appropriations under section 921 or 924, there is a failure to comply substantially with either—

"(1) the applicable provisions of this part;

"(2) the State plan submitted under such section; or

"(3) applicable regulations under this part;

the Secretary shall notify such State health authority, mental health authority, or health planning agency, as the case may be, that further payments will not be made to the State from appropriations under such section (or in his discretion that further payments will not be made to the State from such

appropriations for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Secretary shall make no payment to such State from appropriations under such section, or shall limit payment to activities in which there is no such failure.

"PART C—HEALTH FACILITIES AND SERVICES RESEARCH AND DEMONSTRATION

"GRANTS AND CONTRACTS FOR RESEARCH, EXPERIMENTS, DEMONSTRATION AND TRAINING

"SEC. 931. 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, facilities for long-term care, 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

963), agencies, institutions, or organizations or to the 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, facilities for long-term care, 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, and

"(C) projects for research and demonstration in new careers in health manpower and new ways of educating and utilizing health manpower.

"FEDERAL PARTICIPATION

"SEC. 932. Except where the Secretary determines that unusual circumstances make a larger percentage necessary in order to effectuate the purposes of this part, a grant or contract under section 931 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 a 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.

"PAYMENTS

"SEC. 933. Payments of any grants or under any contracts under this part 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 part.

"PART D—GENERAL

"DEFINITIONS

"SEC. 941. For purposes of this title—

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

"(2) The term 'Council' means the National Advisory Council on the Planning, Organization, and Delivery of

Health Services established pursuant to section 901, unless the context otherwise requires.

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

"GRANTS OF EQUIPMENT, SUPPLIES, AND SERVICES

"SEC. 942. The Secretary, at the request of any recipient of a grant or contract under this title, may reduce the payments of such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the State plan or the project with respect to which the grant or contract under this title is made. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Secretary, but shall, for purposes of determining the Federal share under section 921 or 924 be deemed to have been paid to the State.

"JOINT FUNDING

"SEC. 943. (a) Pursuant to regulations prescribed by the Secretary, where funds are advanced for a single project pursuant to the authority of more than one statute administered by the Department of Health, Education, and Welfare, any one administrative unit within the Department may be designated to act for all in administering the funds advanced. In such cases, a single non-Federal share or participation requirement may be established according to the proportion of funds advanced under each authorization and any such administrative unit may waive any technical grant or contract requirement (as defined by such regulations) which is inconsistent with the similar requirements of the administering unit or which such unit does not impose.

"(b) Pursuant to regulations prescribed by the President, where funds are advanced for a single project by more than one Federal agency to an agency or organization assisted under this title, any one Federal agency may be designated to act for all in administering the funds advanced. In such cases, a single non-Federal share requirement may be established according to the proportion of funds advanced by each Federal agency, and any such agency may waive any technical grant or contract requirement (as defined by such regulations) which is inconsistent with the similar require-

ments of the administering agency or which the administering agency does not impose.

"TRANSFER OF FUNDS

"SEC. 944. Notwithstanding any limitation on appropriations for any program or activity under this title, not to exceed 10 per centum of the amount appropriated to carry out any such program or activity, other than amounts appropriated to carry out section 921 or 924, may be transferred and used by the Secretary for the purpose of carrying out any other such program or activity under this title other than activities under such section 921 or 924, but no such transfer may result in increasing the amounts otherwise available for carrying out programs or activities under any section of this title by more than 10 per centum.

"ANNUAL REPORT

"SEC. 945. On or before January 1 of each year, the Secretary, after consultation with the Council, shall transmit to the Congress a report of the activities under this title together with (1) an evaluation of the effectiveness of these activities in improving the efficiency and effectiveness of the delivery of health services and in carrying out the other purposes of this title, (2) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, including

efforts by the grantees to develop alternate sources of financing after an initial period of support, and (3) such recommendations with respect to modifications of this title as he deems appropriate.

"REGULATIONS

"SEC. 946. The Secretary may, after consultation with the Council, prescribe regulations relating to the general administration of this title and the terms and conditions for approving applications for assistance thereunder, and relating to methods for the coordination of programs assisted under this title with other Federal or federally assisted health programs.

"RECORDS AND AUDIT

"SEC. 947. (a) Each recipient of a grant under this title (other than section 921 or 924) shall keep such records as the Secretary may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

"(b) The Secretary 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 recipient of any such grant which are pertinent thereto.

"(c) In carrying out their functions under this section, the Secretary and the Comptroller General shall take such steps as are reasonably necessary to protect the integrity of the doctor-patient relationship and the confidentiality of information disclosed during the course thereof."

COOPERATIVE SYSTEM OF HEALTH INFORMATION AND STATISTICS

SEC. 3. (a) (1) Clause (1) of subsection (a) of section 305 of the Public Health Service Act is amended by striking out "and" before "(E)", and by inserting after the semicolon at the end of such clause: "(F) health care resources; (G) environmental and social health hazards; and (H) family formation, growth, and dissolution;".

(2) Such subsection is further amended by adding at the end thereof the following new sentence: "No disclosure of any information obtained in accordance with this paragraph may be used for any purpose other than the statistical purposes for which it was supplied except pursuant to regulations of the Secretary; nor may any such information be published if the particular establishment or person supplying it is identifiable except with the consent of such establishment or person."

(b) Section 305 is further amended by redesignating

subsections (b), (c), and (d) as subsections (c), (d), and (e), respectively, and by adding after subsection (a) the following new subsection:

"(b) The Secretary is authorized, directly or by contract, to undertake research, development, demonstration, and evaluation, relating to the design and implementation of a cooperative system for producing comparable and uniform health information and statistics at the Federal, State, and local levels."

SEC. 4. (a) Section 314 of the Public Health Service Act is amended by striking out subsections (a), (b), (c), (d), (e), and (g).

(b) Such Act is further amended by—

(1) striking out "(f)" at the beginning of that subsection of section 314 and inserting in lieu thereof "SEC. 314.";

(2) by redesignating paragraphs (1) through (9) of that subsection, and references thereto, as subsections (a) through (i), respectively, of section 314;

(3) by redesignating subparagraphs (A) through (D) in the paragraph herein redesignated as subsection (c), and references thereto, as paragraphs (1) through (4), respectively;

(4) by redesignating clauses (i) through (iv) in the subparagraph herein redesignated as paragraph (3)

of subsection (c), and references thereto, and as subparagraphs (A) through (D), respectively;

(5) by redesignating subparagraphs (A) and (B) of the paragraph herein redesignated as subsection (g), and references thereto, as paragraphs (1) and (2), respectively;

(6) by redesignating clauses (I) and (II) of the subparagraph herein redesignated as subparagraph (D) of subsection (c) of section 314, and references thereto, as clauses (i) and (ii), respectively, of such subparagraph (D).

(c) Section 304 of such Act is repealed.

EFFECTIVE DATE

SEC. 5. The amendments and repeals effected by sections 2 and 4 shall apply with respect to allotments or grants made from appropriations for any fiscal year beginning after June 30, 1970 and contracts entered into after such date.

[H.R. 17570, H.R. 16425, H.R. 17670, and H.R. 17932, 91st Cong., 2d sess., introduced by Mr. Jarman on May 11, 1970; Mr. Madden on March 11, 1970; Mr. Kuykendall on May 18, 1970; and Mr. Hechler on June 4, 1970, respectively, are identical as follows:]

A BILL

To amend title IX of the Public Health Service Act so as to extend and improve the existing program relating to education, research, training, and demonstrations in the fields of heart disease, cancer, stroke, and other major diseases and conditions, 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 "Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970".

SEC. 2. (a) Section 900 (a) of the Public Health Service Act is amended—

(1) by inserting "and contracts" immediately after "grants";

(2) by striking out "related demonstrations" and inserting in lieu thereof "demonstrations";

(3) by striking out "related diseases" and inserting in lieu thereof "kidney disease, and other major diseases and conditions".

(b) Section 900(b) of such Act is amended by striking out "diagnosis and treatment" and inserting in lieu thereof prevention, diagnosis, treatment, and rehabilitation".

(c) Section 900 of such Act is further amended by—

(1) striking out "and" at the end of subsection (b) thereof;

(2) redesignating subsection (c) thereof as subsection (d); and

(3) inserting after subsection (b) thereof a new subsection (c) which reads as follows:

"(c) to promote and foster regional linkages among health care institutions and providers so as to strengthen and improve primary care and the relationship between specialized and primary care; and".

(d) Section 900(d) of such Act (as redesignated by subsection (c)(2) of this section) is amended by striking out "the health manpower and facilities to the Nation" and inserting in lieu thereof "the quality and enhance the ca-

pacity of the health manpower and facilities available to the Nation and to improve health services for persons residing in areas with limited health services".

SEC. 3. (a) (1) The first sentence of section 901 (a) of such Act is amended by striking out "and $120,000,000 for the next fiscal year, for grants" and inserting in lieu thereof "$120,000,000 for the fiscal year ending June 30, 1970, $150,000,000 for the fiscal year ending June 30, 1971, $200,000,000 for the fiscal year ending June 30, 1972, $250,000,000 for the fiscal year ending June 30, 1973, and for each of the next two fiscal years, for grants".

(2) The second sentence of section 901 (a) of such Act is amended to read as follows: "Of the sums appropriated under this section for the fiscal year ending June 30, 1971, not more than $15,000,000 shall be available for activities in the field of kidney disease."

(b) Section 901 (a) of such Act is amended by striking out the period after "title" and inserting "and for contracts to otherwise carry out the purposes of this title".

(c) Section 901 of such Act is further amended by adding at the end thereof the following new subsection:

"(e) At the request of any recipient of a grant under this title, the payments to such recipient may be reduced by the fair market value of any equipment, supplies, or services furnished to such recipient and by the amount of the

46-566 O - 70 - 4

pay, allowance, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the regional medical program to which the grant or contract under this title is made."

SEC. 4. Section 902 (a) of such Act is amended by striking out "training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and at the option of the applicant, related disease or diseases" and inserting in lieu thereof "training, prevention, diagnosis, treatment, and rehabilitation relating to heart disease, cancer, stroke, or kidney disease, and, at the option of the applicant, other major diseases or conditions".

SEC. 5. Section 902 (f) is amended by inserting between the words "includes" and "alteration" "new construction of facilities for demonstrations, research, and training when necessary to carry out regional medical programs,"

SEC. 6. Section 903 (b) (4) of such Act is amended—

(1) by striking out "voluntary health agencies, and" and inserting in lieu thereof "voluntary health agencies, official health and planning agencies, and"; and

(2) by striking out "need for the services provided

under the program" and inserting in lieu thereof "need for and financing of the services provided under the program, and which advisory group shall be sufficient in number to insure adequate community orientation".

SEC. 7. That part of the second sentence of section 904 (b) of the Public Health Service Act preceding paragraph (1) is amended by striking out "section 903 (b) (4) and" and inserting in lieu thereof the following: "section 903 (b) (4), if opportunity has been provided, prior to such recommendation, for consideration of the application by each public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314 (b) covering any area in which the regional medical program for which the application is made will be located, and if the application".

SEC. 8. Section 905 (a) of such Act is amended—

(1) by striking out "The Surgeon General, with the approval of the Secretary," and inserting in lieu thereof "Secretary";

(2) by striking out "the Surgeon General" and inserting in lieu thereof "the Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs";

(3) by inserting "health care administration," immediately after "the medical sciences,";

(4) by striking out 'study, diagnosis, or treatment of cancer" and inserting in lieu thereof "study or care of cancer"; and

(5) by striking out "and one shall be outstanding in the study, diagnosis, or treatment of stroke" and inserting in lieu thereof "one shall be outstanding in the study or care of stroke, one shall be outstanding in the study or care of kidney disease, and three shall be members of the public".

SEC. 9. Section 907 of such Act is amended by striking out "or stroke," and inserting in lieu thereof "stroke, or kidney disease,".

SEC. 10. Section 909(a) of such Act is amended by inserting "or contract" after "grant", each place it appears therein.

SEC. 11. (a) Section 910 of such Act is amended to read as follows:

"SEC. 910. (a) To facilitate interregional cooperation, and develop improved national capability for delivery of health services, the Secretary is authorized to utilize funds appropriated under this title to make grants to public or nonprofit private agencies or institutions or combinations thereof and to contract for—

"(1) programs, services, and activities of substantial use to two or more regional medical programs;

"(2) development, trial, or demonstration of methods for control of heart disease, cancer, stroke, kidney disease, or other major disease and conditions;

"(3) the collection and study of epidemiologic data related to any of the diseases and conditions referred to in paragraph (2);

"(4) development of training specifically related to the prevention, diagnosis, or treatment of any of the diseases or conditions referred to in paragraph (2), or to the rehabilitation of persons suffering from any of such diseases or conditions; and for continuing programs of such training where shortage of trained personnel would otherwise limit application of knowledge and skills important to the control of any of such diseases or conditions; and

"(5) the conduct of cooperative clinical field trials.

"(b) The Secretary is authorized to assist in meeting the costs of special projects for improving, and developing new means for the delivery of health services concerned with the diseases and conditions with which this title is concerned.

"(c) The Secretary is authorized to support research, studies, investigations, training, and demonstrations designed to maximize the utilization of manpower in the delivery of health services."

(d) The heading to section 910 of such Act is amended to read as follows:

"MULTIPROGRAM SERVICES".

SEC. 12. The heading to title IX of such Act is amended by striking out "STROKE, AND RELATED DISEASES" and inserting in lieu thereof "STROKE, KIDNEY DISEASE, AND OTHER MAJOR DISEASES AND CONDITIONS".

SEC. 13. Sections 902(a), 903(a), 903(b), 904(a), 904(b), 905(b), 905(c), 906, 907, and 909(a) (as amended by the preceding provisions of this Act) are each further amended by striking out "Surgeon General", each place it appears therein, and inserting in lieu thereof "Secretary".

[H.R. 14486, 91st Cong., 1st sess., introduced by Mr. Rogers of Florida on October 23, 1969]

A BILL

To amend title IX of the Public Health Service Act to extend the regional medical health program through fiscal year 1973, to broaden the scope of program to include all major diseases, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 901 (a) of the Public Health Service Act (42 U.S.C. 299a (a)) is amended by striking out "and $120,000,000, for the next fiscal year" and inserting in lieu thereof "$120,000,000 for the fiscal year ending June 30, 1970, $150,000,000 for the fiscal year ending June 30, 1971, $200,000,000 for the fiscal year ending June 30, 1972, and $250,000,000 for the fiscal year ending June 30, 1973".

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SEC. 2. (a) Section 900 (a) of the Public Health Service Act (42 U.S.C. 299 (a)) is amended by striking out "related diseases" and inserting in lieu thereof "other major diseases".

(b) Section 902 (a) of such Act (42 U.S.C. 299b (a)) is amended by striking out "related disease or diseases" and inserting in lieu thereof "any other major disease or diseases".

(c) The heading for title IX of such Act is amended by striking out "AND RELATED DISEASES" and inserting in lieu thereof "AND OTHER MAJOR DISEASES".

SEC. 3. Section 904 of the Public Health Service Act (42 U.S.C. 299d) is amended by adding at the end thereof the following new subsection:

"(c) The Secretary, at the request of any recipient of a grant under this section, may reduce the payments under such grant to such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs incurred in connection with the detail of an officer or employee of the Department of Health, Education, and Welfare to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the regional medical program with respect to which the grant under this section is made. The amount by which such

payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Secretary, but for purposes of section 901 (b) shall be deemed to have been paid to the State."

SEC. 4. That part of the second sentence of section 904 (b) of the Public Health Service Act (42 U.S.C. 299d (b)) preceding paragraph (1) is amended by striking out "section 903 (b) (4) and" and inserting in lieu thereof the following: "section 903 (b) (4), if opportunity has been provided, prior to such recommendation, for consideration of the application by each public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314 (b) covering any area in which the regional medical program for which the application is made will be located, and if the application".

SEC. 5. Section 900 (b) of the Public Health Service Act is amended by striking out "diagnosis and treatment of these diseases" and inserting in lieu thereof "diagnosis, treatment, and prevention of these diseases and in the rehabilitation of persons with these diseases".

SEC. 6. Section 903 (b) (4) of the Public Health Service Act (42 U.S.C. 299c (b)) is amended by striking out "voluntary health agencies" and inserting in lieu thereof

"voluntary and State and local health and health planning agencies".

SEC. 7. (a) The second sentence of section 905 (a) of the Public Health Service Act (42 U.S.C. 299e (a)) is amended by striking out "or public affairs" and inserting in lieu thereof "health care administration, or community or other public affairs".

(b) Such section 905 (a) is amended by adding at the end thereof the following new sentence: "The Council shall also be representative of persons outstanding in the study, diagnosis, or treatment of the other major diseases."

SEC. 8. Title IX of the Public Health Service Act (other than section 908 thereof) is amended by striking out "Surgeon General" each place it appears in that title and inserting in each such place "Secretary".

[H.R. 14284 and H.R. 15135, 91st Cong., 1st sess., introduced by Mr. Staggers on October 9, 1969, and Mr. Cramer on December 8, 1969, respectively, are identical as follows:]

A BILL

To amend the Public Health Service Act to extend for three years the program relating to heart diseases, cancer, stroke, and related diseases; to authorize training and clinical demonstration programs for related chronic diseases; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. (a) The first sentence of section 901 (a) of the Public Health Service Act (42 U.S.C. 299a (a)) is amended by striking out "and $120,000,000 for the next fiscal year" and inserting in lieu thereof "$120,000,000 for the fiscal year ending June 30, 1970, $125,000,000 for the fiscal year ending June 30, 1971, $150,000,000 for the fiscal

year ending June 30, 1972, and $175,000,000 for the fiscal year ending June 30, 1973".

(b) Effective with respect to appropriations made under such section 901 (a) for any fiscal year beginning after June 30, 1970, the second sentence of such section is repealed.

SEC. 2. Section 900 of the Public Health Service Act (42 U.S.C. 299) is amended—

(1) by striking out "and" at the end of paragraph (b), by redesignating paragraph (c) as paragraph (d), and by adding after paragraph (b) the following new paragraph:

"(c) to support research, investigations, studies, training, and demonstrations with respect to the optimum utilization of manpower in the delivery of health services in the fields of heart disease, cancer, stroke, and related diseases; and"; and

(2) by inserting after "Nation" in paragraph (d) (as so redesignated by this section) the following: "and to improve health services relating to heart disease, cancer, stroke, and related diseases for persons residing in areas with limited health services".

SEC. 3. Section 903 (b) of the Public Health Service Act (42 U.S.C. 299c (b)) is amended (1) by striking out "and" at the end of paragraph (3), (2) by striking out the period at the end of paragraph (4) and inserting in lieu

thereof "; and", and (3) by adding after paragraph (4) the following new paragraph:

"(5) a satisfactory showing that the procedures of the advisory group described in paragraph (4) of this subsection provide (A) a reasonable opportunity for membership on the group to a representative of any health-related institution or organization which (i) is carrying on activities in the field of heart disease, stroke, cancer, or related diseases, (ii) applies for representation on the group, and (iii) is in the area to be served by the regional medical program with respect to which the applicant is seeking assistance for planning the development, and (B) for prompt consideration by the group of any project application which it must recommend before the project may be assisted under section 904".

SEC. 4. (a) Subsection (b) of section 904 of the Public Health Service Act (42 U.S.C. 299d(b)) is amended (1) by striking out "and" at the end of paragraph (3), (2) by striking out the period at the end of paragraph (4) and inserting "; and", and (3) by inserting after paragraph (4) the following new paragraph:

"(5) the applicant has taken into consideration the relationship of the regional medical program for which his grant application is made and any comprehensive regional, metropolitan area, or other local area plan or

plans referred to in section 314 (b) covering any area to be served by such program or, if there is any area to be served by the program for which no such plan has been made, the State plan (approved under section 314 (a)) for the State in which such area is located or if such area is located in more than one State, the State plan approved under such section for each State in which such area is located."

(b) Such section 904 is amended by adding at the end thereof the following new subsections:

"(c) If an advisory group described in section 903 (b) (4) decides not to recommend an application for a project to be assisted under this section, the Council may require such advisory group to submit in writing to the Council the reasons for making such decision.

"(d) The Secretary, at the request of any recipient of a grant under this section, may reduce the payments under such grant to such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs incurred in connection with the detail of an officer or employee of the Department of Health, Education, and Welfare to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out

the regional medical program with respect to which the grant under this section is made. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Secretary, but for purposes of section 901 (b) shall be deemed to have been paid to the State."

SEC. 5. Title IX of the Public Health Service Act is amended—

(1) by inserting between the heading for such title and the heading for section 900 the following:

"PART A—REGIONAL MEDICAL PROGRAMS";

(2) by striking out "title" each place it appears and inserting in lieu thereof "part"; and

(3) by adding after section 910 the following:

"PART B—CHRONIC DISEASE PROGRAMS"

"TRAINING AND CLINICAL DEMONSTRATION PROGRAMS IN DIAGNOSIS, TREATMENT, AND PREVENTION OF CHRONIC DISEASES

"SEC. 921. (a) The Secretary may in conjunction with any regional medical program established under part A—

"(1) develop and conduct field trials and clinical demonstrations in,

"(2) establish programs for clinical training of professional and technical personnel in,

"(3) establish traineeship and fellowship programs in matters relating to,

"(4) support and conduct epidemiological studies relating to, and

"(5) support programs providing health services for, the diagnosis, treatment, and prevention of heart disease, cancer, stroke, diabetes, emphysema, kidney disease, and other diseases relating to heart disease, stroke, or cancer.

"(b) The Secretary may make grants to, and enter into contracts with, any public or nonprofit private agency, institution, or organization to assist in meeting the costs of special projects for improving, and developing innovative means for, the delivery of health services concerned with the diseases listed in subsection (a).

"(c) The Secretary may make such grants and enter into such contracts as he determines are necessary to carry out the purposes of subsection (a). The Secretary may provide appropriate stipends and allowances (including travel and subsistence expenses) for trainees and fellows in programs established under subsection (a) (4).

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 922. To carry out the purposes of section 921, there is authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1971, and for each of the next two fiscal years."

SEC. 6. (a) Section 301 (h) of the Public Health Service Act (42 U.S.C. 241 (h)) is amended by striking out "five succeeding fiscal years" and inserting in lieu thereof "eight succeeding fiscal years".

(b) Section 304 (d) of such Act (42 U.S.C. 242b (d)) is amended by inserting after "June 30, 1970" a comma and the following: "and for each of the next three fiscal years".

(c) Section 704 of such Act (42 U.S.C. 292c) is amended by striking out "$30,000,000" and inserting in lieu thereof "$40,000,000".

SEC. 7. (a) (1) Title IX of the Public Health Service Act (other than section 908 thereof) is amended by striking out "Surgeon General" each place it appears and inserting in lieu thereof "Secretary".

(2) Section 909 (b) of such Act (42 U.S.C. 299i (b)) is amended by striking out "of Health, Education, and Welfare".

(b) Paragraph (c) of section 2 of such Act (42 U.S.C. 20 (c)) is amended to read as follows:

"(c) The term 'Secretary', unless the context otherwise requires, means the Secretary of Health, Education, and Welfare."

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[H.R. 15895, 91st Cong., 2d sess., introduced by Mr. Rogers of Florida on February 16, 1970]

A BILL

To amend the Public Health Service Act to extend the programs of assistance to the States and localities for comprehensive health planning.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. This Act may be cited as the "Comprehensive Health Planning and Services Act of 1970".

SEC. 2. (a) Section 314(a)(1) of the Public Health Service Act is amended by striking out "and" immediately after "June 30, 1969," and by inserting immediately before the period at the end thereof the following: ", $17,500,000 for the fiscal year ending June 30, 1971, $22,500,000 for the fiscal year ending June 30, 1972, and $25,000,000 for the fiscal year ending June 30, 1973".

(b) Section 314 (a) (2) (B) of such Act is amended by inserting "(including representatives of the regional medical program)" immediately after "concerned with health".

SEC. 3. (a) Section 314 (b) of the Public Health Service Act is amended by striking out "ending June 30, 1970" and inserting in lieu thereof "ending June 30, 1973".

(b) Such section is further amended by striking out "and" immediately following "June 30, 1969," and by inserting immediately before the period at the end the following: ", $15,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $40,000,000 for the fiscal year ending June 30, 1973".

(c) Such section is further amended by inserting "(1)" immediately after "(b)" and by adding at the end thereof the following new paragraph:

"(2) Grants under this subsection may be made only upon an application approved by the Secretary which contains or is supported by reasonable assurances that—

"(A) areawide agencies have provided for the establishment of an areawide health planning council, which shall include representatives of public, voluntary, and nonprofit private agencies, institutions, and organizations concerned with health, including representatives of the interests of local government, of the regional

medical program, and of consumers of health services; and

"(B) the areawide health planning agency has made provision for assisting health care facilities in its area to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan which will meet the needs of the State and the area for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner."

SEC. 4. Section 314(c) of the Public Health Service Act is amended by striking out "ending June 30, 1970" and inserting in lieu thereof "ending June 30, 1973"; by striking out "and" immediately after "June 30, 1969,"; and by inserting immediately before the period at the end thereof the following: ", $10,000,000 for the fiscal year ending June 30, 1971, $12,500,000 for the fiscal year ending June 30, 1972, and $15,000,000 for the fiscal year ending June 30, 1973".

SEC. 5. (a) Section 314(d)(1) of the Public Health Service Act is amended by striking out "and" immediately after "June 30, 1969", and by inserting after "June 30, 1970," the following: "$125,000,000 for the fiscal year

ending June 30, 1971, $140,000,000 for the fiscal year ending June 30, 1972, and $160,000,000 for the fiscal year ending June 30, 1973,".

(b) Section 314(d)(2)(C) of such Act is amended by striking out "and (iii)" and inserting in lieu thereof "(iii)" and by inserting before the semicolon at the end thereof the following: "; and (iv) the plan is compatible with the total health program of the State".

SEC. 6. (a) Section 314(e) of the Public Health Service Act is amended by striking out "and" immediately after "June 30, 1969," and by inserting after "June 30, 1970," the following: "$70,000,000 for the fiscal year ending June 30, 1971, $60,000,000 for the fiscal year ending June 30, 1972, and $50,000,000 for the fiscal year ending June 30, 1973,".

(b) The second sentence of such section is amended to read as follows: "Any grant made pursuant to clause (1) or (2) of the preceding sentence with respect to projects involving the furnishing of public health services may be made only if the application for such grant has been referred for review and comment to the appropriate areawide health planning agency or agencies (or, if there is no such agency in the area, then to such other public or nonprofit private agency or organization (if any) which performs similar functions) and only if the services will be provided in accordance

with such plans as have been developed pursuant to subsection (a)."

SEC. 7. Part B of title III of the Public Health Service Act is amended by striking out "Surgeon General" each place it appears and inserting in lieu thereof "Secretary".

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., February 27, 1970.

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 requests for the views of the Bureau of the Budget on H.R. 14284, H.R. 15895, and H.R. 15960, bills which would amend various provisions of the Public Health Service Act relating to the organization and delivery of health services.

The Secretary of Health, Education, and Welfare recently submitted to the Congress legislation, which is the same as H.R. 15960, to be cited as the "Health Services Improvement Act of 1970." This bill would extend, integrate, and make certain other improvements in three health services programs—the Comprehensive Health Planning and Services Program, the Regional Medical Program, and the National Center for Health Services Research and Development. The bill would also enlarge the scope of the National Health Survey authorized under the Public Health Service Act.

Accordingly, we recommend that your Committee favorably consider H.R. 15960, in lieu of H.R. 14284 or H.R. 15895. The enactment of H.R. 15960 would be in accord with the program of the President.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., June 2, 1970.

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 of March 18, 1970, for the views of the Bureau of the Budget on H.R. 16425, a bill "To amend title IX of the Public Health Service Act so as to extend and improve the existing program relating to education, research, training, and demonstrations in the fields of heart disease, cancer, stroke, and other major diseases and conditions, and for other purposes."

The Secretary of Health, Education, and Welfare recently submitted to the Congress legislation, which is the same as H.R. 15960, the "Health Services Improvement Act of 1970." This bill would extend, integrate, and make certain other improvements in three health services programs—the Comprehensive Health Planning and Services Programs, the Regional Medical Program, and the National Center for Health Services Research and Development. The bill would also enlarge the scope of the National Health Survey authorized under the Public Health Service Act.

Accordingly, we recommend that your Committee favorably consider H.R. 15960, in lieu of H.R. 16425. The enactment of H.R. 15960 would be in accord with the program of the President.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., June 3, 1970.

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 of May 13, 1970, for the views of the Bureau of the Budget on H.R. 17570, a bill "To amend title IX of the Public Health Service Act so as to extend and improve the existing program relating to education, research, training and demonstrations in the fields of heart disease, cancer, stroke, and other major diseases and conditions, and for other purposes."

The Secretary of Health, Education, and Welfare recently submitted to the Congress legislation, which has been introduced as H.R. 15960, the "Health Services Improvement Act of 1970." This bill would extend, integrate, and make certain other improvements in three health services programs—the Comprehensive Health Planning and Services Program, the Regional Medical Program, and the National Center for Health Services Research and Development. The bill would also enlarge the scope of the National Health Survey authorized under the Public Health Service Act.

Accordingly, we recommend that your Committee favorably consider H.R. 15960, in lieu of H.R. 17570. The enactment of H.R. 15960 would be in accord with the program of the President.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

GENERAL ACCOUNTING OFFICE,
OFFICE OF THE COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., May 8, 1970.

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

DEAR MR. CHAIRMAN: By letter of February 19, 1970, you requested our comments on H.R. 15960, 91st Congress, which if enacted into law would be known as the "Health Services Improvement Act of 1970."

While we have no special information as to the advantages or disadvantages of this measure and, therefore, make no comments regarding its merits, we recommend revision of the maintenance of records and access to records provisions in subsections 947 (a) and (b).

The bill would, among other things, amend title IX of the Public Health Service Act, as amended, 42 U.S.C. 299–299j (Supp. IV), to authorize several grant and contract programs. The proposed subsection 947(a) would require "Each recipient of a grant under this title (other than section 921 or 924)" to keep such accounting records as the Secretary of Health, Education, and Welfare may prescribe. Subsection 947(b) provides:

"The Secretary 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 recipient of *any such grant* which are pertinent thereto." (Emphasis supplied.)

The phrase "any such grant" in subsection 947(b) apparently refers back to the phrase "a grant under this title (other than section 921 or 924)" in subsection 947(a) with the possible effect of exempting grants to States under sections 921 and 924 from the access to records authority of the Comptroller General not only under this proposed legislation but also under the provisions of section 202 of the Intergovernmental Cooperation Act of 1968. We recommend deletion of the language "(other than section 921 or 924)" in order to preclude this construction of subsection 947(b) and make applicable all the provisions of section 947 to State grants under sections 921 and 924.

Further, the committee may want to consider making section 947 applicable to contracts as well as grants, since both forms of financial assistance are authorized in title IX.

These changes can be accomplished by revising subsections 947 (a) and (b) to read as follows:

"947(a) Each recipient of assistance under this title pursuant to grants received or contracts entered into under other than competitive bidding procedures (including recipients of such assistance from a State) shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such assistance, the total cost of the project or undertaking in connection with which such assistance is 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 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 or contracts entered into under this title under other than competitive bidding procedures."

If these language changes are not desired, we recommend that the committee indicate in the legislative history an intent that the grants to States authorized in sections 921 and 924 will be subject to the provisions of section 202 of the Intergovernmental Cooperation Act of 1968, Pub. L. 90–577, 82 Stat. 1101, 42 U.S.C. 4212, which provides generally for the Comptroller General's access to records pertinent to State grants.

The increased emphasis of our Office on evaluation of grant program results shows a need for the establishment of more specific criteria which will be the basis for approval of grants. Unless such criteria are incorporated in the various provisions authorizing grants in H.R. 15960, we suggest that the committee reports accompanying H.R. 15960 include a paragraph emphasizing the responsibility of the Secretary under section 946 to develop and publish detailed and specific terms and conditions for approving applications for assistance, including, for example, evidence that the grantee has examined the public information available from prior closely related developments and has determined that additional knowledge will be obtained from the proposed plan.

Sincerely yours,

R. F. KELLER,
Assistant Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., April 7, 1970.

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

DEAR MR. CHAIRMAN: This is in response to your request of February 19, 1970, for a report on H.R. 15960, a bill "To amend and improve the Public Health Service Act to aid in the development of integrated, effective, consumer-oriented health care systems by extending and improving regional medical programs, supporting comprehensive planning of public health services and health services development on a State and areawide level, promoting research and demonstrations relating to health care delivery, encouraging experimentation in the development of co-operative local, State, or regional health care delivery systems, enlarging the scope of the National Health survey, facilitating the development of comparable health information and statistics at the Federal, State, and local levels, and for other purposes."

This bill embodies the provisions of a draft bill submitted to the Speaker of the House of Representatives by this Department on February 16, 1970. The details of the bill are explained in a letter of the same date to the Speaker, a copy of which is enclosed for your convenience.

For the reasons stated in the enclosed letter, we urge enactment of the bill.

The Bureau of the Budget advises that enactment of this proposed legislation would be in accord with the programs of the President.

Sincerely,

ROBERT H. FINCH, *Secretary.*

Enclosure.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., February 16, 1970.

HON. JOHN W. MCCORMACK,
The Speaker,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed for the consideration of the Congress is a draft bill [1] "To amend and improve the Public Health Service Act to aid in the development of integrated, effective, consumer-oriented health care systems by extending and improving regional medical programs, supporting comprehensive planning of public health services and health services development on a State and areawide level, promoting research and demonstrations relating to health care delivery, encouraging experimentation in the development of cooperative local, State, or regional health care delivery systems, enlarging the scope of the National Health Survey, facilitating the development of comparable health information and statistics at the Federal, State, and local levels, and for other purposes."

This bill would assist us in our efforts to improve the systems through which health care is provided in our Nation. In keeping with the developing health strategy of this Department, existing resources and programs would be focused more intensively on the building of functioning, effective, consumer-oriented health care systems.

The bill would:

1. Extend, improve, and integrate three key programs aimed at improving the organization and delivery of health services—the Comprehensive Health Planning and Services Program, the Regional Medical Programs, and the National Center for Health Services Research and Development—by placing them in a single title in the Public Health Service Act, giving them a common statement of purpose, a single advisory council, and a single annual report on their progress toward health care system building.

2. Promote the establishment of more efficient and effective health service systems, and promote the coordination of programs under this and other titles of this Act with related activities authorized under the Social Security Act and other Federal and federally-assisted health and health-related programs, with particular attention to the relationship between the organization and delivery of health services and the financing thereof.

3. Provide authority for intensive experiments and demonstrations in selected States, regions, and localities which are to be designed to stimulate and assist the development of health care systems in those areas, and to develop models of health care systems which might be used elsewhere in the Nation. These experiments and demonstrations, to be conducted jointly by State, regional and local Regional Medical Programs and Comprehensive Health Planning agencies, will also be designed to develop the best methods for coordinating and interrelating the thrust of these and related programs toward improved systems of health services at the local level, which give a greater return on our health dollars.

4. Provide new authority for the initial steps in the development of a Federal State-local system of health information and statistics which is a necessary resource for effective planning and operation of improved health systems.

The crisis in health care services is increasingly apparent. We view this legislation as an essential initiative for improving the Department's health programs to meet the urgent need for improved health care for the Nation and for improvements in the coordination of health programs. We urge your prompt and favorable consideration of this draft bill.

We would appreciate your referring the enclosed draft bill to the appropriate committee for consideration.

The Bureau of the Budget advises that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely,

ROBERT H. FINCH, *Secretary.*

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[1] The draft bill referred to was introduced as H.R. 15960. See p. 2, this hearing, for text of bill.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT,
OFFICE OF THE GENERAL COUNSEL,
Washington, D.C., March 2, 1970.

Subject: H.R. 15960, 91st Congress (Staggers, et al.).

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

DEAR MR. CHAIRMAN: This will acknowledge your request for a report from this Department on H.R. 15960, a bill "To amend and improve the Public Health Service Act to aid in the development of integrated, effective, consumer-oriented health care systems by extending and improving regional medical programs, supporting comprehensive planning of public health services and health services development on a State and areawide level, promoting research and demonstrations relating to health care delivery, encouraging experimentation in the development of cooperative local, State, or regional health care delivery systems, enlarging the scope of the National Health Survey, facilitating the development of comparable health information and statistics at the Federal, State, and local levels, and for other purposes."

A report on this bill is being prepared and will be forwarded to you as soon as possible.

Sincerely yours,

NORMAN C. ROETTGER,
for SHERMAN UNGER.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF ECONOMIC OPPORTUNITY,
Washington, D.C., May 13, 1970.

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

DEAR MR. CHAIRMAN: We appreciate being asked to comment on H.R. 15960, the "Health Services Improvement Act of 1970".

The Office of Economic Opportunity favors the enactment of this legislation which is designed to extend and improve the Regional Medical Programs and other related programs authorized under the Public Health Service Act. In our view the proposed legislation will facilitate the development of a more effective, consumer oriented, health care delivery system in our Nation. It is of particular significance, insofar as the poor are concerned, since it is these persons who too often find that adequate health care is not available to them because of their deprived circumstances. In his July 1969 "Report on the Health of the Nation's Health Care System, the Honorable Robert A. Finch, Secretary of Health, Education, and Welfare, stated:

". . . As long as there are people in this country who are denied essential health services because of poverty, or race, or lack of access for any reason, we have fallen short of our promise as a Nation."

We concur with the Secretary's views in this matter, and we believe that the enactment of H.R. 15960 will contribute to the alleviation of this unfortunate situation.

We defer to the Department of Health, Education, and Warfare for comment on specific provisions of H.R. 15960, inasmuch as that agency would have primary responsibility for administering the programs with which this legislation is concerned.

The Bureau of the Budget advises that the enactment of H.R. 15960 would be in accord with the program of the President.

Sincerely,

DONALD RUMSFELD, *Director.*

Mr. JARMAN. Our first witness this morning will be Dr. Roger O. Egeberg, Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs.

Dr. Egeberg, it is good to have you back with the committee, and if you would introduce your associates we would be pleased to hear your testimony in any form in which you have preference.

STATEMENT OF DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY IRVING LEWIS, DEPUTY ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; JOHN MOSCATO, ACTING ASSISTANT ADMINISTRATOR FOR LEGISLATION, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; DR. PAUL SANAZARO, DIRECTOR, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

Dr. EGEBERG. Thank you, Mr. Chairman. On my right, is Mr. Irving Lewis, who is the Deputy Administrator of Health Services and Mental Health Administration; on my left is Mr. John Moscato, who is Acting Assistant Administrator for Legislation in that agency.

I would like to submit, if I may, a reasonably lengthy, 18-page statement for the record. I would like to read a much shorter part of it, and really only the first part of it.

Mr. JARMAN. Your statement will be accepted in full, Doctor, and you may proceed as you wish.

Dr. EGEBERG. Thank you.

I am pleased to have the opportunity to discuss with you proposals for extending and improving the regional medical programs, partnership for health, and other related programs central to our efforts to improve the organization and delivery of health services in the Nation.

As you know, Mr. Chairman, health is a basic right in our society. Yet, in spite of our knowledge of health, in spite of our sophisticated technology, and in spite of our vast material resources, we have a crisis in health care in this country.

The Federal Government has an obligation to encourage development of a more responsive health care system for the Nation. It will be a long process, but we must start now.

The proposal we are making today represents an important initiative in this effort by the Federal Government designed to improve the quality and availability of health care in our Nation. The proposal is based on several assumptions about any Federal effort directed toward improving the organization and delivery of health services and a reduction of the crisis we face in health care.

1. Existing Federal health efforts represent nearly one-third of the Nation's $61 billion health industry. This is indicative of the public stake and the national commitment to provide health care for those Americans who are poor and elderly and to provide protection to all from health hazards. It also reflects our governmental responsibility to disseminate the findings of research on the causes and prevention of disease and our interest in assuring that the health care

system, which is primarily a combination of various private care arrangements, provides high quality care for all Americans.

2. There must be a dynamic, effective partnership among those in the private sector who provide health and medical services, government at all levels, and the consumers of health services if we are to match delivery and new knowledge and thereby achieve maximum effectiveness and efficiency in the delivery of health care.

3. While there are now several separate Federal efforts directed to different aspects of the organization and delivery of health care, they must be better coordinated and more closely integrated.

4. Federal assistance should be provided to cooperative efforts among public and private agencies and institutions at all levels for the development of more effective and efficient health care delivery systems.

Against this background, the Department is taking specific steps to help solve the major problems of building better and more consumer-oriented health care systems. Some of these steps affect the financing of health services. The health cost-effectiveness proposal, incorporated in the Social Security Amendments of 1970, and the preliminary recommendations of the medicaid task force, for example, are intended to improve the effectiveness of health care financing mechanisms.

We recognize fully that improvements in financing are only a partial response to the problems of effective health services for all. We also need to improve substantially the way our health care resources are organized and our health services are delivered if they are to meet adequately the growing demands now being placed on them. Fortunately we have already made a beginning. The three major programs covered by the Health Services Improvement Act—regional medical programs, comprehensive health planning and services program, and health services research and development—fill important gaps in our health system. Each is aimed at a particular need. While they are in early stages of development, these programs have already engaged the institutions, organizations, and individuals whose active participation and support are essential for the tasks ahead.

Through the legislation we are endorsing today, H.R. 15960, the "Health Services Improvement Act of 1970," the Department will be able to give a renewed sense of purpose and direction to those efforts to improve the health care delivery system which are already underway, by capitalizing on the unique strengths of each of the existing programs. At the same time, we intend to focus special efforts and funds on selected experimental situations which promise more effective and efficient delivery of health care. These experiments will be used to identify the best ways of using the existing programs to improve systems of health care and yield a greater return on our health dollars. They will be carefully designed to provide knowledge about effective health system organization and to provide a variety of demonstrated models of improved health services for utilization in other parts of the country. The experiments will also provide a better basis for further modification, in the coming years, of the health programs we are discussing today.

The experiments will involve the health programs authorized in this bill and other Federal, State, and local health programs and sources of health care financing. In particular, we intend to coordinate

these activities with related programs authorized by the Social Security Act, especially the maternal and child health program, the medicaid demonstrations, and the medicare incentive reimbursement experiments.

The National Advisory Council provided for in H.R. 15960 is specifically designated to advise the Secretary of Health, Education, and Welfare on the coordination of these programs with other Federal and federally assisted health programs, giving particular attention to the relationship between the organization, delivery, and financing of health services and our Nation's health goals. In this regard, the legislation proposes that the Secretary give the Congress an annual report on improvements in the delivery of health services accomplished under the bill, including a statement of the relationship between the programs contained in this bill and financing arrangements authorized by the Social Security Act.

Here, Mr. Chairman, are the highlights of the legislation. The bill provides a new title IX in the Public Heath Service Act which would include 3-year authorizations for Comprehensive Health Planning and Services—now authorized by section 314—for regional medical programs, for Health Services Research and Development—now authorized by section 304—and for the initial steps in developing a Federal-State-local health information and statistical system. The bill provides a single statement of purpose which augments the purposes of the individual programs and makes clear their interrelationships in improving health services. It authorizes a new National Advisory Council on the Planning, Organization, and Delivery of Health Services which will provide policy advice and recommendations to the Secretary on the administration of these programs and will provide policy guidance for the selected experiments and demonstrations to be developed.

The scope of the regional medical programs is broadened beyond the original focus on heart disease, cancer, and stroke to permit support of a wider range of activities related to the more systematic organization and the quality of health services. The bill would facilitate local coordination of regional medical programs and comprehensive health planning agencies by requiring official health planning agency representation on RMP regional advisory councils and RMP representation on State and local planning councils. It would provide for areawide health planning agency review and comment on applications for health services development grants and similar opportunity to both State and areawide agencies on regional medical program activities. It would also permit joint funding of projects and the transfer of a limited portion of the funds between programs when this is essential to the accomplishment of the purposes of the bill. Finally, it would authorize contracts for research, demonstration, and evaluation activities leading to the development of a cooperative health information and statistics system operable at the Federal, State, and local levels.

At this point I would like to make brief reference to other related bills presently before this subcommittee. H.R. 14486, as introduced by Mr. Rogers; H.R. 16425, as introduced by Mr. Madden; H.R. 17570, as introduced by Mr. Jarman; H.R. 17670, as introduced by Mr. Kuykendall; H.R. 14284 and H.R. 15135, as introduced by Mr. Staggers and Mr. Cramer, respectively, would extend and amend the regional

medical programs authorization, as well as the latter two, extending the Health Services Research authority under section 304 of the PHS Act. H.R. 15895, also by Mr. Rogers, provides for the continuation and revision of the Partnership for Health legislation. Since all of these bills contain a number of provisions similar to the Health Services Improvement Act, we could support many features of them if it were still possible to consider RMP, health services R. & D., and the partnership for health as unrelated programs. However, we believe that legislation is most urgently needed which can begin to set into motion initiatives that ultimately will reshape the health care system. Accordingly, we do not think separate extensions of these programs will provide the needed momentum for creative and cooperative innovation in health services organization, delivery, and financing. Further, we believe that reductions in authorizations for the project grant mechanism in the partnership for health programs contained in H.R. 15895 would harm the administration's efforts to achieve this momentum.

Mr. Chairman, we view the Health Services Improvement Act of 1970 as an essential initiative to improve the coordination of the Department's health programs and to help meet the urgent need for better health care throughout the Nation.

At that point, I will stop reading the testimony, and we will all be very glad to answer your questions.

(Dr. Egeberg's prepared statement follows:)

STATEMENT OF DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the subcommittee, I am pleased to have the opportunity to discuss with you proposals for extending and improving the Regional Medical Programs, Partnership for Health, and other related programs central to our efforts to improve the organization and delivery of health services in the Nation.

As you know, Mr. Chairman, health is a basic right in our society. Yet, in spite of our knowledge of health, in spite of our sophisticated technology and in spite of our vast material resources, we have a crisis in health care in this country.

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1. Existing Federal health efforts represent nearly one-third of the Nation's $61,000,000,000 health industry. This is indicative of the public stake and the National commitment to provide health care for those Americans who are poor and elderly and to provide protection to all from health hazards. It also reflects our Governmental responsibility to disseminate the findings of research on the causes and prevention of disease and our interest in assuring that the health care system, which is primarily a combination of various private care arrangements, provides high quality care for all Americans.

2. There must be a dynamic, effective partnership among those in the private sector who provide health and medical services, government at all levels, and the consumers of health services if we are to match delivery and new knowledge and thereby achieve maximum effectiveness and efficiency in the delivery of health care.

3. While there are now several separate Federal efforts directed to different aspects of the organization and delivery of health care, they must be better coordinated and more closely integrated.

4. Federal assistance should be provided to *cooperative* efforts among public and private agencies and institutions at all levels for the development of more effective and efficient health care delivery systems.

Against this background, the Department is taking specific steps to help solve the major problems of building better and more consumer-oriented health care systems. Some of these steps affect the financing of health services. The Health Cost-Effectiveness proposal incorporated in the Social Security Amendments of 1970, and the preliminary recommendations of the Medicaid Task Force, for example, are intended to improve the effectiveness of health care financing mechanisms.

We recognize fully that improvements in financing are only a partial response to the problems of effective health services for all. We also need to improve substantially the way our health care resources are organized and our health services are delivered if they are to meet adequately the growing demands now being placed on them. Fortunately we have already made a beginning. The three major programs covered by the "Health Services Improvement Act"—Regional Medical Programs, Comprehensive Health Planning and Services Program, and Health Services Research and Development—fill important gaps in our health system. Each is aimed at a particular need. While they are in early states of development, these programs have already engaged the institutions, organizations and individuals whose active participation and support are essential for the tasks ahead.

Through the legislation we are endorsing today, H. R. 15960, the "Health Services Improvement Act of 1970," the Department will be able to give a renewed sense of purpose and direction to those efforts to improve the health care delivery system which are already under way, by capitalizing on the unique strengths of each of the existing programs. At the same time, we intend to focus special efforts and funds on selected experimental situations which promise more effective and efficient delivery of health care. These experiments will be used to identify the best ways of using the existing programs to improve systems of health care and yield a greater return on our health dollars. They will be carefully designed to provide knowledge about effective health system organization and to provide a variety of demonstrated models of improved health services for utilization in other parts of the country. The experiments will also provide a better basis for further modification, in the coming years, of the health programs we are discussing today.

The experiments will involve the health programs authorized in this bill, and other Federal, State and local health programs and sources of health care financing. In particular, we intend to coordinate these activities with related programs authorized by the Social Security Act, especially the Maternal and Child Health Program, the Medicaid demonstrations and the Medicare incentive reimbursement experiments.

The National Advisory Council provided for in H.R. 15960 is specifically designated to advise the Secretary of Health, Education, and Welfare on the coordination of these programs with other Federal and federally-assisted health programs, giving particular attention to the relationship between the organization, delivery and financing of health services and our Nation's health goals. In this regard, the legislation proposes that the Secretary give the Congress an annual report on improvements in the delivery of health services accomplished under the bill, including a statement of the relationship between the programs contained in this bill and financing arrangements authorized by the Social Security Act.

Here, Mr. Chairman, are the highlights of the legislation. The bill provides a new Title IX in the Public Health Service Act which would include three-year authorizations for Comprehensive Health Planning and Services (now authorized by Sec. 314), for Regional Medical Programs, for Health Services Research and Development (now authorized by Sec. 304) and for the initial steps in developing a Federal-State-local health information and statistical system. The bill provides a single statement of purpose which augments the purposes of the individual programs and makes clear their interrelationships in improving health services. It authorizes a new National Advisory Council on the Planning, Organization, and Delivery of Health Services which will provide policy advice and recommendations to the Secretary on the administration of these programs and will provide policy guidance for the selected experiments and demonstrations to be developed. The scope of the Regional Medical Programs is broadened beyond the original focus on heart disease, cancer and stroke to permit support of a wider range of activities related to the more systematic organization and

the quality of health services. The bill would facilitate local coordination of Regional Medical Programs and Comprehensive Health Planning Agencies by requiring official health planning agency representation on RMP Regional Advisory Councils, and RMP representation on State and local planning councils. It would provide for areawide health planning agency review and comment on applications for health services development grants, and similar opportunity to both State and areawide agencies on Regional Medical Program activities. It would also permit joint funding of projects and the transfer of a limited portion of the funds between programs when this is essential to the accomplishment of the purposes of the bill. Finally, it would authorize contracts for research, demonstration and evaluation activities leading to the development of a cooperative health information and statistics system operable at the Federal, State and local levels.

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Mr. Chairman, we view the "Health Services Improvement Act of 1970" as an essential initiative to improve the coordination of the Department's health programs and to help meet the urgent need for better health care throughout the Nation.

By highlighting the progress of the programs included in the Administration's proposal, I want to emphasize that the accomplishments of these programs have been substantial. We expect to capitalize on these achievements as we focus more intensively on the development of better systems for the organization and delivery of health services.

First, let me briefly review the Regional Medical Programs.

Although there has been a rapid rise in *public* expenditures for health in the last decade, especially for personal health services, the provision of medical care is largely through non-governmental arrangements. Over three-quarters of personal health care is provided by private physicians, private group practices, voluntary hospitals, and clinics. When governmental agencies set out to encourage changes which affect these arrangements, the effort should be carefully designed to encourage participation and cooperation in the change process of those affected. Since, to a very large extent, we are dependent for the provision of health care on existing resources—physicians, hospitals, and all other health professionals and institutions—we intend to take actions which assure their active and constructive involvement in any attempt to improve the system. We are committed to change through and with these resources and not in spite of them. Certainly we do not intend to hamper the effectiveness of participants in the system, but rather to enhance it.

The unique advantage of the Regional Medical Programs is their ability to improve the quality and availability of health services by enlisting the leadership and support of those professionals—in medical schools and in community practices—who have demonstrated by their actions the growing value of health services to the quality of life. Over the five years since the programs were first authorized, they have shown significant potential for bringing about change through the development of cooperative arrangements among the principal providers and consumers of health care services at the regional level.

Let me describe some of the ways these programs work.

A network of coronary care units has been established in an isolated Appalachian area of Western North Carolina, known as the State of Franklin, with financial and technical assistance from the North Carolina RMP. Eight small hospitals, all with less than 50 beds, have been linked together and to the Bowman-Gray School of Medicine in Winston-Salem, over 100 miles to the east, by a telephone line for the transmission and analysis of electrocardiograms. Beyond improving coronary care in the State of Franklin, this "network" improves the prospect that the individual participating hospitals may be accredited.

In many regions the RMP assists representatives of the inner-city to plan for improved health services; the Watts-Willowbrook section of Los Angeles is a notable example.

The New Jersey RMP has assigned full-time urban health coordinators to the Model Cities offices of Newark, Trenton and Hoboken to work with citizens' panels, to help identify priorities for health services, and to develop action proposals as integral parts of the overall Model Cities plans.

In East Texas, an RMP project has brought high quality stroke rehabilitation to a small, rural town. The Southwestern Medical School in Dallas developed a joint program with the East Texas Treatment Center in Kilgore, a geographically isolated community 125 miles from the medical school. Though the Center was modern and the sole rehabilitation facility within a fifty-mile radius, it was under-utilized. As a result of the cooperative RMP project, permanent staff and consultative personnel have been added, skills of existing personnel have been upgraded, treatment and rehabilitation techniques have been improved, and it is now likely that the Center will become self-sufficient.

I want to cite one other illustration of the cooperation of health groups through RMP support. One of the initial actions of the Georgia RMP was to promote the establishment of hospital-based local advisory groups to identify local needs and problems and to serve as a local liaison with the region's core staff and the regional advisory group. There are now 129 such groups in that region with 478 participants, including 127 practicing physicians, 128 hospital administrators, 114 nurses and allied health personnel, and 109 public members.

It is this kind of widespread, grassroots participation in Regional Medical Programs by providers and the public which has enabled it to move ahead quickly and which makes it a promising mechanism for bringing about change in our health care system. The achievements and potential of the Regional Medical Programs warrant wholehearted support of the extension of the authorization.

The second major program extended by the proposed "Health Services Improvement Act of 1970," is the "Partnership for Health." This program supports comprehensive health planning at the State and community levels, State public health services, health services development projects, and related training. The proposed bill clarifies the relationship of these activities to the Regional Medical Programs and locates the statutory authority in Title IX of the Public Health Service Act.

After less than three years of actual experience, the comprehensive health planning program is gaining widespread acceptance as the need for a coordinated approach to health is more widely understood, and as the agencies funded demonstrate that they have a key role to play in developing plans to bring about coordination. We now have comprehensive health planning agencies in 55 States and other jurisdictions (out of 56 eligible jurisdictions). There are also 113 area-wide agencies, of which 11 have already made the transition from the organizational to the operational stage, with 30 more coming into operation within a few months.

The activities of these State and local groups cover the entire range of health interests from jurisdictional planning for diverse geographic areas and political units to developing priority health programs of Statewide or multi-State scope; from involvement with methods for the treatment of individuals to concern with the state of the environment.

Planning agencies have direct impact upon the delivery of health services in their areas. In Magnolia, Arkansas, for instance, the agency brought about effective cooperation between two hospitals which had duplicated services and had planned individual expansion. In Minnesota, the State agency conducted a study of residential care which stimulated legislative action, including State reimbursement of counties for residential placement of retarded children and the development of State hospitals as multi-purpose regional centers. On the basis of study recommendations made by the New Hampshire CHP Advisory

Council, courses to prepare students for several health occupations will be in the curriculum of the New Hampshire Vocational and Technical Institute next year.

A variety of training programs are expanding our health planning capabilities. Approximately 250 students in eighteen graduate training programs are working toward degrees in health planning. In 1969, 520 professionals and 674 consumers were offered some form of special training.

Encouraging changes are also taking place in the way States are using block grants for comprehensive health services, not only to continue existing categorical programs but also to develop new systems and methods for the delivery of health services, especially to high-risk groups like the poor.

Significant differences are also emerging in the 1970 State comprehensive health plans. States are focusing on specific priorities. Vermont and New York, for example, place major emphasis on home health services. West Virginia gives high priority to State-wide expansion of family planning, environmental health, and dental health services. New Mexico reflects some redirection toward suicide prevention, drug abuse, and integrated mental health services. And some States are now distributing more funds to local health jurisdictions.

Project grants for Health Services Development, another part of the "Partnership" program, are a flexible tool for responding quickly to new challenges and for developing innovative health services; for example, prevention of a German measles epidemic, rat control in cities, or comprehensive health services programs. While we encourage a variety of activities, we emphasize programs which (1) assure accessible ambulatory care, (2) incorporate sound preventive health measures, (3) provide total family care, and (4) insure continuity of care—prevention, diagnosis, treatment, and rehabilitation.

The progress made through the Partnership for Health Program to date argues persuasively for extending the authorization and indicates the contribution these programs can make to the development of more effective health care systems.

As noted earlier, our principal reason for not endorsing the "Comprehensive Health Planning and Services Act" (H.R. 15895) introduced by Mr. Rogers is our conviction that these programs need to be considered in the total context of our health delivery capabilities rather than as separately focused portions. We might add, however, that the 314 (e) appropriations authorizations provided in Mr. Rogers' bill would severely hamper present and future program activities, particularly the assumption from OEO of responsibility for assisting several Neighborhood Health Centers, as justified in the President's 1971 Budget.

A major new thrust of the proposed "Health Services Improvement Act of 1970," Mr. Chairman, is to undertake intensive experiments to develop a set of models for fully effective, consumer-oriented health care systems. To do this, special resources will be made available to half a dozen to a dozen areas for health care system building. These experiments will be carried on jointly through volunteer local RMP and CHP agencies with cooperation, technical assistance, and financial support from the Federal government.

RMP and CHP agencies in some places are already engaged in joint efforts. For example, the Upper Kennebec Valley Regional Health Agency, in Waterville, Maine, has become the areawide health planning agency for the same subregion for which it carries out RMP planning functions. With a combination of RMP, DOT, and local funds, the agency also directs a Home Heatlh Care Service, a Regional Blood Bank, and operates an emergency care transportation and communications division. Similarly, the Colorado State CHP agency, the Health Department, and the Regional Medical Program, assisted by the American Public Health Association, are jointly funding a study of public health services in the State. In Worcester, Massachusetts, an areawide agency and the RMP have undertaken a joint study of stroke, radiotherapy, coronary care, and chronic pulmonary care. The areawide agency in metropolitan St. Louis is working with local consumer and provider organizations to develop badly needed ambulatory care programs.

It is this sort of cooperation which gives us confidence that we can put these existing programs to the larger task of developing effective comprehensive health care systems. Our proposal is a first careful step toward that broad goal.

We cannot now forecast in exact detail the character and outcome of the experiments since experimental designs and approaches will, of course, depend upon negotiations with specific States, localities and public and private organizations. We have in mind, however, some of the following approaches:

1. In relatively small or simple situations, multiple functions could be served

by a single RMP-CHP staff, by two staffs and a single board, or by one staff and two boards.

2. Under a more complicated and dynamic approach an areawide CHP agency could be given community responsibility for structuring the local health care system, including considerable influence over programs and capital funding decisions. The RMP would provide specialized regional aid, including technical assistance on the development of primary care, training, continuing education, specialized regional services and professional supervision of quality control.

3. Another model would provide for the assumption of geographic responsibility by community hospitals, extending across all levels of care and concerning the efficiency of the total system rather than the efficiency of acute care only.

4. Yet another model might experiment with competitive prepaid group practices with various options including the ownership of a hospital.

5. Another experiment might focus on relationships along a continuum of care—prevention, diagnosis, treatment, and rehabilitation—attempting to distribute responsibility among community institutions for each of these functions and to create the relationships necessary to make it possible for consumers to know how, where, and when they could and should go for various types of treatment and what that treatment will cost.

These health care system experiments will be carefully designed, monitored, and evaluated by HEW and the State, local and private participants. We hope to develop a series of models appropriate to varying geographic areas, to varying demographic conditions and to areas with different patterns of health care needs and resources. We have no single model in mind now, nor do we expect to have a single model in the future. Rather, we expect to develop a series of effective models which could, with modifications, be used in appropriate settings throughout the Nation.

In addition to the Regional Medical Programs and Partnership for Health which I have already discussed, the "Health Services Improvement Act of 1970" extends the authority for Health Services Research and Development. It should be clear from my earlier testimony that research and development activities play an integral part in any effort to improve the delivery of health services. We intend to bring the findings of research and development to bear directly on the design, development and evaluation of health care systems experiments. We also plan to devote some of the future Health Services Research and Development funds and the outstanding expertise of the National Center to the conduct of these experiments.

It is clear to us that we must improve the techniques of applied health services research and that we must establish appropriate experimental methods if we are to establish cause and effect relationships between innovative efforts and apparent health improvements. We must ensure that we know about successful enterprises to reproduce them.

As you know, Mr. Chairman, despite the problems which plague the Nation's health industry, most health services research and development activities of the past have been spotty, fragmented, uncoordinated and limited to isolated geographic or categorical problems. Enactment by the Congress of Section 304 of the Public Health Services Act in 1967, and establishment of the National Center for Health Services Research and Development in 1968, represented the first clearly focused Federal initiatives in this area. We now have the vehicle to support applied health services research and development through the type of sustained, concentrated and adequately funded activities which have characterized, for example, the biomedical research programs of the National Institutes of Health.

We are committed to a bold research and development program to deal with (1) rising costs and inadequate financing methods, (2) unequal distribution and utilization of health services, (3) failures to develop or adopt new technologies for health care and delivery, (4) shortages of professional and paraprofessional personnel, and (5) the need for adequate criteria and methods for evaluating the effectiveness of health services.

With the extension of the authority under Section 304, in the context of the "Health Services Improvement Act of 1970," the National Center for Health Services Research and Development will continue its critical role in these priority areas with a new impetus to help improve the organization and delivery of heatlh services.

Finally, Mr. Chairman, the proposed bill amends Section 305(a) of the Public Health Service Act to reflect the increasing demand for data on health care

resources, environmental and social health hazards, and family formation, growth and development. It also establishes authority for the initial steps (research, development, and evaluation) in the development of a cooperative health information and statistics system—a continuing joint endeavor by Federal, State and local units, based upon comparable definitions, standards, and methods for the collection and processing of data. The nucleus of a system like this already exists in the area of vital records. While this system has some technical problems it is, nonetheless, an example of a long-standing cooperative Federal-State-local activity which has provided consistently, over the years, valuable data for the development of health programs.

Health statistics currently generated by State and local areas are of uneven quality. While many jurisdictions have recognized this problem, they can not remedy the situation on their own. States and localities which have developed their own data systems may be producing statistics which are not comparable to those of other States or of the Federal government. The States continue to rely on us for some types of data. Yet it would be more reasonable if, in conformance with national standards of uniformity and quality, they could produce detailed data which meet their needs as well as ours. We view the joint system as a critical component of our continuing health partnership with the States and communities.

Mr. Chairman, we have given careful thought and study to the proposals contained in the "Health Services Improvement Act of 1970." We made an especially detailed examination of the Regional Medical Programs and the Comprehensive Health Planning Programs. We have had the advice of outside consultant groups, including the initial recommendations of the Task Force on Medicaid and Related Programs. Based on these efforts, we are convinced that our proposals will lead to a more productive use of Federal programs and resources, and to a more fully coordinated and systematic approach to organizing and delivering health care. Our aim, like yours, is to help the American citizen exercise his right to the highest level of care attainable.

My colleagues and I would be pleased, Mr. Chairman, to answer any questions which you and the members of the Subcommittee may have.

Mr. JARMAN. Thank you very much, Dr. Egeberg. The committee will be reading your entire statement and studying it with care.

Now I have one basic question that I might ask at the beginning of the hearing. As in so many authorization bills, I notice in the bills before us, there is provided—specifically in H.R. 15960—a 3-year authorization period and the term "such sums as may be necessary" for grants and contract authority. Could you give the committee any more definite information as to the administration's financial and monetary recommendation?

Dr. EGEBERG. I will refer it to Mr. Lewis.

Mr. LEWIS. Yes; I think, Mr. Chairman, we either already have or will supply to the committee a statement of our financial projections. While they will carry a certain amount of, I think, disclaimer from the Bureau of the Budget, they nevertheless do represent our best estimates and have been cleared by the administration for submission here.

I use the word "disclaimer" in terms of whether or not it actually binds the administration in submitting those specific amounts. But we do have projections which we have already furnished or will furnish to the committee in specific amounts.

Mr. JARMAN. Is there anything further in a general sense that you could submit on that?

Mr. LEWIS. Yes; I have this here. Our total for 1971, using round figures, Mr. Chairman, which would be refined in the statement which we will submit—for 1971, our total estimate is about $393 million for all of the programs covered here, and $490 million for 1972, and for 1973 it is $575 million.

Those amounts are broken down by the various programs, comprehensive health planning, health services research and development, national health statistics program, and regional medical programs. And would you wish those broken down now, sir, or would the statement for the record suffice?

Mr. JARMAN. I think the statement will suffice unless other members want to ask questions on it at this time. Thank you. Mr. Rogers.

(The budget estimates referred to follow:)

BUDGET ESTIMATES

	Fiscal year 1969 actual [1]	Fiscal year 1970 estimate	Fiscal year 1971 estimate	Fiscal year 1972 estimate	Fiscal year 1973 estimate
COMPREHENSIVE HEALTH PLANNING AND SERVICES					
314(a) State planning	7,329	10,371	7,675	10,000	12,000
314(b) Areawide planning	6,174	7,700	10,200	15,000	20,000
314(c) Health planning training	3,186	4,125	4,125	6,000	7,500
Total planning	16,689	22,196	22,000	31,000	39,500
314(d) Formula grants	65,642	[2] 100,000	90,000	105,000	115,000
314(e) Project grants	75,851	82,762	[3] 109,500	[4] 135,000	[4] 157,000
Program directions	[5] 1,011	[5] 3,185	[5] 4,564	[6] 3,800	[6] 4,000
Total	159,193	208,163	226,064	274,800	315,500
HEALTH SERVICES RESEARCH AND DEVELOPMENT					
Grants and contracts	16,846	37,440	50,867	[8] 70,600	[8] 85,000
Direct operations	7,850	3,850	5,025	6,100	7,200
Program direction	1,390	1,212	1,511	1,700	1,800
Total	26,086	42,502	57,403	78,400	94,000
NATIONAL HEALTH STATISTICS					
National vital and health statistics	6,860	8,633	9,358	17,340	18,140
State-Federal health statistics system	*	*	*	2,500	2,500
Program direction	616	537	560	1,010	1,010
Total	7,476	9,170	9,918	20,850	21,650
REGIONAL MEDICAL PROGRAM					
1. Regional medical programs:					
(a) Grants	72,365	[9] 78,500	[9] 94,500	109,500	137,500
(b) Direct operations	896	1,771	1,812	1,993	2,243
2. Technical assistance and disease control [7]		(18,287)	(13,168)	(18,305)	(25,805)
Regionalization activity	2,038	1,795	1,805	2,205	2,805
3. Program direction	1,402	1,947	2,022	2,202	2,452
Total	76,701	84,013	100,139	115,900	145,000
Grand total	269,456	343,848	393,524	489,950	576,150

[1] Does not include budget item "Change in selected resources" for any of the programs.
[2] Includes increase of $10,000,000 for rubella immunization program.
[3] Includes $30,000,000 transfer of funds and program responsibility from OEO.
[4] Includes $30,000,000 for OEO projects transferred in fiscal year 1971 plus additional $5,000,000 in fiscal year 1972 and $7,000,000 in fiscal year 1973 for increased costs and growth of projects.
[5] Total program direction of CHS.
[6] Program direction for sec. 314 only.
[7] Includes chronic disease program.
[8] Includes added $5,000,000 for experimentation.
[9] Includes $5,000,000 in fiscal year 1970 and $15,000,000 in fiscal year 1971 carryover from the $20,000,000 held in "Reserve" from fiscal year 1969.

Mr. ROGERS. Thank you very much, Mr. Chairman. Dr. Egeberg and your associates, it is good to have you back before the committee. It seems to me on the proposal you are presenting to the committee it would change the thrust of the legislation that the Congress originally enacted in these two programs. Would you comment on that, please?

Dr. EGEBERG. I don't think it will, sir, for this reason: There will be an opportunity for independent action, independent budgets, within this overall umbrella. The purpose of the cancer, heart, and stroke program was to involve the private sector of medicine in two things primarily: in raising the level of medical care and in seeing to it that continuing education and possibly some investigative procedures as to how health care could be better distributed, such as has been done with ambulances in some places, so that they are now saving many of the coronary occlusion cases that would otherwise have died before they got to the hospitals. It was to help medical schools, community hospitals, doctors, and practices to work together toward those two purposes.

The other program was and still is the broad, comprehensive planning which ties in with States, which ties in, in some instances, with welfare and in some instances with the health department of the State to see that in the broad organization there is not too much duplication, that there is a pattern of planning toward a common end; and these two will be worked separately; but, already there has been a fairly large amount of working together, cooperation between comprehensive health care planning and the regional medical programs.

I need not give you an example, but one comes to mind. In Maine, the RMP people also run the other, and in a number of States they have gotten together on projects for delivery of health service to the poor, and there has been a feeling-out of how they should relate. This gives them an opportunity to relate but not to become one, and I can assure you personally I feel very strongly about the regional medical programs.

I was chairman of the California group for a long time, and I feel this gives them a better opportunity to carry out their mission than if they sort of continue just independently.

Mr. ROGERS. Well, this is my concern. If we put them under one title, I am not sure we are quite ready for this, I mean combining them, because it seems to me to lay the foundation for a combination which I don't think we are quite ready for.

When we passed the regional medical program, the thrust of this was to come down from our research centers to bring the knowledge down and get it out quickly to community hospitals and to the profession so it could be disseminated quickly, continuing education, whereas areawide planning was just the opposite. It was to start from the grassroots as to what they needed, what this community needed, how many facilities they should have, and to start the initiative from the local level, going up.

Now to put them both together, it seems to me to pervert what the Congress was trying to do at the time—to bring the greatest knowledge from all of the millions we spend, at the National Institutes of Health and so forth, to get it down quickly but to get delivery and to where action needs to be taken locally to generate it from the people who should know best who are in the community.

If we begin to tie this together, I am not sure but one or the other brings about a perversion of what we are trying to do. This is my concern.

Dr. EGEBERG. Well, it would be mine, too, sir, except that we are not bringing them together in that sense. They will have independent action, they will have added correlation of memberships on their committee, of RMP on other committee and vice versa.

Mr. ROGERS. I think we can, in the regular legislation, say: They shall have interchange of representatives on their boards or councils.

I agree with this, and I think it is well to have this coordinated, but I am not sure that the regional medical program should dominate areawide planning or vice versa, because of the situation of the two different thrusts of those programs.

Dr. EGEBERG. I don't think either one should or will dominate the other, and this gives an opportunity for a focus in an overall committee to do a great deal about shaping the future of the delivery of health care.

You can take a look at the budget that is projected, and it is a better budget than would have existed if RMP had been alone. One of my concerns has been to really preserve RMP.

Mr. ROGERS. Yes. I hope this is so, but judging by the request of the administration for money—and I know you say that these funds, although they don't bind the administration, the present thinking in HEW is in this direction, at least in a part of HEW, and I am not sure it really has the whole departmental approval.

Mr. LEWIS. Yes.

Mr. ROGERS. The Secretary is going to stand behind the figures?

Dr. EGEBERG. It does not have final budget approval but has been discussed far enough so that we think so.

Mr. ROGERS. What I ask: Is Secretary Finch going to stand behind this?

Mr. LEWIS. I would assume he would. It has had departmental clearance—these data.

Mr. ROGERS. How do you get departmental clearance? Who gave it? This concerns me.

Mr. LEWIS. Well, I could not assure you that Secretary Finch had personally reviewed each figure.

Mr. ROGERS. This is what I wonder, because this is a problem which I want to question you on quickly, because I keep seeing this problem, that we have statements and we talk about health crises, but somehow something is not communicated to the Secretary.

This is the point I am talking about—the budget request, and I understand budgetary limitations, because we have to deal with them all the time in these programs we authorize, and we authorized above what has been requested by the budget or appropriated, naturally, and this seems to be a pattern, but I am concerned about the communications now and I keep reading reports in the paper, so many lately here, that I wonder if we are getting the message of health crises to Secretary Finch.

For instance—and I don't want to embarrass you, and if you don't want to answer, it is all right, Mr. Secretary—but how many times have you seen Secretary Finch and had a real working conference with him?

Dr. EGEBERG. Well, I would hate to guess at that. We certainly have had working conferences, I would say, on the average——

Mr. ROGERS. I am talking about with the Secretary, now.

Dr. EGEBERG. Yes; I mean with the Secretary present, but with also others than me present, and I would say we have had those several times a week. The Secretary has been away and I have been away, but when we are here, I would say that is true.

I have seen the Secretary when I have a problem to talk about, and, of course, I get to see him then; but maybe I should explain what we do with legislation: first we pull it together in the agency involved, and in this case the agency involved is the Health Services and Mental Health Administration. Next we bring it into my office, where Dr. John Zapp, who coordinates all health legislation and serves as Special Assistant for Dental Affairs, reviews and analyzes it and prepares it for submission to Creed Black's office. Creed Black, as you know, is HEW Assistant Secretary for Legislation, and in his office it is polished and finished and then correlated with the Bureau of the Budget. If there is need for further correlation, beyond that, with the White House, it is also done by Mr. Black, and then it is taken to Mr. Veneman, HEW Undersecretary, and I would say he probably discusses things with Mr. Finch 20 or 30 times a day, so it gets taken to Mr. Finch that way.

Offhand, I would have to guess in this case, but I would say that Mr. Finch has seen this and approved it; or else Mr. Veneman has seen it and felt in principle it was close enough to what Mr. Finch would agree to so that he has approved it.

Mr. ROGERS. What about Mr. Malleck?

Dr. EGEBERG. Mr. Malleck would be not particularly involved in this program.

Mr. ROGERS. In management?

Dr. EGEBERG. I think that Mr. Butler would be more involved in this.

Mr. ROGERS. What does Mr. Butler do?

Dr. EGEBERG. Well, Mr. Butler's job is HEW Assistant Secretary for Planning and Evaluation, and since he covers education and welfare, as well as health, he has a broad view. I would say that Mr. Butler, if it is pertinent to his particular work at the time, may have it brought to his attention, but it may not be if it is something that he is not concerned about at the time.

Mr. ROGERS. Here is what I want: Can you get in to see the Secretary immediately without any difficulty, or do you have to go through the staff and have someone meet with you?

Dr. EGEBERG. No, nobody has to meet with me. If I call the Secretary's office and say, "I would like to discuss something with him," the first question is, "Would you like to be alone?" and whenever I am asked that, they usually ask what I would like to talk about to help the Secretary get ready. If I feel that it is rather personal, which does not often happen, I will say, "I will tell him when I see him"; otherwise I will advise them of the subject.

Mr. ROGERS. So you have no problem in communicating with the Secretary himself?

Dr. EGEBERG. No. I have not found any real problem in communicating with the Secretary.

Mr. ROGERS. Could it be improved?

Dr. EGEBERG. It could be improved if we all had a little more time. HEW is a very busy Department.

Mr. ROGERS. Yes. Here is what concerns me. For instance, when the Secretary talks about crises in health and then we, well, we don't see this carried out in action, such as when he made his statement to the employees through Mr. Veneman, I believe, because he had to go to the hospital, I didn't see anything about health talked about there. I saw education and welfare but not health, and some people have even been referring to the Department as "Little 'h,' capital 'E,' capital 'W'." This concerns me.

Now I see a beginning of combination of programs, and I am not sure that this is meeting it. I can't see that we really are marking progress here by just simply trying to bring the two together when the whole intent is contrary as to where the ideas originate.

Dr. EGEBERG. I can assure you when I first came here, I have been accused of not being very political, but I am aware of certain things and though I may not be very sensitive in that direction, I was very surprised by the fact that in and outside of HEW there was not adequate realization of the importance and the difference that the regional medical programs express. I have helped to enlighten people, both inside and outside of the Department, about this.

I feel very deeply about it. It was my impression that we could strengthen them by doing this. We are not bringing them together in the sense you are afraid of. I can see how once you built a platform, maybe they would fall together or something like that.

The purposes are different and the people involved are quite different. I believe that the people in practice, the doctors in practice, are not quite ready to be brought together by a State plan for comprehensive health care planning on the whole. I think they have representatives who speak for them, who feel that they are coming in that direction. I think that increasingly they have become very happy with the regional medical programs, but I would say, as far as health is concerned, there have also been some major crises in other areas.

Now, naturally, I think there have been major crises in looking forward in health care delivery, and I will still have confidence that we are going to get the money to do something about getting ready to deliver health care. We have plans, we have many plans, but there is not much point in talking about a plan if you can't do something with it financially. I am still confident that health will have its day.

Mr. ROGERS. I wish I were as optimistic, Dr. Egeberg. I feel if they will all listen to you—and I know you are making your voice heard over there—health will be in a much stronger position; and it is not an easy job, I understand, and I do recognize the problem in education and welfare, too. But health, as we talk of crisis—and even the President has mentioned it—yet the actions do not back up the rhetoric. That is what I am concerned with and that is what I think we need to do something about.

How many areawide planning groups do we have in the country?

Mr. LEWIS. I think there are about 113 that have already been funded.

Mr. ROGERS. Is this for planning or operation?

Mr. LEWIS. For planning, and there are approximately 10 or 15 that are in operation, and there are another 30 others which will be operational soon.

Mr. ROGERS. How long has this been going on?

Mr. LEWIS. How long has the program been in effect?

Mr. ROGERS. Yes.

Mr. LEWIS. The law was passed in 1967.

Mr. ROGERS. How many operational in 1967?

Mr. LEWIS. Ten to fifteen—I think I will have to check the records for the exact figure. We will have another 30 or so that will be fully operational. So we will have 40 to 50 totally operational.

Mr. ROGERS. I understand, or the figure I had was 11 operational.

Mr. LEWIS. We have another 30 coming up. By the end of this fiscal year, we should have approximately somewhere around 35 that will be actually receiving planning grants.

Mr. ROGERS. Planning grants?

Mr. LEWIS. For actual planning. We have been, since the beginning of the program, providing a 2-year organizational grant, and by the end of this year approximately 115 total, of which some 35 will be planning.

Mr. ROGERS. Operational?

Mr. LEWIS. Yes, sir.

Mr. ROGERS. How many do you anticipate when the program is completely operational? How many operational areas do you anticipate when the program is completely operational?

Mr. LEWIS. I don't know that we have a total figure, but 113 or so areas cover approximately 50 to 55 percent of the total population of the country at this time.

Mr. ROGERS. That is 100 and what?

Mr. LEWIS. Roughly 115 which currently have grants covering approximately 55 percent of the population of the country.

Mr. ROGERS. These are not operational grants, though?

Mr. LEWIS. No; that is right. I would assume we would need 250 to 300 areas.

Mr. ROGERS. What is the population coverage, do you presume, of the 12 or 13 that are operational?

Mr. LEWIS. We can get that figure, Mr. Chairman.

(The following information was received for the record:)

POPULATION IN AREAS RECEIVING 314(b) PLANNING GRANTS

At the end of the third funding period, approximately April 1, 1970, there were 13 areas receiving grants to conduct areawide comprehensive health planning; that is, they had completed their organizational period. The population in these areas is approximately 16 million, or 8 percent of the national population. At the end of fiscal 1970, there will be 36 areas receiving such planning grants, with a total population slightly over 31 million, or about 15 percent of the national population. By the end of fiscal 1971, there will be over 95 agencies conducting areawide comprehensive health planning, covering areas with over half the national population.

It should be noted that many areawide comprehensive health planning agencies still supported by grants for organizational purposes conduct some planning activities in response to community demand or opportunity.

Mr. ROGERS. It seems to me we are not putting enough input or pressure to get these going.

Mr. LEWIS. I think, Mr. Chairman, that the process of developing a new type of community institution is not a rapid process, and I don't think we should expect that it is a very rapid process. It is not just a question of Federal desire. There has to be fundamentally a recogni-

tion at a local level that a new kind of relationship has to develop between public and private bodies to concentrate on particular social problems, which is essentially what the development of the areawide planning agency amounts to.

The development of the regional medical programs has been faster but one had fundamental institutions that one could deal with, one had a fairly defined focus of dealing with certain kinds of diseases, coming out of a specific Presidential report. I think one had a more precise kind of momentum in that area than medical planning.

Mr. ROGERS. How many regional programs do we have?

Mr. LEWIS. We have 55 regions, and I believe by the end of this fiscal year, all will be operational, and one more will be operational next year. You asked me about the regional medical programs?

Mr. ROGERS. Yes.

Mr. LEWIS. In addition to the problems of creating a new community institution, I would just like to point out that although the legislation was enacted in 1966, we did not receive appropriations for a considerable period of time after that and that the first areawide planning grant was made only 2 years ago, in 1968, so there has been delay since the enactment of the enabling legislation.

Mr. ROGERS. Since 1967?

Mr. LEWIS. Yes; in the fall of 1967 the appropriation was made available.

Mr. ROGERS. Here we are, almost the fall of 1970. This is 3 years, and 12 to 13 are operational. It seems to me that we could give more impetus. I realize this was new, but I think we ought to press for more operational areawide planning groups than those we have.

Mr. LEWIS. I would say, Mr. Chairman, in our budgetary projections and priority determinations stressing the planning front, the emphasis has been on areawide agencies, and every time there has been an uncomfortable budgetary choice, which is daily, we tried to put our funds on the development of areawide planning.

Mr. ROGERS. What about statewide planning agencies?

Mr. LEWIS. Well, we have, I think, 56 eligible jurisdictions—I guess there are territories and so on involved here—and 55 are now participating. The State of Nevada has been out for awhile but has had a change of heart, and I think the State of Nevada is coming back in.

Mr. ROGERS. Are they all operational?

Mr. LEWIS. Yes, sir, I believe they are. They vary in location. Some are in the Governor's office, and I think there are 35 or so which are not in the Governor's office and are in health departments or similar type of departments. The others are in the Governor's office or a similar institution close to the Governor, and there has been a clear movement at the State level to move the State health planning function closer to the Governor and out of the more traditional health or health and welfare departments, so it would have a broad planning function originally envisioned. There have been a number of agencies which actually have moved from a department to the Governor's office.

Mr. ROGERS. Mr. Chairman, I will pass for right now and maybe come back.

Mr. JARMAN. Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman. I wondered about the dollar figures for fiscal years 1971, 1972, and 1973; how do they compare with the previous 3 years?

Dr. EGEBERG. I don't have the previous figures. You can answer.

Mr. LEWIS. In 1969, the total amount was $269 million, and in 1970 it was $344 million, and then in 1971 it was $394 million and then $490 million and then $576 million.

Mr. NELSEN. The money appropriated for those years, was that all expended? Was there any carryover?

Mr. LEWIS. You are talking about 1969 and 1970. There were carryovers that were in the regional medical programs which were developed as a result of expenditure controls, not as a result of program lag. They have been carried over but are planned to be fully expended in 1970 and 1971.

Mr. NELSEN. Now, these centers, in view of there having been a limited number developed, it might appear that perhaps there has not been enough pressure from the top, but there is a great amount of activity required from the grass roots level to make such a program operational, isn't that true?

Dr. EGEBERG. To make both of them operational, yes.

Mr. NELSEN. I have a tender spot for witnesses—I was once a witness myself—and sometimes witnesses get criticism from the legislative side when, in effect, those who may be in charge can only operate from their level, hoping that cooperation from the grass roots level matches their effort to get things going. So I want to say to you, Dr. Egeberg—you say you are not very political, but I want you to know we appreciate the forthrightness that you do bring to our attention when you do appear. Perhaps what is needed is a combination of trying to get the grass roots level and the top level meshed together, and it takes some time to do it.

I remember when the bill authorizing these programs first came before us, the cancer and stroke bill was a pretty gigantic bill as to the size and scope of activities it provided for, but we revised it and provided for a more modest and more workable approach. I realize the big job you have, and I hope that we can work out a successful program. I am sure we can, and I want to say thank you for appearing here today. Drop in to see us at our offices at your convenience anytime.

Dr. EGEBERG. Thank you, sir. I think I should explain that I was considered noncontroversial at one point and therefore I was asked to convene the meetings that started the health planning activities in southern California, and they had difficulties, just as these regional medical programs did, wondering who was going to get the range and at the same time try to involve medicine, organized medicine. I think organized medicine is involved in both programs now and looking to them for help—in one way possibly, a little more with the regional medical programs.

Mr. NELSEN. Has there been pretty good acceptance with the medical profession? Have they tuned in pretty well to some of these programs?

Dr. EGEBERG. Speaking for California, I would say that the regional medical programs became rather well accepted because of the people involved. I think Dr. Marston was the one that started them, and he got an amazing group of people together who are a combination of people with a great standing in the medical community plus good salesmen, and they did go out to the hospitals, to the small hospitals, and they could be seen all over California, trying to make the rela-

tionship between the teaching institution and the hospitals that were delivering the care.

The other program really began—the one that you talk about that comes from the grassroots—when it came down to the grassroots from the Governor, and it took a while to take root, but it is, in California, doing equally well with the regional medical programs at the present time.

I believe—and I certainly had this intent when I approved of this method of approach—that this will help both programs, and it will be a relief to many people to find that there is some kind of basis on which they can cooperate, and I still feel it is a boon to the regional medical programs.

Mr. NELSEN. Speaking of hospitals—which may be a little apart from the hearing here today—we just completed the conference on the Hill-Burton bill, and the evidence from some of the more sparsely populated rural areas was that a complete hospital was perhaps miles and miles away and that there is a need for smaller units not so expertly staffed. It was indicated that some people could go to such a unit, previous to going to a hospital, for some care and attention. I think something could be worked out, and I think our conference report recognizes a need to move in the direction of recognizing these problems. Do you have any comment about that?

Dr. EGEBERG. When you talk with people in rural areas, they use the distance that they are from the doctor or hospital. If they would transpose that to hours or minutes, they are a lot closer than most people in the city. I think in looking at the overall problem, we are probably going to look at it that way.

Our feeling at the present time is that our most desperate need is to start the education of enough nurses so we can have 200,000 more than we have at the present, enough doctors so we can have 50,000 more, and once we get that, we can look at the distribution problem with some hope of meeting the needs. We also have a committee working on that for rural areas.

Mr. LEWIS. I might add to that, Mr. Nelsen, that actually sometimes this problem is a question, particularly in the rural areas, of involvement of new types of manpower, and one of the programs in this bill is the area of research and development, and in just flipping through my notes, your comments reminded me I have seen something here which I thought bears on the point.

We have, for example, a project in New Mexico which involves the development of nurse practitioners to work in conjunction with physicians, utilizing a facility, not a fullblown hospital but a medical facility which had been constructed, or previously constructed by funds provided through a foundation; by the development of this type of manpower, working in conjunction with what is our scarcest resource—namely, doctors, and we can't produce them fast enough to meet our total requirement—by development of skills for a nurse to work with a doctor and cover a wide area, utilizing the technology of telephones or whatever modern conveniences can provide, we are able to get out and use facilities short of a large hospital and with maximum use of manpower.

Mr. NELSEN. This is a concern expressed by one of the Senators from Colorado who had a real concern about this problem. This is

the reason I brought it up and I thank you for your appearance here today.

Dr. EGEBERG. Thank you.

Mr. JARMAN. Mr. Rogers?

Mr. ROGERS. Should kidney disease be covered in regional medical programs?

Dr. EGEBERG. I would like to see it broadened and lose its specificity. By the time you include kidney disease, with cancer, heart, and stroke, you have covered about 80 percent of the illnesses.

Would you say that?

Mr. LEWIS. Yes.

Dr. EGEBERG. Maybe it is a little more. After that, categorization perhaps loses its beneficial effect. The categorization gives you a chance to focus, but if it is focusing on 80 to 85 percent of the illnesses in man, it might be kinder to let it include the other 15 or 20 percent, so I would favor going all the way.

Mr. ROGERS. Now, you plan to use in your comprehensive Health Planning and Services Act, project grants to carry on OEO projects?

Dr. EGEBERG. We are acquiring $30 million worth, but I don't know how many projects that is at the moment.

Mr. LEWIS. The numbers are being negotiated and probably in the area of 30.

Mr. ROGERS. It would be what?

Dr. EGEBERG. We are getting $30 million worth of projects from OEO, but because of the ways the buildings are financed, OEO can finance certain kinds of buildings that we can't because of their law, we are having some problem. It is taking some time to decide which projects should be turned over to us. The concept is that OEO starts things, and they had the original idea with the neighborhood centers, and thus having established them as successful ventures, they should start turning them over to the agency whose job it is to keep things going.

Mr. ROGERS. Are those funds transferred from the OEO budget or to you request them yourself?

Mr. LEWIS. They are included in a budget request for 1971 for HEW. They were eliminated from the OEO budget.

Mr. ROGERS. As of when? 1971?

Mr. LEWIS. Yes, sir, fiscal year 1971.

Mr. ROGERS. How much is that, $30 million?

Mr. LEWIS. The decision was to transfer $30 million of on-going budgetary requirements for the neighborhood health centers. That was a presidential decision. There was no decision as to the number of centers and we have negotiations with OEO as to criteria to be followed in selecting the particular centers and we would assume during this month we will come to final wrapup on it.

Mr. ROGERS. You don't know how much of the $30 million you will transfer yet?

Mr. LEWIS. Yes, sir; the whole $30 million.

Mr. ROGERS. Suppose you don't agree on a particular center?

Mr. LEWIS. One cannot have a Presidential decision without having the agencies come to agreement. The agencies have to come to agreement.

Mr. ROGERS. I wish that was true.

Mr. LEWIS. The President has decided that $30 million of OEO centers will be transferred to HEW and I am using my full and best efforts to make sure it comes out.

Mr. ROGERS. The committee will be interested in seeing if you are successful and which ones.

Mr. LEWIS. Fine.

Mr. ROGERS. I am sure OEO will, but I thought you said there was difficulty? What is the difficulty?

Mr. LEWIS. There was a basic difficulty, sir, that a number of the centers, a number of the centers that OEO has, were actually located in old buildings and, therefore, there was a new building requirement that was levied by OEO or by the center in its development.

Our present statutory authority is not broad enough to cover the same downpayment, interest payment, mortgage payment, and so forth, possibilities which OEO has in its law. This has been a definite stumbling block in our working out the right centers to transfer. By the "right centers," I am talking about which one OEO would want to maintain and which ones we want to accept. We are in the process of working it out this month and I am confident it will be settled.

Mr. ROGERS. It depends not on how long the program is going when it is ready to be turned over, but how you are going to fund the building?

Mr. LEWIS. That is part of the problem. It could be a center which really ought to be moved over from OEO, but which has, however, a building commitment ahead of it. Therefore, we have not selected that center yet, but we may want to take it over with a delegation of authority, and we would like to have the provision which we asked for here to make our authority as broad as is necessary to cover the downpayment and interest payment requirements.

We have made that request in our legislation.

Mr. ROGERS. In this legislation?

Mr. LEWIS. Yes, sir.

Mr. ROGERS. What section is that covered in?

Mr. LEWIS. It relates to, and I am not sure of the new section, but it is the old 314(e) section.

Mr. MOSCATO. The proposed new section in section 925 of the Health Services Improvement Act. The kind of authority it needs is authority to use 314(e) grant funds for equity requirements, downpayment, and also the authority to assist in the amortization of loans, which is what Mr. Lewis was speaking of here.

Mr. ROGERS. In other words, construction?

Mr. MOSCATO. There may be some construction authority involved.

Mr. ROGERS. What about acquiring land?

Mr. MOSCATO. This kind of thing, the acquiring of land, as well as acquiring a building. Frequently OEO neighborhood health centers, rather than build a new building, will acquire existing structures. If only minor renovation is required in an existing structure, existing 314 authority can take care of it and assist, but in terms of cost of acquiring land or buildings, 314(e) authority is not sufficiently broad.

Mr. ROGERS. I think this committee has never approved acquiring of land, I though we just went through that on Hill-Burton again and we feel that local efforts ought to at least provide land.

Dr. EGEBERG. I can tell you about the one in Los Angeles. We had

the land donated by the city, but it was an area, probably a mile and half long, where every building had been burned and it looked like one long skating rink, and all of the concrete slabs were there, but no buildings were to be had in the whole area where we wanted the service. That is one.

So we got the prefabricated buildings which were put up rather quickly, but with the amortization procedure which was allowed under OEO. That is not allowed under HEW.

Mr. LEWIS. That is my understanding.

Mr. ROGERS. Because we do go into construction, for instance, Hill-Burton, and these types of programs, but I don't recall our approving acquisition of land because we felt that all of the money would go to the land then and we may never get anything done then.

I would think we would want to know your full contingency and all of the authority that would be asked of the committee.

Mr. LEWIS. Mr. Chairman, I would like to be able to follow your request and to amplify it to make sure the record is clear as to what the centers are and what the various building or equity financing problems may be. I am quite sure really that we have land funds. I know we have a number of centers that are good and are really in business on which building commitments have been made and if we are to carry through with the transfer, then this type of legislative amendment would be necessary, of course. I would like to give you a good statement for this record on that.

(The following information was received for the record:)

NEED FOR TECHNICAL AMENDMENT TO SECTION 314(e) TO PERMIT TRANSFER OF OEO PROJECTS

The Administration has developed a policy that certain mature neighborhood health centers as supported by OEO will *annually* be transferred to DHEW for their continued support. This policy will become effective with the FY '71 appropriations. Accordingly, some $30 million has been requested as part of the FY '71 DHEW appropriation to support a given number of OEO neighborhood health centers under 314(e) of the PHS Act. However, while the OEO program has broad authority vis a vis the use of funds for neighborhood health centers, the existing authority of section 314(e) of the PHS Act is not sufficiently broad to utilize 314(e) funds to continue the same degree of support to these transferred neighborhood health centers. More specifically, although many of the projects to be transferred from OEO to DHEW are presently utilizing OEO funds to meet mortgage payments and other equity requirements associated with the purchase of a building, present 314(e) authority does not permit use of grant funds for these purposes. Accordingly, while the Administration has requested $30 million as part of our 314(e) request for FY 1971 to support a given number of OEO neighborhood health centers, existing authority is not sufficient to provide the total support necessary.

Lines 10 and 11 on page 28 of H.R. 15960, the Health Services Improvement Act, would provide the needed authority, if the phrase "equity requirements" were inserted between the words "including" and "amortization," omission of this phrase was inadvertent. "Equity requirements" is generally understood to encompass a down-payment money and other kinds of liquidity requirements associated with purchasing a building.

Mr. ROGERS. I think that would be helpful. Thank you. What do you plan to do with health service research and development?

Dr. EGEBERG. We look on regional medical programs and comprehensive health care planning and the statistical center as an opportunity to lead the delivery of health care in this country. The research and development part under Dr. Sanazaro would have many possible opportunities.

The one that I personally envisage it would have, aside from operations it runs on its own budget, is the opportunity to educate this overall committee, which will not be giving out grants, but whose purposes will be the broad trends that they think the programs should follow. It would be involved, as I said, and in addition to its own granting for research projects and delivery of health care, it could be inestimable importance in keeping the committee, which I think will be an extremely important committee, aware of where we might best be going, of things that have been tried and of directions that look promising.

Mr. ROGERS. What do you or how do you plan to tie in the environmental health features into health planning and regional medical programs?

Dr. EGEBERG. I think I am going to wait and see what the Ashe committee recommends.

Mr. ROGERS. I just wonder about this.

Dr. EGEBERG. We had that problem to face in southern California when we established the comprehensive health care planning. We involved the health departments of the various counties or cities or whatever municipality might have a health department, in the overall planning, and they had usually the head of the department on the board that helped make the decisions. Their interests were in milk sheds and in small sheds and in sewage disposal and in reconstitution of water and they were brought into the planning, at every level that we could bring them in, including the safety level.

Mr. ROGERS. Well, I would think that we need to move, rather than wait for Mr. Esch and his committee, because I don't know how long we are going to have to wait. We have been waiting in the marine field for some time now. That is to see what we are going to do, that is, whether we are going to have a separate agency there.

But it seems to me we ought to have areawide health planning certainly putting an input on the health factors of the environment and this should have, I would think, a rather high priority and I would hope that that could be done or cranked in.

Dr. EGEBERG. We have input from the extensions of our environmental health services at the regional office level who coordinate with these programs and then, we have the input of the people actively interested in the environment at each level on the advisory committees and in levels where they can ask for money.

Mr. ROGERS. Now I see in your statement on page 16 you say: We are committed to a bold research and development program to deal with, one, rising costs and inadequate financing methods.

What bold research and development program are we really carrying out? That is for health costs? I have not yet seen any and I am concerned and I think the American people are, about the fantastic rise in our costs and I would agree we do need to do something.

Dr. EGEBERG. Dr. Sanazaro has, in his area, a number of projects with hospitals, clinics, with cities, and with other governmental subdivisions, studies as to how one can change the delivery of health care.

Now I don't know that this is the place to speak about it, but we will also be watching the changes in things that we think are forthcoming, changes in medicare, where we have opened up a new option, so that doctors who are practicing and who are certainly in a better position to see how they can be more efficient can come up with their own efficiencies rather than having us try to spell them out in Washington.

That will, of course, be evaluated to a degree in Dr. Sanazaro's area. Would you like some more specifics, because Dr. Sanazaro is here?

Mr. ROGERS. Yes, if he can give it quickly and concisely.

Identify yourself.

Dr. SANAZARO. Dr. Paul J. Sanazaro, Director of National Center for Health Services Research and Development.

The problems of rising costs and inadequate financing are, of course, related to other major priorities of the department, which is to improve the availability and access of health services in the face of inadequate distribution and availability of resources. We all recognize that. Therefore, no fundamental attack on the disproportionate inflation can be effective if it does not deal precisely with matters of maldistribution and inadequate resources.

Therefore, the National Center's attack on the cost problem is twofold: First, to identify the unnecessary overhead and expenditures that are encountered in present federally supported programs and, in proper partnership relation with the private sector, identify and work toward the development of new mechanisms that eliminate the unnecessary overhead expenses.

Mr. ROGERS. What are some that you found?

Dr. SANAZARO. The one which is well along is the approach to all-inclusive rate charges by hospitals rather than reimbursement on an itemization basis, that is, substitution of a standard rate reimbursements for so-called "a la carte" reimbursement methods. This change will eliminate the need for a large number of personnel who now do nothing except handle little pieces of paper which in no way contribute to quality of care.

It is a simple efficiency measure. If present estimates are borne out by the project in development, there will be recurrent annual savings nationally of somewhere between $300 and $700 million by the elimination of this type of unnecessary overhead.

Mr. ROGERS. In other words, you would have a flat rate for service per day to a patient going into a hospital?

Dr. SANAZARO. Yes.

Mr. ROGERS. And would it save the patient or the hospital cost?

Dr. SANAZARO. It would, to the extent that the savings in expenditures are distributed between the provider and consumer, both would benefit.

Mr. ROGERS. Well, how am I going to benefit if I would not have to have all of those services?

Dr. SANAZARO. Yes.

Mr. ROGERS. Would I have to pay for them or take care of those given to somebody else?

Dr. SANAZARO. To the extent that the rates charged to the patient included unnecessary overhead which would be eliminated, and this proportion varies by service in the hospital, by location of the hospital by geographic area, the savings would be divided between the consumer and the various third parties.

Mr. ROGERS. Have you any other suggestions?

Dr. SANAZARO. Yes. The second major point of attack on costs is the interinstitutional arrangement problem, that is, an arrangement that exist between hospitals, extended care facilities, nursing homes, other care facilities, and organized home care.

At the present time there are some regulations which require certain procedures to be followed that increase the cost of adequate care. For example, there is the requirement for payment of extended care benefits under title XVIII that the patient be confined to an acute hospital bed for 3 days, and this clearly adds unnecessarily to the cost.

Mr. ROGERS. Has that been changed?

Dr. SANAZARO. No.

Mr. ROGERS. Have you recommended that it be changed?

Dr. SANAZARO. This is a matter for the Department.

Mr. ROGERS. Yes. Dr. Egeberg, could you comment on that? Has the Department recommended a change?

Dr. EGEBERG. This is one of the things we are looking into. The idea is to get the patient into the cheapest bed in which he could be cared for adequately and I think one of the experiments that Dr. Sanazaro is interested in is this segmentation, even within a single hospital, that one can have patients in a $150-a-day bed and $35-a-day before one moves to a nursing home or lesser care facility.

We are working on this and it would seem to me to be almost a potential $1 billion. If every patient who stays in a hospital on medicare and medicaid were kept one extra day, we have estimated it would cost somewhere between $350 and $400 million a year just on that one issue. That becomes a very difficult one.

For instance, a doctor who has operated on a woman, decides on a Thursday that she can go home on Friday. She says, "My husband can pick me up much easier on Saturday and you know I have three children at home and I have to go back and take care of them, and I might need an extra day's rest."

Well, she does and if she stays that extra day, and everybody does, that amount of money then is involved. You know also if she were paying the bill, she probably would have gone home on Wednesday at her own insistence.

Now this is a difficult problem, but by integrating the expensive services in a hospital with the more reasonable services and perhaps developing even self-service areas of the hospital, tying that in with a nursing home, the doctor does not have to make that decision. He can put her into a $20-a-day bed, let us say, instead of the $80-a-day bed.

We are working on this and it is something that we expect will begin to appear in the part C, so-called, of the medicare program where the options start. I think the doctors themselves will not only keep people out of hospitals a lot, but will get them into the cheapest area of the hospital that they can.

Mr. ROGERS. Well, I think this is one approach that we need. In fact, we have written this into the Hill-Burton bill, as you know, this year encouraging hospitals to build extended care within the core of the hospital or immediately adjacent thereto, so it can be done, as you know, and we hope the department will really press it.

Dr. EGEBERG. We are going about it at all levels.

Mr. ROGERS. I think that will be helpful.

Now, are there any other particular suggestions?

Dr. SANAZARO. I want to simply stress that direct savings could be realized by implementation of knowledge and information gained

from research in health services. Integrated extended care facilities are extremely important in this regard because it has been documented that use of free-standing extended care facilities has added to the cost under title XVIII. This is the lesser approach, but it is the "bird in the hand" and that is why we go after it.

The major attack on health care costs will involve the distribution problems and resources problem. The National Center is focusing upon the systems development of health care where there will be predictable results from investment in health care resources and distribution, This relates to your concern, that the local areawide planning group would be able to have assurance their decisions will lead to desirable consequences rather than, as has sometimes been observed, unforeseen undesirable consequences.

Mr. ROGERS. Yes. Let me ask you this. What is being done about unequal distribution, utilization of health services, that is, and shortage of professional and paraprofessional personnel?

Dr. SANAZARO. Yes, the two are inseparable because services basically means manpower doing what they are trained to do. In view of the inability of anyone to influence the distribution of physicians in the United States, the National Center has proposed and set in motion a 5-year demonstration project using physician assistants to substitute for certain physician actions in areas there are no physicians. For example, returning corpsmen and pediatric nurse associates are capable of performing what are called "primary care services," that is, caring for the ordinary things that happen to a great bulk of people in which physician services are not indispensable.

In the next 5 years we propose to support training of enough of these individuals in enough parts of the United States to answer the questions that have to be answered before we can say that physician assistants ought to be a permanent part of medical care in this country. We are not sure that ought to be so, but because we can't turn to more physicians and because we can't move physicians, we can train these personnel at a much lower cost, and more importantly, we can see to it they are deployed in the areas of greater need.

Mr. ROGERS. How many corpsmen are you using in this project?

Dr. SANAZARO. The initial pilot project in the State of Washington involves only 14 in actual field deployment with general practitioners. We are about to support a series of replications which will increase that number to approximately 100 in the coming year. Over the next 5 years we intend to support up to 1,000 corpsmen, with the understanding they will be carefully evaluated and deployed in areas of greater need.

Pediatric nurse associates will be trained in approximately the same number, again for purposes of evaluation. The current evidence is that two such individuals properly supervised can substitute for one physician in providing primary care.

Dr. EGEBERG. We also have a committee under Dr. William Anlyan, dean of the School of Medicine at Duke University, looking into the use of people who have finished training in areas such as slums and remote rural places.

Obviously, you just can't put a doctor there and expect him to take root. You have to have some kind of a structure. As we look ahead, there has to be a structuring of this so one might have, let us say, a

clinic capable of using eight or 10 people and have two or three of those full time, which might be one of the new purposes of the corps of the Public Health Service.

Then, to these structures will come a turnover of these doctors who have finished their training. We are at the present time wondering whether to try this as a pilot project on a volunteer basis or whether we feel that we should have to ask for legislation someday making it compulsory.

You can't buy them into some of these areas. You can't do it with money. The strange thing is that in other countries where there is a policy of distributing doctors where they are needed, the doctor will often fall in love with that place or with the people's dependence upon him and stay a much longer time than he is really required to.

Mr. ROGERS. In areas where you cannot get doctors to go, shouldn't the Public Health Service assign doctors to that area to get health care in there?

Dr. EGEBERG. Yes, we are reviewing the whole Public Health Service.

Mr. ROGERS. You have authority to assign commission corps officers?

Dr. EGEBERG. We can assign them and this would be one of the purposes that I think the commissioned corps might be asked to carry out.

Mr. ROGERS. I would think we probably will have to. There are many communities that you cannot get a doctor to go to.

Mr. LEWIS. We don't have that authority.

Mr. ROGERS. You cannot now assign a commissioned officer anywhere in the world?

Mr. LEWIS. No.

Mr. MOSCATO. It is not the assignment, Mr. Rogers, but a question of what the commissioned officer will do.

Mr. ROGERS. He can open a Public Health clinic, can't he?

Mr. MOSCATO. The authority the Public Health Service is to deliver direct health care services to specified beneficiaries, and that is limited by statute in remote areas to Federal employees, to Indians, to members of the Armed Forces and their dependents, this kind of thing.

On an emergency basis, of course, any civilian would be eligible to receive health care.

Mr. ROGERS. I say it is emergency if you haven't got the medical health care there in the community, wouldn't you, if you are sick?

Well, I think the law is probably sufficiently broad, as I recall, to allow you to operate in these areas in emergencies without question.

Mr. LEWIS. It particularly was restricted a couple of years ago with respect to where Public Health Service officers could serve during a 2-year period of service, which was in lieu of serving in the military.

Mr. ROGERS. Who restricted it?

Mr. LEWIS. Congress.

Mr. ROGERS. To what point?

Mr. LEWIS. I can't speak to that point.

Mr. ROGERS. You mean to the point of military service credit?

Mr. LEWIS. Yes.

Mr. ROGERS. I am not talking about that.

Mr. LEWIS. Well, that is a large part of the Public Health Service.

Dr. EGEBERG. That is where we are looking into the whole problem, both of the commissioned corps and of this particular problem of

distribution of health care. They will come together, I think in a suggestion for some new legislation when our committee is through.

Mr. ROGERS. What is the time element on that, would you think?

Dr. EGEBERG. I would say if you let the committee take its time, it would be 2 years, but I can guarantee it will be 3 or 4 months.

Mr. ROGERS. That is encouraging because I think we should begin using the Public Health Service to serve the public in these areas where there is no help.

What are we really doing in a bold program to develop preventive medicine?

Dr. EGEBERG. Part C of medicare, which we hope to also develop with the states for medicare, would, to my mind, make doctors see the advantages of doing everything they can to keep a patient well.

Now, when you have a cost-plus system of care, both for the hospitals and physicians' fees and for all the rest of it; it is a long way from that kind of incentive to improve the system. By giving this to the doctors, I think we are going to see a tremendous improvement in the system.

They will make sure that everything is done to keep their patients out of a hospital and see to it that they are kept well through education, through adequate frequent visits, and I think that is the most active push we can make on that score. It will be a push on all medicare patients and it will be a push on the medicaid patients where the states agree with us.

A group of doctors can get together, a medical society, a medical school, a hospital staff, a clinical staff, and using the local costs that we already know it takes to care for 1,000 people on medicare in that community for a year; they can make a bid that they will do it for about 5 percent less and they will do all righ by keeping the people healthier and by seeing to it that they are not in the most expensive beds in the hospitals and the whole thing will come on their shoulders.

It is not they have been laggard, but I think they have been confused as to handling these problems.

Mr. ROGERS. In other words, group practice, in effect?

Dr. EGEBERG. Group practice, prepaid group practice.

Mr. ROGERS. And try to give an incentive to keep a patient out rather than putting them in the hospital.

Dr. EGEBERG. We are going to call it something like incentive health care.

Mr. ROGERS. How many projects?

Dr. EGEBERG. This has not been passed yet. This is in committee now.

Mr. MOSCATO. No, it was passed by the House, as the Social Security Amendments of 1970, a week or 2 ago.

Mr. LEWIS. It is before the Senate.

Mr. ROGERS. Can you anticipate about how many projects?

Dr. EGEBERG. We would anticipate quite a few, and it might take a year to tool up and a year to find out what the potential is, but once it is understood, I would anticipate a tremendous upsurge.

Mr. ROGERS. Similar to the Kaiser plan?

Dr. EGEBERG. Yes, similar to the Kaiser plan. It is our last effort or the last one I can see on a big scale where we are trying to give the ball back to the doctors to solve the problem because you can't solve them here.

Mr. ROGERS. Do you use a peer group determination of fees and quality of care?

Dr. EGEBERG. No, in this case they would say, well, say it averaged—and I don't know what it would be—but say it averaged $300.

Mr. ROGERS. Well, I understand that. I was not now speaking of a group practice, but I am talking about in any of our programs now, are we using peer review?

Dr. EGEBERG. Yes, we use peer review in a large number. Peer review is a very difficult time-consuming thankless job and those counties or States or areas that have done well with it have really sacrificed to do it and where it is done properly and with enough force behind it, it is the opinion among the doctors it can do a tremendous thing in cutting down costs.

But it takes a long time to establish this. I don't know how much peer group review is being successful at the present time. If you asked the doctors, I would think that a great deal would be stated, but if you ask the hospitals, they are not quite so sure.

Mr. ROGERS. Dr. Egeberg, we keep hearing reports that morale is low on the health side of HEW, that resignations—or some resignations have indicated, that I think Dr. English's resignation has, and do you anticipate more resignations and what is your comment on the morale?

Dr. EGEBERG. Well, I think the morale is, a sort of unhappy nature as far as the money is concerned, but these institutions have been able to survive that all along. They can face stringent budgets and adjust accordingly. It would be a failure of their duties if they didn't complain.

I think the morale issue has been sort of bothered unduly by the personnel question, as relatively few people have been affected that way. I think they will be cheered by the fact that the job that Dr. English holds will again be made a career job and Dr. Marston will be reassured that his job is a career job and I think it desperately important that this be done.

The Secretary has expressed his strong desire to do that. I would like, that when that happens, there will be a different feeling in morale. But when you see a lot of problems that need solving and you are working in a period of a very stringent budgets, and particularly if you have been used to some of the budgets that National Institutes of Health have had in past years, you have to make quite a bit of readjustment yourself.

I don't believe the morale is bad. I think that right now they are worried and if these two changes that I mentioned are made, as they are about to be, I think that will make the morale problem just a usual problem.

Mr. ROGERS. So the head of the National Institutes of Health is being reassured this is a career and not a political appointment?

Dr. EGEBERG. Yes, sir.

Mr. ROGERS. And also Dr. English's job, you say, will be in that category?

Dr. EGEBERG. Yes, it is about to be changed back to a career job.

Mr. ROGERS. How much of politics actually invaded the department, would you say?

Dr. EGEBERG. Well, if I could just use my own personal experience, I am a Democrat, as you know, and I felt since I was offered this position in a Republican administration I should try to get Republicans in because it is an opportunity for them to get educated on this subject.

Well, you can laugh, but the Republicans among the doctors are mostly in practice and, as I go through my friends that I have suggested or people that I know, which I have suggested for jobs, it is amazing how many of those that have the qualifications have been Democrats.

It explains why it has taken me longer to fill out my own staff than it otherwise would. Now, this is being done without any sacrifice of quality. It is just taking longer to find them and we are now going ahead, and I think we will be able to announce several more appointments in my office shortly.

Once we have a full complement, it is going to make a tremendous difference, because that description of a one-armed paperhanger with the hives is a pretty good description of what most of us have felt in the last 6 or 8 months.

Mr. ROGERS. Is it my understanding, then, that it is a practice for a political clearance before appointment now?

Dr. EGEBERG. Well, the major positions in my office are considered as political appointments. I think that is the reason the office was set up that way.

Mr. ROGERS. I see. What about throughout the health field now?

Dr. EGEBERG. Well, one hears about it at times.

Mr. ROGERS. Yes, I had understood some letter went out and I don't know—well, I read this in the paper—some letter went out to the deans for recruiting of people and saying they should be of a particular party or at least not of the other party.

Dr. EGEBERG. I saw that letter and quickly forgot who even wrote it, because it sounded like quite a letter to me.

Mr. ROGERS. Yes, it did. I was quite concerned.

Dr. EGEBERG. I don't suppose this is the place to talk about politics, but the Republicans have not had people in these positions and they need training in them. I must say I have not, except for very little been outmaneuvered.

Mr. ROGERS. I would be concerned that we equate health services with a political party. I realize I am not naive enough to know this is not done by every administration to a certain degree, but I am concerned that it seems to be almost a prerequisite now, according to the reports, and I hope this is not so and I hope you can assure the committee of that, that this is not a prerequisite to service in the Department of HEW.

Dr. EGEBERG. I think you will find in some moves we probably will be making in the next month it is not a prerequisite.

Mr. ROGERS. Well, I would hope that is so.

Dr. EGEBERG. Well, as I remember it, Mr. Gardner found he could not influence the Public Health Service as much as he needed to, to follow up any ideas that he and the administration had, and that is why they set up the Offices of the Assistant Secretaries in HEW.

They are political to help the administration put forth its ideas in the direction that something should go. To my mind, it is equally important to encourage the career people by having them have the opportunity to go right to the top of the agencies. That does not mean you will always find them within an agency, but it does mean that they feel it is not a political appointment.

I think these changes will make a big difference. You already are aware of the fact that this question of scientists is being looked over in a rather narrow way, both politically and otherwise, and has been solved. Secretary Finch appointed a committee of outside consultants to look into the whole question and really faced it squarely.

Up to then, I think people had taken care of each individual issue by making an exception at the Secretary's level, but he did take that step forward and that issue has been solved.

Now if we get assurance that these two top jobs are career jobs, I think you will find a completely different atmosphere.

Mr. ROGERS. And a change of morale?

Dr. EGEBERG. Yes.

Mr. ROGERS. I hope so and I think it is encouraging.

Let me conclude by saying I am glad you are in there fighting and I hope you will stick with it and I realize this is not easy. I also think that we have spent millions, and I am now trying to assemble that figure, millions of dollars on research on delivery of health care. Ever since I have been on this committee, we have been talking about research for delivery of health care and I know it is important, but I haven't seen too much result come out of it and now we know what we need basically—personnel in the right place to give the care and then, of course, we have a cost factor.

But surely I would hope that, for instance, you talk about a 5-year program on corpsmen and I realize some of these things take time, but I would think we could up our timetable to where we have 25,000 of those young men coming out and I would hope we would appeal to more than 14 or 100 in an active way, to get them involved in the health field and to expand your commissioned corps, if necessary, to get health care to the communities that do not have it.

I think this committee is willing to cut across some red tape and if you will get some requests if you need more authority, because I think the Congress will respond, because we are in a health crisis and we talk about it and yet we are cutting costs on support of medical schools and cutting the costs in support of scholarships and that is not the way to solve it, because we have to have manpower.

I am encouraged, though, by some of the steps that I think you are beginning to take and I think if you could give them a little more jab, which I think you are capable of doing, Dr. Egeberg, I think we will see health improvement.

Thank you and thank you, Mr. Chairman.

Dr. EGEBERG. Thank you, sir.

Mr. JARMAN. Mr. Nelsen?

Mr. NELSEN. I don't know that I have any more questions, but I want to congratulate Dr. Egeberg in getting by in spite of the fact he is a Democrat. I ran the Rural Electrification Administration

under President Eisenhower and I did find it necessary, in policy level positions sometimes, that you have somebody that is in tune with policy. Quite often I found that there could be throat-cutting exercise going on down below which mde it very difficult. I am sure there is that possibility in every department of Government, so I want to say in defense of some screening that it is sometimes necessary to get the job done. I am sure that Paul recognized it as I do and I want to join with Paul and the committee in saying, "Thank you, Doctor." We believe you are really sacrificing something to spend your time in your present position since you might have done better financially in private practice. We are glad you are there and congratulate you on your task.

Dr. EGEBERG. Thank you, sir.

Mr. JARMAN. Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman.

Dr. Egeberg, I want to just ask you about something that I read about in my own newspapers back in Maine this weekend, the Maine Sunday papers, or one Sunday paper, had an article that talked about the Maine Medical Center, which is our largest hospital in Maine, and it talked about the reduction or shutting off of funds for research into heart and blood and it indicated the concern of a doctor, or doctors, and it brought to my attention again a small program, but an important one, in our State and I would like you to tell me what are we going to do to get research funds back and what can we do in this committee to help you?

Dr. EGEBERG. Well, I think you should know that for the first time in 4 years the National Institutes of Health budget has gone up $65 million and as it was steady for the previous 3 years, this is an administration indication of intent not to let research fall below that level. It was felt that the $65 million, which is roughly 5.5 percent, I believe, would take care of the inflationary costs and they would be able to continue.

Before that, having continued on roughly a $1 billion level, give or take a couple of hundred million, and this is the only place we speak of $100 million as "point 1," it has been steady and with the inflation it probably means that during that period there has been a reduction of about 25 percent in productive research.

Now this has perhaps been good. If you have had fat years, sometimes lean years are helpful, and in the course of lean years one often hurts people that should not be hurt, but gradually one finds those that are either not very imaginative or those whose work is over and who need to approach something entirely new.

I think you will find very many people in the research community who feel that doing the cutting that has occurred so far has been all right, but they all express alarm if the cutting continues any further. There is no doubt in my mind that research and education are our two greatest national resources and they make gold or platinum or iron look pale, and I can assure you that we are going to do our best to see that research does not go down during these next 2 or 3 difficult years.

One hopes that as soon as we get by there, that the research community itself will have made enough noise so we can start going up again.

Mr. KYROS. Thank you, Doctor, one of the things in these bills before us, of course, is extending the heart, cancer, and stroke programs, is that right?

Dr. EGEBERG. Yes, sir.

Mr. KYROS. Now having come to the age now we begin to take acute and sensitive awareness of people in their 40's dying from having a stroke or heart attack, let me ask you, do we have available a diagnostic kit that we could give cardiologists where inexpensively they could take every man as he approaches his 40's and give him a blood profile test to tell what all his characteristics would be and set him up in a kind of regimen so we could save these people, because I think they are pretty valuable to their families and country in their 40's. The question is, do we have a kit which we could take out to cardiologists?

Dr. EGEBERG. I would say taking it out to cardiologists is probably "taking coals to Newcastle." I am sure they have 10 or 15 kits apiece. It is to others that perhaps such a kit should be taken. We certainly do have now an availability of blood chemistry tests done amazingly cheap compared to old times through the computer and through electronics, and I am not sure I understand how it is done, but one can now get 10 or 12 or 15 tests done where for the price of one would formerly have to pay for, say, two.

This is certainly going to change the attitude and the practice of medicine. In the old days the doctor took a history, which meant the patient came to him because he had a symptom and then he did a physical examination and when he got through, he hypothecated one or two diagnoses and then said, "Well, we will do one or two tests and see which one it is."

Now we hope to see the patient, as you suggest, before he has his symptoms so we can warn him.

It is this panel of tests that will help us to determine those patients who might have trouble with their vascular system later.

There is certainly one thing that is helpful there. Look at your own family's vascularity and if you have had people in your family who have died of strokes or heart attacks at an early age, it would particularly behoove one to do something himself. I think right now that the availability of these multiple tests is spreading across the country about as fast as they can be manufactured and there will be opportunity for every doctor, wherever he is, to find out if a person should be warned and to start on a regimen.

After that, it is a job of selling.

Mr. KYROS. Perhaps I stated it wrong. I said, "Sent out to the cardiologists," and as you pointed out, they probably already have them. But I meant to send them out to doctors, particularly in rural areas where you don't have a man specializing so that the general practitioners can make this test somehow and get the blood to somebody and send it somewhere and come back with a spectrum analysis and we

can get to talk about lymphoids and all of the items in the blood.

Can we have that done?

Dr. EGEBERG. This type of equipment is being put into smaller and smaller hospitals. There has to be a certain load, to make the hospital feel it could afford it, but once it gets over that threshold, it certainly makes ten tests available where only one used to be available.

I can't think of many places that would not have a hospital where it could be done rather close at hand or a laboratory where these could be done rather close at hand. Certainly, that is where the great pressure of education is right now.

The heart is a very proper organ to be associated with and in medicine this a great deal of stature or status in association with heart disease. Things go in medicine the way they do elsewhere, and I think much of this will happen in a combination between the doctors and industry and the hospitals.

Mr. KYROS. Thank you very much.

Dr. EGEBERG. Thank you.

Mr. JARMAN. Any further questions?

Doctor, we appreciate the able testimony that you and your colleagues have given to the committee this morning.

The committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12 o'clock noon the subcommittee adjourned, to reconvene at 10 a.m., Tuesday, June 2, 1970.)

COMPREHENSIVE HEALTH PLANNING AND REGIONAL MEDICAL PROGRAMS

TUESDAY, JUNE 2, 1970

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. John Jarman (chairman) presiding.

Mr. JARMAN. The subcommittee will please be in order.

We will continue the hearings on H.R. 15960 and other bills relating to the heart, cancer, and stroke programs and the comprehensive health planning program.

Congressman Biester, we are pleased to have you testify first this morning.

STATEMENT OF HON. EDWARD G. BIESTER, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. BIESTER. Thank you, Mr. Chairman. I will not tax the time of the subcommittee greatly this morning. I know that you have a list of very distinguished and very expert witnesses prepared to testify in detail with respect to pending legislation.

I simply wanted to be here to express the interest which is widespread, I believe, in the Congress with respect to action on the part of the Congress in the area of kidney disease.

I was privileged to be one of the sponsors of a bill styled as the National Kidney Disease Act of 1970, in which over 110 of our colleagues were cosponsors.

I believe that in addition to that legislation there has been other legislation submitted, both by the very distinguished ranking member, the gentleman from Minnesota, the gentleman from Kentucky, and other members of both your subcommittee and the full committee.

I am simply here, not as an expert and not as one who can presume to discuss in detail the full problem in its national sense, but simply as one who, as a result of his work with other Members of Congress in this field, believes that the time has come to do something and to do something soon, that time is running out. And I wish to express my support for the chairman's bill here this morning. I feel it is important that the chairman and the committee support this bill.

I request permission to file a statement for the record.

Mr. JARMAN. Without objection your statement will be placed at this point in the record.

(Mr. Biester's prepared statement follows:)

STATEMENT OF HON. EDWARD G. BIESTER, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I want to thank the members of the Subcommittee for the opportunity to present this statement.

One of the major problems facing medicine and public health is the lack of trained personnel, available facilities, research and equipment for the diagnosis evaluation, treatment and prevention of kidney disease. No parallel situation exists in medicine; that is a situation in which successful techniques have been developed for the diagnosis and prevention of diseases which would save lives, and yet at the same time, people continue to die from kidney disease because of the lack of facilities to supply those techniques for diagnosis and treatment.

Over 110 Congressmen, including myself, have introduced legislation entitled "The National Kidney Disease Act" which would authorize funds for five years to support cooperative arrangements among medical schools, research institutions and other institutions and agencies to develop and activate larger capacity to prevent and control kidney disease. Identical legislation has been introduced in the Senate.

Physicians report that 10,000 of the kidney disease patients who die each year are considered medically to be good candidates for artificial kidney machine treatment and kidney transplantation. An additional 10,000 patients would benefit from such treatment. Only 3,000 patients have received artificial kidney machine therapy since 1960, including the 500 new patients treated in the past year. Many patients whose lives might be maintained for a significant number of years are now dying because treatment is not available. In spite of the fact that improvements in both dialysis and transplantation technology are needed, I believe, as do many experts (and I am not an expert), that these two forms of therapy are sufficiently well advanced to warrant launching a national program to provide such treatment for those medically suitable patients for whom it is not available today.

Dialysis and transportation are both extremely expensive and many individuals whose lives depend upon receiving one of these methods of treatment simply are not able to afford it. I don't think we can justify any longer the selection of candidates for treatment on the basis of ability to pay.

A physician should not be forced to choose among his patients as to who shall receive the life-saving treatments, but should be in the position of offering these treatments to all of his patients who might significantly benefit from them and would die without them.

In presenting the 1967 report of the Committee on Chronic Kidney Disease, which had been charged by the Bureau of the Budget with the responsibility of considering all aspects of the problems posed by chronic kidney disease, the committee chairman, Carl Gottschalk, M.D. stated:

"If a national treatment program is adopted, the Committee wishes to emphasize that it must be a continuing program that has as its objective the provision of these treatment modalities at the earliest possible date for all who require them. Until treatment capability meets demand, agonizing decisions concerning patient selection are inevitable at both the local and national level."

I believe it is time for Congress to give immediate consideration to legislation providing for a comprehensive approach to kidney disease. I consider this one of the most pressing health problems in the United States, because we can and must take advantage of the discoveries of medical research to provide the proven life-saving treatment to the sufferers of kidney disease. Failure to take this step would be a demonstration of a cruel performance gap, a gap which lies between our known and proven capability and our inadequate performance.

This legislation addresses a matter of human concern no less than the very lives of thousands of American people each year. I urge your favorable consideration.

Mr. JARMAN. Thank you very much, Mr. Biester.

Are there any questions?

Mr. NELSEN. I have no question, except to thank my colleague for his appearance here and also to point out, as he had already mentioned, I am one of the sponsors of a kidney disease bill.

This first came to my attention from a Legionnaire in Fairmont, Minn., who has a relative that had been forced to make use of the equipment, if you can call it that, and was very concerned about it. And I think there is great merit in your testimony. And I thank you for your statement.

Mr. BIESTER. Thank you very much.

Mr. JARMAN. Thank you very much for being with us.

Mr. BIESTER. Thank you, Mr. Chairman.

Mr. JARMAN. Next we have with us this morning the Honorable Howard W. Robison, our colleague from New York. Mr. Robison has a statement he would like to present to the committee. Proceed as you see fit, sir.

STATEMENT OF HON. HOWARD W. ROBISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. ROBISON. Mr. Chairman, I appreciate the opportunity to express to this subcommittee my views on the question of public health for I believe that this subject is of vital interest to all Americans. Our attention must not only turn to the question of how to provide adequate medical services to American families, but also how to do so in such a way that these families can afford to participate. Just as other costs are increasing, so too are costs of medical services. Anyone who has had the misfortune to suffer a recent illness can readily testify to the high cost of doctor bills, operations, medicine and hospital care. These costs are most relevant to these hearings because often the cost of medical care absorbs a major portion of one's income during a time of serious illness. The result for one with limited insurance coverage, or no coverage, can be financially disastrous, bringing about bankruptcy in some cases and a lowering of the family's standard of living in many others.

Some of the increased cost of medical care comes from normal cost-of-living increases, but much of it is due to other, more complicated factors. Some have suggested that the costs of medical care are directly related to the benefits paid by medical insurance policies and that as one increases so too does the other, in an ever-increasing spiral fashion. Others have suggested that the increased costs are directly related to the shortages of doctors and facilities.

No doubt there are many reasons for the rise in costs, but increasingly the argument is being made, and logically so, that duplication of effort and equipment is a cause for much of the increase. Duplication of effort is always a cause for concern, but when it involves the lives and health of people, such counterproductive efforts become dangerous and costly.

In this perspective, my bill H.R. 16147 and the companion bills which establish integrated and regional medical programs, would take an important first step in determining the medical needs of a community—now and in the future—and then combine all available resources to provide for those needs. The concept of regional planning

would allow us to concentrate efforts in an area large enough to allow us to reap the benefits of economies of scale while at the same time keeping the total problem area small enough so that effective service could be designed and provided. Moreover, this proposed legislation would allow for the focusing of attention on other important areas of concern, namely health-care systems, research related to health-care delivery, and experimentation with those systems.

It seems to me that adequate health care is not only a question of great concern in the abstract, but is also a question which needs immediate attention. Our Nation is recognizing the needs in this area and the responsibility to our citizens to make such care available. We have not found it necessary to turn to a nationalized system of health care and hopefully we shall find other answers to meet the growing need. I believe that H.R. 16147 will offer at least part of the solution to those needs and potential answers to others that remain unsolved. A forward-looking approach is necessary if we are going to make satisfactory provisions for the health of our citizens. The size and scope of the problem mandates that we begin making those provisions now.

Mr. JARMAN. Thank you, Mr. Robison, for sharing your views with us this morning.

Mr. ROBISON. Thank you, Mr. Chairman, it has been my pleasure.

Mr. JARMAN. Our next witnesses will be Dr. Schreiner and Dr. Parry, as the leadoff witnesses in part of a panel of four, of whom the other members are Dr. John Najarian, professor and chairman of the Department of Surgery at the College of Medical Sciences, University of Minnesota, and Dr. John Merrill, who is director of the Cardiorenal Laboratory at the Peter Bent Brigham Hospital, Boston, Mass.

I might mention that Dr. Schreiner is president of the National Kidney Foundation and professor of medicine and director of the Renal Division of Georgetown University. And Dr. Parry is professor of urology and chairman of the Department of Urology at the University of Oklahoma.

Gentlemen, please sit at the table and present your testimony in the form you have in mind. The subcommittee will be very interested in hearing it.

Dr. Parry.

STATEMENTS OF DR. WILLIAM PARRY, PROFESSOR OF UROLOGY AND CHAIRMAN OF THE DEPARTMENT OF UROLOGY, UNIVERSITY OF OKLAHOMA; DR. JOHN S. NAJARIAN, PROFESSOR AND CHAIRMAN, DEPARTMENT OF SURGERY, COLLEGE OF MEDICAL SCIENCES, UNIVERSITY OF MINNESOTA; DR. JOHN P. MERRILL, DIRECTOR, CARDIORENAL LABORATORY, PETER BENT BRIGHAM HOSPITAL; AND DR. GEORGE E. SCHREINER, PRESIDENT, NATIONAL KIDNEY FOUNDATION, AND PROFESSOR OF MEDICINE, DIRECTOR OF RENAL DIVISION, GEORGETOWN UNIVERSITY; IN BEHALF OF THE NATIONAL KIDNEY FOUNDATION

Dr. PARRY. I welcome the opportunity to appear before your subcommittee not only to support the extension of the regional medical program (RMP) but also to amend its title to include "Kidney Di-

sease." I am William L. Parry, M.D. My position is professor and head of the Department of Urology at the University of Oklahoma. The request that I testify, I believe, is based largely on the fact that I am the director of the regional medical project in Oklahoma that currently happens to be the only one to date in urology throughout the country. In the academic community, I also serve as secretary-treasurer of the Society of University Urologists and for the National Institutes of Health, I am a member of the Committee on Urology and Renal Diseases of the National Institute of Arthritis and Metabolic Disease.

Both large groups of medical and surgical doctors who specialize in the care of patients with kidney diseases, nephrologists and urologists, already have joined together in a common effort to improve the health care of this vital body system. Representatives of both groups will testify this morning as to the value of giving kidney disease for the first time a point of visualization for the public to understand where attention to his major health problem can be directed, and also of giving kidney disease for the first time representation on the RMP council for seeking appropriate priority of support towards the amelioration of these serious afflictions. I realize that others may have apprised you of general overall statistics of disability and preventable deaths of kidney disease. You might be interested to know that our urologic or surgical portion of care amounts to approximately $4½ billion dollars a year. Dr. John K. Lattimer, of New York, who has been designated by our national urologic organizations to gather information on kidney disease is here this morning and can break down these cost figures for you further, if desired.

In Oklahoma, the urology regional medical project is evaluating the care at the community level of patients diagnosed with kidney system disorders admitted over a three year period to the 152 registered hospitals of the region. The first disease course treatment being measured is cancer of the prostate, a malignancy that with the expanding older population kills more American males today than any other tumor except lung cancer. This condition by blocking the urinary tract also can lead to kidney failure and usually is referred to a urologic surgeon. Later the project will evaluate and compare care of a kidney condition such as nephritis or high blood pressure commonly referred to a medical specialist and then be correlated subsequently with the care of kidney system conditions in children often associated with congenital abnormalities.

Our RMP experiences to date in Oklahoma have been so rewarding in measuring the level of community practice and for continuing education of health personnel to control kidney disease in the region that this model can readily serve as an example for other regions. Already we have had requests for the protocol from three other States. The benefits extend beyond the confines of the State in that many patients in Oklahoma turn for help to hospitals in neighboring areas and already our staff is cooperating with neighboring regions involving the follow-up care of cases in 48 additional hospitals.

Certain problems were encountered in launching the project because some of the medical profession were suspicious that the RMP might be measuring essentially social-economic factors. Consequently, as a pretest, 12 medical students went out into the field to work with individual physicians before hiring and training permanent personnel

for the RMP. These students were real ambassadors. Not only did they sell the program to the community physician but each returned with a better idea of what the practice of medicine was all about as their classmates noted in viewing them in retrospect. The responses of the participating urologists were even more individually enthusiastic. For example, one specialist in Tulsa phoned me to say that for the first time he felt that his own experiences with cases in everyday practice were going to help in the overall direction of urologic care instead of it being predominantly influenced by series of cases reported by medical centers. A general practitioner from a small community in Oklahoma, who serves on the project's advisory committee and who also acts as a liaison physician in a community where no urologist is available, is so impressed with the results so far that he has offered to drop everything and come and help at any time.

We need this kind of general practice physician help because this kidney system project, now fully implemented, has opened up possibilities never available before. For example, shortly a large amount of significant data will be available—already data of nearly 1,800 cases in 133 hospitals of just one disease entity that threatens kidney function has been identified, computerized, and analyzed—to compare the course of disease in areas with none or only one physician, compared to areas with medical groups, compared to metropolitan areas with and without a medical center, et cetera. We can also compare in Oklahoma how the Indian group fares for example in relation to the non-Indian groups. The project already has data indicating that in some respects findings in our region do correlate with already published national institution studies to make the latter more meaningful for the community physician. For example, the average age of various stages of cancer of the prostate in Oklahoma is similar, as had been questioned, with the national Veterans' Administration cooperative study of cancer of the prostate.

Important beneficial effects of the regional kidney program are its continuing education features. Doctors in distant parts of the State who have little time to keep up with newer developments and applications are also recognizing their shortcomings to an extent that is surprising everyone. One staff discovered that less than one-half of the men admitted to their hospital over 50 years of age had had a routine rectal examination, the best way to detect cancer of the prostate at a curable stage. The findings of the regional medical program in urology in addition are playing a role in redirecting the emphasis of the medical school curriculum to push back the day of diagnosis and to encourage more preventive medicine. The high percentage of unsuspected serious kidney disease referred only for obstructive urinary symptoms is one kind of evidence that indicates teaching programs need to be changed.

The Oklahoma project also has brought to attention a source of untapped health manpower. In recruiting permanent field personnel no nurses were hired from other active duty positions. There was an unexpected abundance of trained nurses available and anxious to work on a part-time basis, if they could regulate their own hours around home schedules.

Finally, several byproducts of the RMP are conspicuous already. From an epidemiologic standpoint, this survey has brought to light for

the first time one area of the State has an unexplained unusually high incidence of kidney system cancer that deserves special investigation. Looking into other situations, substantial reductions in costs can be effected throughout the 500 nursing homes of the State simply in their better management of patients with indwelling catheters for urinary drainage. With more optimal application of modern urology, many of these appliances, so offensive to patients and relatives, can be eliminated.

Mr. Chairman, my own involvement in the urology regional program has brought an extra assignment. As the representative of the south-central section on the Research Committee of the American Urological Association, the science information exchange of the Smithsonian Institute has printed out for me (see demonstration) the currently listed projects in the kidney disease field. From this kind of data both groups represented here today, the nephrologists and the urologists, are going to be in a better position to recommend priorities for regional planning and training programs in the future.

Thank you again, Mr. Chairman, for the opportunity to appear before your subcommittee. May I also insert in the record along with my own testimony a statement of further information from Dr. John Lattimer, professor and head of the Department of Urology, Columbia University College of Physicians & Surgeons, and immediate past president of the Society of University Urologists.

Mr. JARMAN. It will be done.

(The statement of Dr. John K. Lattimer, referred to, follows:)

STATEMENT OF DR. JOHN K. LATTIMER, PROFESSOR AND CHAIRMAN, DEPARTMENT OF UROLOGY, COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS

Mr. Chairman, the importance of the Jarman bill (H.R. 17570) to extend the regional medical programs to include kidney diseases, is so great, in my opinion, that I have asked to appear before your committee to lend my support to the measure.

I am professor and chairman of the Department of Urology of the Columbia University College of Physicians and Surgeons, Director of the Squier Urological Clinic, immediate past president of the Society of University Urologists, past president of the American Urological Association's New York section and of the section on urology of the New York Academy of Medicine, Governor of the American College of Surgeons, chairman of the Undergraduate Education committee of the American Urological Association, and a member of the Committee on the Genito-Urinary System of the National Research Council and National Academy of Sciences.

The urologists (who are kidney surgeons) and the nephrologists (who are kidney internists) have united in their support of this bill, as an indication of its importance to the health of the Nation. I would like to explain in detail why we urologists feel this way about this bill.

Urology is a specialty which protects the life of the patient by protecting his kidneys from obstructions, defects or diseases in the conduits which co'lect the urine from the kidneys and transport it through the bladder, prostate and urethra. Any obstruction, however slight, ultimately causes damage to the kidneys. As urologists prevent this damage, they decrease the need for kidney transplantation or dialysis, which mark the end stages of damaged kidneys. Prevention of destruction of the kidneys is a large component in the practice of urology, which extends from childhood to advanced age. In men, the most common obstruction occurs when the prostate gland grows large, in response to 50 years of the male sex hormone, and obstructs the outflow of urine from the kidneys. In women, the commonest source of trouble is a narrow urethra, with resulting cystitis and pyelitis, as for example, honeymooner's cystitis, the pyelitis of pregnancy and then death from pyelonephritis in middle age. In the case of men,

the disease strikes them at the very height of their most productive years. In the case of women, it strikes when the children are only partly grown and are still very dependent upon their mother.

Many defects of the urine collecting system do not become apparent until young adulthood, resulting in many infections and much time lost from work, as well as undermining the support of the young family and its children.

COST OF UROLOGICAL DISEASES

The cost of urological disease, as estimated from standard government sources, comes to approximately 4.5 billion dollars each year. (See fig. 1).

PATIENT CARE

The doctor shortage (there is one urologist for every 40,000 people in the U.S. at the present time) has led urologists in general to recognize the necessity for concentrating on delivering patient care, at the expense of all other facets of the specialty, 97% of all the urologists in the country are concentrating on patient care as their primary duty, to the detriment of the academic and research areas, which are severely understaffed. The need for more urologists becomes quite clear when one sees that 10% of all the hospital discharges in the U.S. are for urological conditions, whereas only 3% of the physicians in the U.S. are urologists. (See fig. 2). It is quite evident that there are not enough urologists to keep up with the amount of disease. It is further evident that only half of these urologists are certified as specialists by the American Board of Urology.

QUALITY OF CARE

The American Board of Urology which certifies urological specialists is extremely strict, requiring that candidates have at least five years of training after medical school, followed by two years of practice in the community where they will have their office, to make sure that they are competent and of the highest integrity. Then they may take three examinations (a written, an oral and a practical pathology examination) which are very strict, with many failures. The residency training programs are very strictly surveyed by a special committee which is so strict that they disqualify and put on probation many programs each year. This is done despite the vigorous resistance of those who are disqualified. Further special examination techniques are being introduced by the American Board of Urology and the residency review committee.

EDUCATION

Ongoing education is vigorously sponsored by the American Urological Association and the many urological organizations. Several excellent publications are sponsored, ranging from abstract journals through highly technical and even research oriented journals, as well as many for the man in practice. The editorial board is very selective and rejects at least half the manuscripts submitted, as not being up to their high standards.

Ongoing education in the form of post-graduate seminars are heavily attended, with many candidates turned away each year. Now we are doubling the number of seminars in an effort to accommodate all who wish to come. In 1970 there are two post-graduate seminars, one post-graduate convention and an annual convention lasting an entire week, with a gamut of multiple programs. The American College of Surgeons also conducts a program in urology of extensive type, as does the American Medical Association and at least five other urological organizations, each dealing with some special facet of urology. A national coordinating council of urology is now in existence to further spread the information explosion and to coordinate our activities in the educational field, especially. An overall survey committee to gather statistics on urology is also active as, is a long range planning committee. A separate organization to conduct educational meetings dealing with social problems as related to urology has also been formed. A society of university urologists represents the urologists in the Association of American Medical Colleges, and deals with problems of the medical school urology faculties. Committees on undergraduate and residency education are heavily engaged in these fields, as are committees on medical motion pictures and the development of audio tapes and other educational devices to assist in continuing education. The National Research Council and the National Academy of Sciences also sponsor a committee on the genito-urinary system, which conducts seminars and refresher courses.

MANPOWER

The shortage of urologists indicated above is strictly related to the shortage of undergraduate medical students. About 2% of the graduates of American medical schools are becoming certified urologists, according to current figures, resulting in a total of about 600 American candidates for the residency positions for specialty training in urology. This is not enough to keep up with the population explosion, even if the American public accepts the notion that two children per couple is the ideal number.

There is no bottleneck in the capacity of American urological hospital programs to train medical school graduates to become skilled, certified urologists. In fact, there are almost twice as many physicians available for training in hospitals, as there are American-born candidates to fill these positions. Of the remaining 40% of residency training positions, 25% are filled by graduates of foreign medical schools, many of whom will not practice in America, and thus will not add to our manpower pool. The remaining 15% of positions are vacant. Thus, our overall manpower pool is being starved by the undersupply of graduates of American medical schools, rather than by our capacity and capability to train more urologists. It is obvious that we must concentrate on increasing the number of graduates of American medical schools if we are to improve the shortage of urologists in general.

It should be noted that the foreign graduates are heavily clustered in the non-university hospitals, although a fair number of foreign graduates are in the programs of university hospitals, and the vacant positions are about equally divided between the university and non-university hospitals.

Academic manpower is in extremely short supply, with only 3 percent of urologists in academic or research activities, as compared with 5 percent for dermatologists and 6 percent for all physicians in the United States. We believe that this reflects the starvation of the public for patient care and the concentration of our specialists in that area. The seriousness of a poor educational and research program in supplying the needs of future generations has to be recognized as a problem, and measures taken to improve this aspect of our specialty.

RESEARCH

Research in urology is highly advanced in some medical schools, because of the availability of the urological tract for study through the highly perfected instruments such as the cystoscope, the motion picture X-ray of the urinary tract and the application of advanced techniques of radioactive tagging of medications, germs and viruses. Since diseases of the urinary tract can be studied by diagnostic methods which are superior to almost any other specialty, resulting in about a 95 percent accuracy of diagnosis, and since urological organs can be observed so competently and rebiopsied at intervals, they lend themselves to study in a way which is not always available in other systems of the body. For example, it was the discovery that withdrawing hormones would stop the growth of cancer of the prostate that led the medical profession to realize that many cancers could be controlled by manipulating the hormones of the body. The discovery of viruses in various cancers and other diseases of the kidney, when electronmicroscopes suddently broadened our ability to see things we never saw before (due to the jumping of magnifications from 1,000 times up to 10 million times) it made many things visible and available which never could be seen before.

The money spent on research and research training for urologists is miniscule, compared to the money spent in other fields of even medical research. It is certainly not in accord with the $4.5 billion annual cost of diseases of this tract, to the American public.

The distribution of work now going on in urological research conforms only roughly to the frequency of the problems in urology. For example, while infections are the leading cause of urological illness, infections rank well down on the list of amounts spent on research by urologists against infections, according to the science information exchange of the Smithsonian Institution. On the other hand, the distribution of moneys conforms in an approximate way, when the national scene is surveyed, whereas local surveys tend to show research concentrated on local problems. For example, in the stone belt of the southern United States there is much more stone research going on than in other parts of the country, whereas in the New York area there is more research money spent on population control.

DISTRIBUTION OF UROLOGISTS

The distributing of urologists conforms fairly closely to the population distribution, reflecting the fact that complicated unstrumentation and facilities are needed by urologists, and that patients with severe urological diseases are not easily treated as outpatients, but require hospital facilities for acute care. It is therefore much more efficient to have them concentrated in larger population centers.

On the other hand, urologist-distribution maps of many States indicate that no person in the U.S. is very far from a urologist, by automobile, to say nothing of airplane. In the State of New Jersey, for example, no person is more than 40 miles froom a urologist, even in the seashore vacation communities of Cape May or the other extreme in the wooded vacation-spots of the northernmost county. All of the other counties have at least one urologist, and many have several, plus hospitals with urological services.

Maps of the U.S. showing the concentration of urologists have shown a steady widening of the distribution of urologists away from the population centers, even though the numbers in the numbers in the population centers are also growing steadily.

SUMMARY

In short, urology is a highly organized, highly technical specialty which accounts for 10 percent of the discharge diagnoses from American hospitals. Yet only 3 percent of the practicing doctors are urologists, indicating a severe shortage.

Urologists have countered this shortage by concentrating on patient care, thus decreasing the numbers in academic and research activities. Urologists are concentrated in the population centers, but are becoming better distributed with every passing year.

Urological continuing education is superior, with many meetings, all of which are heavily attended by urologists eager to learn and to keep up with what is new, in this burgeoning field.

The manpower shortage is a result of a shortage of undergraduate medical school graduates. The pipeline for training specialists could accommodate almost twice as many graduates of American schools as are at present in the pipeline. Quality control is very strict and the standards of education and training in urology are very high indeed.

Research is underfunded, but the quality of the research done is superior, since the specialty lends itself to research and study of urological diseases to a greater extent than most specialties.

In short, urology is a highly organized, highly accurate specialty which has a manpower shortage due to the lack of graduates from American medical schools but has the capacity to train all the specialists that are needed, despite the population explosion, if more medical students could be provided.

The kidney is a very important organ and its preservation is heavily dependent upon the urologist, who is the only man who can maintain adequate and free passage of urine, so that back pressure and damage to the kidneys does not result. Thus the urologist prevents kidney disease by preventing obstruction, infection and death of the kidneys. RMP programs in urology can be stimulating and effective in bringing in the resources of the area doctors, as illustrated by the superior RMP program in Oklahoma, for example.

Urology has been severely under-supported in the past, and the importance of kidney diseases seems to justify the addition of "*kidney diseases*" to the "heart, cancer, stroke" title, as well as representation on the national RMP Council.

Thank you, again, Mr. Chairman, for permitting me to appear before you, to increase my faith in your bill.

FIGURE 1.—*Annual cost of urological diseases—Total direct and indirect costs of urological disease in the United States 1969 (est.)*

[Millions of dollars]

Direct costs:	
Physicians' services	$818
Hospital care	1,531
Nursing home care	42
Drugs	470
Other professional services	45
Other health care expenditures (research, construction of facilities, etc.)	811
Subtotal	3,717
Indirect costs:	
Wages lost because of illness	672
Wages lost because of death	65
Subtotal	737
Total cost of urological disease	4,454

Sources: U.S. Department of Health, Education, and Welfare, PHS No. 947–6, pp. 3, 8, 81; personal communication from Dr. Herbert E. Klarman, May 1970.

FIGURE 2

Only 3% of American doctors are urologists; 10% of the hospital discharges are urological.

FIGURE 3.—WHY UROLOGY IS ESSENTIAL

Ten percent of 5 million hospital discharges were urological.

The cost of urological disease is 4.5 billion dollars per year.

Pediatric urology can *prevent* troubles such as the need for dialysis and transplants.

Everyone needs a urologist as he or she grows older.

CURRICULUM VITAE: JOHN KINGSLEY LATTIMER, M.D.

PERSONAL AND EDUCATION

Born: October 14, 1914, Mount Clemens, Michigan.

Married: 1948, to Jamie Elizabeth Hill—three children: daughter—Evan, born 1949; son—Jonathan, born 1951; son—Gary, born 1953.

Education

1935: B.A. Columbia College, New York City, N.Y.

1938: M.D. Columbia University, College of Physicians and Surgeons, New York City, N.Y.

1943: Med. Sc. D., Columbia University College of Physicians and Surgeons, New York City, N.Y.

1944: Balliol College, Oxford, England (courses in Humanities, no degree).

1945: Army Medical Service School, Paris, France (courses in Military Medicine, no degree).

PROFESSIONAL APPOINTMENTS (ACADEMIC AND HOSPITAL)

1938–1940: Rotating (Surgical) Intern, Methodist-Episcopal Hospital, Brooklyn, N.Y.

1940–1943: Resident in Urology, *Presbyterian Hospital*, Babies Hospital and Vanderbilt Clinic, New York, N.Y.

1943–1946: On leave of absence for military service in World War II (England, Normandy, Germany), Chief of Urology or Surgery, U.S. 3rd. Army and 7th, Army, Field and General Hospitals (see below).

1946–1948: Assistant Urologist, *Presbyterian Hospital*, Babies Hospital and Vanderbilt Clinic.

1940–1948: Assistant in Urology, Columbia University, College of Physicians and Surgeons, New York City, N.Y.

1946–1948: Attending Consultant in Urology, Veterans Administration Hospital, Bronx, New York (in charge of Research Unit for Genitourinary Tuberculosis).

1948–present: Consultant Urologist, Veterans Administration, Central Office Committee on Surgery in Tuberculosis.

1948–1950: Instructor in Urology, Columbia University, College of Physicians and Surgeons, New York City, N.Y.

1950–1952: Associate in Urology, Columbia University, College of Physicians and Surgeons, New York City, N.Y.

1952–1955: Assistant Professor, Clinical Urology, Columbia University, College of Physicians and Surgeons, New York City.

Present

Professor of Urology and Chairman, Department of Urology, Columbia University, College of Physicians and Surgeons, New York City.

Director, Squier Urological Clinic and of Urology Service, *Presbyterian Hospital*, Babies Hospital, and the Francis Delafield Hospital, New York City.

Senior Consultant in Urology, Kingsbridge Veterans Administration Hospital and Harlem Hospital, New York City.

Consultant in Urology to: Methodist Hospital, Brooklyn, New York; Englewood Hospital, Englewood, New Jersey; St. John's Riverside Hospital, Yonkers, N.Y.; U.S. Public Health Service Hospital, Statan Island, N.Y.; U.S. Naval Hospital, St. Albans, Jamaica, N.Y.; Babies Hospital of Newark, New Jersey; Harlem Hospital, New York

ARMY SERVICE

1943: 1st Lt. Medical Corps, Army of the United States; Medical Officers' Training School, Carlisle, Penna.; Urologist to 182nd U.S. Army General Hospital, England.

1944: Captain, Medical Corps, Army of the United States; Chief of Urology, 115th U.S. Army General Hospital, England, France, Germany, Consultant to the 116th U.S. Army General Hospital, England; Chief of Urology, 194th U.S. Army General Hospital, France.

1945: Major, Medical Corps, Army of the United States; Chief of Surgical Service, 12th Field Hospital; Assigned to Third Army Headquarters, Germany; Assigned to Seventh Army Headquarters, Heidelberg, Germany; Assigned to Supreme Headquarters, Allied Expeditionary Force, Frankfurt, Germany.

1946: Chief of Urology, 98th U.S. Army General Hospital, Munich, Germany; Urological Consultant, Southern Germany, U.S. Zone.

PROFESSIONAL SOCIETIES

Academy of Medicine, New York—Past Chairman, Section on Genitourinary Surgery (Chairman 1960–61), Section on Medical History.

American Association for Advancement of Science (10/67).

American Association of Genitourinary Surgeons.

American Board of Urology—Diplomate.

American Academy of Pediatrics, Chairman—Committee for Pediatric Urology 1960–1968.

American College of Surgeons—Chairman, Advisory Committee for Urology, 1962–1965; Elected Governor, 1966– ; Member of Education Committee, 1967– ; Member of Committee to Study Size and Composition of Board of Governors.

American Medical Association—Fellow.

American Trudeau Society—New York Trudeau Society.

Association of American Medical Colleges; Representative for the Society of University Urologists, to the Council of Academic Societies, 1968– .

New York State Pediatrics Society.

New York County Medical Society.

New York State Medical Society.

American Urological Association—Chairman; Committee on Pediatric Urology; Member, Committee on Surgery; Member, the Long Range Planning and Advisory Committees. Also on Editorial Committee, Journal of Urology; National

Executive Committee; Chairman, Committee to Gather Information About Urology, 1968– ; Chairman, Committee on Undergraduate Education, 1969–1974; Chairman, Editorial Committee, N.Y. Section 1969–1970.

Association of Military Surgeons of the United States.

British Society of Genitourinary Surgeons.

The John Jay Society.

Varsity C Club.

American Association for Advancement of Science (10/67).

Presbyterian Hospital Alumni Association—President, 1967–1968.

National Association for Advancement of Science.

Babies Hospital Alumni Association.

Methodist Hospital Alumni Association.

Clinical Society of Genitourinary Surgeons.

Columbia College Alumni Association; Executive Committee of the Faculty of Medicine, July 1, 1968–June 30, 1969.

The Harvey Society.

College of Physicians and Surgeons Alumni Association.

International Society of Urology—Vice-President, 1967; U.S. Representative, 1969–1970.

National Institute of Social Sciences.

National Tuberculosis Association.

New York Academy of Sciences.

New York Section, American Urological Association—President, 1967–1968.

National Institutes of Health, National Institute of Arthritis and Metabolic Diseases, Bethesda, Maryland; Member of Renal Diseases and Urology Training Grant Committee, 1967– ; National Research Council, National Academy of Sciences—Committee on the G–U System; NIH—Committee to Consider Training Grants, Member of Training Program Directors.

Society of University Urologists: President-elect, 1967–1968; President, 1968–1969.

Association of American University Professors (1968–).

World Medical Association.

World Health Organization (10/67) Member of Expert Advisory Panel on the Biology of Human Reproduction (1968).

Institute of Cancer Research, Columbia University Coordinating Committee.

National Tuberculosis Association.

AWARDS

Joseph Mather Smith Prize Diploma—1943; Columbia University, College of Physicians and Surgeons, New York City, for research on kidney function.

American Urological Association—First Prize, 1948; for best clinical research in Urology (rental tuberculosis).

American Medical Association—Award, 1954 for Scientific Exhibit on the treatment of Genitourinary Tuberculosis.

American Academy of Tuberculosis Physicians, Award, 1957, for signal scientific service to urology and tuberculology.

Morgenstern Foundation, New York, Freedom Award, 1960.

American Urological Association—First Prize, 1960; for Scientific Exhibit on Enzyme Inhibitors.

American Medical Association—Award, 1961; Section on Physiology and Pathology, Exhibit on Bacterial Urease.

American College of Surgeons—Award, 1962 Clinical Congress.

American College of Chest Physicians, Citation for work in Genitourinary Tuberculosis, 1964.

American Urological Association (New York Section) Award, 1964, Scientific Exhibit.

American Urological Association (New York Section) Award, 1964, Scientific Exhibit.

American Urological Association (New York Section) Award, 1964, Scientific Exhibit.

American Urological Association (New York Section) Award, 1964, Scientific Exhibit.

American Medical Association—Award, 1965 for Exhibit on Genitourinary Tuberculosis.

American Urological Association—Award—1966 for Exhibit on Educational Purposes and Historical Subjects.

American Urological Association—Award—1966 for Exhibit on Laboratory Research.

American Urological Association—Award—1967 for Best Scientific Motion Picture of the Year "A Tool for Studying Human Prostate: Growth of Prostatic Cancer Cells in Tissue Culture".

NONPROFESSIONAL ACTIVITIES—GENEALOGICAL SOCIETIES

Order of Founders and Patriots, Society of Colonial Wars, Saint Nicholas Society, Sons of the Revolution, Sons of the American Revolution, Society of the War of 1812, Military Order of Foreign Wars.

NON-PROFESSIONAL SOCIETIES

New Jersey Historical Society, Manuscript Society, Arms and Armor Club, Museum of Natural History, Company of Military Historians, Revolutionary War Round Table, Metropolitan Club, New York City, American Ordnance Association (1968–), Englewood Field Club, Honorary Surgeon—New York Police Department—1969.

ATHLETIC

AAU 200-meter hurdles champion and record holder for 14 years. Decathlon champion, Columbia University.

200-meter hurdles champion, G. I. Olympics, U.S. Seventh Army, Heidelberg, Germany.

National Sprint Relay Championship team.

Winner, 50-yard dash Milrose Games, Madison Square Garden.

Battalion wrestling champion at Medical Field Service School, Carlisle Barracks, Pennsylvania.

Member, several National AAU championship teams, with New York Athletic Club, all prior to 1945.

CIVIC

Contributor of museum displays and publications, of the Smithsonian Institution, the Museum of the City of New York, Fort Ticonderoga Museum, New York, and the Englewood, New Jersey, and Columbia University, New York City, Libraries, as well as to the National Park Service.

Past Board Member, Englewood Community Chest, New Jersey.

COLLECTOR OF AMERICANA

Largest collection of American silver-hilted swords by early silversmiths, including swords of George Washington, Ethan Allen, Esek Hopkins. Many others.

A considerable collection of documentary material, including letters by Isabella and Ferdinand, Henry VIII, George Washington, Abraham Lincoln, and many other historical figures.

These and a large collection of family historical relics are loaned to museums and National Park Visitor Centers for appropriate displays, on occasion.

Mr. JARMAN. The subcommittee will withhold questioning until we have heard the four gentlemen who are on the panel this morning complete their testimony.

STATEMENT OF DR. JOHN P. MERRILL

Dr. MERRILL. I am Dr. John P. Merrill, Harvard University, professor of medicine at Harvard, chief of the kidney section of the Brigham Hospital. I appreciate the opportunity to appear before the subcommittee as a representative of the National Kidney Foundation.

I do have a prepared statement. But in the interest of brevity I will read only a small part and stress what I think are some of the

salient points. And Dr. Najarian and Dr. Schreiner can fill in some of the other points.

My interest in kidney disease has gone on for about 25 years. And my qualifications for testifying before this committee include some of the following.

In 1949, my colleagues and I treated the first patient in the United States with an artificial kidney, which was designed and built in the United States.

In 1954, our group did the first successful kidney transplant between twins. And in 1959 we did the first successful kidney transplant between individuals who are not identical twins.

In 1963, currently, without the Dr. Schibner's group, for the first time we put an artificial kidney in at a patient's home and enabled the family to treat him at home.

Our interest has continued since that time.

What I am going to talk about briefly is the New England area, the kidney-system program in that area. But I think it can be extended, certainly, to other areas.

In 1967, the kidney disease control program, which is now a part of the regional medical programs service, contracted with Tufts University School of Medicine in Boston for the development of a metropolitan plan for the control of kidney disease. A key element of this plan was the coordination of medical facilities and services in the Boston area to provide efficient employment of resources in the prevention and control of kidney disease.

It was not long, Mr. Chairman, before this planning work became statewide in scope because of the wide pattern of patient population which is served by the Boston medical complex, and the rapidly widening pool of institutions, agencies and individuals which was seen early to be necessary to appropriately coordinate available resources.

When the planning was completed early this year, 10 hospitals in Massachusetts were collaborating in the area on kidney-disease services and problems, the metropolitan and State health and welfare offices were actively involved, participation was evoked from the comprehensive planning agency and the Massachusetts Rehabilitation Commission, the Blue Cross and the Massachusetts Health Insurance Council were strongly represented, the Massachusetts Kidney Foundation, the United Community Service of Boston, State legislators, the clergy and lay and professional leaders at all levels combined to make the plan a sterling example of effective and dynamic integration of human endeavor for the betterment of man's health.

As the potential program assumed a profile, I think it was significant and appropriate that the tri-State regional medical program became an active member of the planning body, and today has assumed a leadership role in the implementation of the kidney program in the tri-State region which serves New Hampshire, Rhode Island, and Massachusetts.

I think, as an example of this, I might use our integrated kidney program, which includes maintenance of people on artificial kidneys, which go on to transplantation. In order to do it, we must obtain kidneys from cadavers, and it includes by necessity the cooperation of regional hospitals, not only in Massachusetts but other States.

We have a central, so-called organ bank, where tissues are typed. And we have a computer so that the patient who needs the kidney that is being maintained on the artificial kidney can be matched by the computer to the prospective donor, or when he comes in and the kidney then is removed and transported to the appropriate recipient. This, I think you will realize, requires a tremendous regional cooperation, not only as a State but the community and even at the inter-hospital level in the cities.

I think it is a model for the kind of cooperation, cooperative-endeavor treatment and delivery of services to patients with chronic disease which might be applied to other chronic diseases.

I think one of the real thrusts of this kind of program is, as Dr. Parry mentioned, the training—in-hospital medical personnel are trained in this, but more than that, out of the hospital in the communities the physicians and paramedical personnel are trained. And such a source of continuing post-graduate education and training of paramedical personnel cannot help but improve the manpower pool, which, I know you realize, is of critical importance.

Secondly, we provide a network of services in that in the center patients are fed into us from outlying communities. They are treated by dialysis, and then sent back to the community in which they are living. And to be taken care of by them at the site, we need the cooperation of local physicians. And we have even gotten Blue Shield to provide a special fee for the physician who does the specialized work in the home.

I think that important also is the fact that with the expansion of our program, the delivery cost at this time has been reduced. For example, I quote you the fact that one of the types of apparatuses used in the artificial kidney has had its cost reduced from $82 to $18 for the past 4 years. And with a setting up of satellite units for treatment by dialysis, that is, out of the acute hospital phase, the cost is some hundred dollars less per patient.

I believe equally important are advances we made in attempting to fund this operation, because it is not going to be an interminable drain on Federal sources of funding. At the present time, for instance, more than two-thirds of the patients we are treating are supported by State and private funds. We have set up a system of fees, schedules with Blue Cross and Blue Shield, operative from title XIX and for the rehabilitation agencies, and are continuing efforts in this regard to make the operation self-supporting.

Another important point, I think, is we by necessity must set up a cooperative endeavor with various disciplines in medicine. Some of you, I am sure, are aware of the fact that in the past not surgery but medicine and neurology have not indicated interest to cooperate but in transplantation not indicated interest to cooperate but in transplantation dialysis they must—and it is, in fact, only possible with the cooperation of these various disciplines.

Finally, I think one of the important results of this has been the spinoff. And I would like in conclusion to quote to you simply two examples.

We had occasion to transplant early a kidney from a patient who died from cancer of the lung, and there was no evidence of cancer in the kidney. And when the kidney was transplanted to another indi-

vidual and we impressed his immune response to the kidney, we also apparently impressed his immune response to cancer which grew from the recipient, cancer of the lung transplanted by a normal kidney.

When we stopped the suppression of immune response, both the kidney and the cancer were rejected. I think this kind of observation in the human is critically important in the program, spin off of the kidney.

Finally, I think we have seen a number of cases of nephritis, Bright's Disease, developed in humans during transplantation. For the first time we have a prospective study of disease in man, where before we had only retrospective study or studies in the experimental animal.

Since nephritis and Bright's Disease is the major cause of kidney disease which results in a necessity for transplantation and dialysis, I think if the knowledge we gained from this kind of spinoff can modify the disease before the progress to the point of renal failure, we can phase out a significant part of the dialysis in the kidney-transplant operation.

This, of course, does require continous support of this operation for a period of time. But if it is possible—and I think it is—to make significant inroads on the treatment of kidney disease before the progress to kidney failure, requiring dialysis and transplantation, then the rewards, both economic and medical, to the community, I think, obviously will be enormous.

Thank you.

(Dr. Merrill's prepared statement follows:)

STATEMENT OF DR. JOHN P. MERRILL, DIRECTOR, CARDIO-RENAL LABORATORY, PETER BENT BRIGHAM HOSPITAL, BOSTON, MASSACHUSETTS

Mr. Chairman, I deeply appreciate the opportunity to appear before this Committee as a representative of the National Kidney Foundation. I am Director of the Cardio-Renal Section, Peter Bent Brigham Hospital, Boston, Massachusetts, and Associate Professor of Medicine, Harvard University, Cambridge, Massachusetts. I have asked to appear here to call the attention of the Congress to the urgent need to assure adequate funds for continued work in kidney disease as an important part of the regionalization of medical services and resources carried out under the Regional Medical Programs Service. In New England, Mr. Chairman, the kidney disease program has been the vehicle for the development of regionalization in a manner I believe is unequalled elsewhere in this country.

In 1967, the Kidney Disease Control Program, which is now a part of the Regional Medical Programs Service, contracted with Tufts University School of Medicine in Boston for the development of a metropolitan plan for the control of kidney disease. A key element of this plan was the coordination of medical facilities and services in the Boston area to provide efficient employment of resources in the prevention and control of kidney disease. It was not long, Mr. Chairman, before this planning work became Statewide in scope because of the wide pattern of patient population which is served by the Boston medical complex, and the rapidly widening pool of institutions, agencies and individuals which was seen early to be necessary to appropriately coordinate available resources.

When the planning was completed early this year, 10 hospitals in Massachusetts were collaborating in the area on kidney disease services and problems, the metropolitan and State health and welfare offices were actively involved, participation was evoked from the comprehensive planning agency and the Massachusetts Rehabilitation Commission, the Blue Cross and the Massachusetts Health Insurance Council were strongly represented, the Massachusetts Kidney Foundation, the United Community Service of Boston, State legislators, the

clergy and lay and professional leaders at all levels combined to make the plan a sterling example of effective and dynamic integration of human endeavor for the betterment of man's health.

As the potential program assumed a profile, I think it was significant and appropriate that the Tri-State Regional Medical Program became an active member of the planning body, and today has assumed a leadership role in the implementation of the kidney program in the Tri-State region which serves New Hampshire, Rhode Island, and Massachusetts. Mr. Chairman, this amazing program is still growing. Later this month, a conference will be held in New England to begin work on the coordination of four Regional Medical Programs, Vermont, Maine, Connecticut, and the Tri-State, to coordinate work in the prevention and control of kidney disease.

I am delighted to point to two States, Massachusetts and Maine, which have enacted State legislation to support services for kidney disease patients. A third State, Connecticut, will consider such legislation later this year.

Kidney disease, as we are able to practice therapy today, uniquely lends itself to regionalization, with the resultant coordination of facilities and collaboration of medical and lay leaders. A home dialysis training program must train at least 12 patients each year to operate efficiently. Statisticians tell us that this requires a population base of at least 500,000 people. For kidney transplantation, an efficient program requires that the largest possible number of dialysis patients be tissue-typed so that best use can be made of available kidney organs. To assure an adequate number of kidneys, a coordinate program or organ retrieval and preservation must be established. Transplantation centers at carefully selected locations need to be developed which will service the needs of the large population from which patients are selected, and at the same time provide leadership in collateral research and specialized training.

The regionalization of health services across the country such as is being developed through the Regional Medical Programs Service, offers the most appropriate channel through which to attack kidney disease problems. The multidiscipline, regional approach of the Regional Medical Programs Service is the best way to assure efficient use of men, money and facilities to attack the problem of kidney disease.

The need for a broad, organized attack on kidney disease has been repeatedly emphasized. Diseases of the urinary tract attack 9,000,000 Americans each year. Approximately 56,000 of these individuals progress to terminal uremia each year and die. Because kidney diseases are likely to cause death of patients in their most productive years, they make a greater economic impact than basic data suggests. They cost this country an estimated $1.4 billion annually in lost future income.

Mr. Chairman, it is critically important to the continued improvement of patient services in this country that the Regional Medical Programs Service, and the kidney activity be adequately supported in 1972.

Mr. JARMAN. Thank you, Doctor.

STATEMENT OF DR. JOHN S. NAJARIAN

Dr. NAJARIAN. Mr. Chairman, I too would like to thank you for the opportunity to appear before this subcommittee in regard to the bill for the recent medical programs.

I am Dr. John S. Najarian, professor and chairman of the Department of Surgery, University of Minnesota Hospital and have been concerned with the field of organ transplantation for some time. I am particularly interested in the areas of the delivery of care for transplantation in patients with kidney disease and kidney transplants.

As the director of the unit at the University of Minnesota, I transplanted over 200 kidneys up to the present time and have had the privilege of being a member of the Committee on Chronic Diseases, which is chaired by Carl Gottschalk, member of the Scientific Advi-

sory Committee for the National Kidney Foundation for the past 3 years.

In addition, I am currently writing a textbook on transplantation.

In the interest of brevity, I will highlight some of the statements from my prepared statement, which I would like to submit for the record.

I think it is a known fact there are approximately 8 million people in the United States afflicted with kidney disease. Of these, 50,000 individuals die each year from kidney disease. This is primarily kidney disease.

The unfortunate thing, Mr. Chairman, is that about 70 percent of these young people are under the age of 35. These patients are dying simply because the kidneys no longer function.

As a member of the Gottschalk committee, in 1966 and 1967, we determined that approximately 7,000 to 10,000 of these patients could be successfully treated each year with either dialysis or transplantation. At that time the criteria we established for entry into the program included young patients, patients between the ages of 15 and 45, patients without other conditions afflicting their kidneys. And since that time, in the past 2 years kidney transplantation has evolved in the sense that at the present time we now transplant patients from generally 6 months of age to as old as 65.

We have extended the age criteria and also transplantation patients with diabetes and other diseases afflicting the kidneys, so our conservative estimate at the time of the Gottschalk report was 7,000 patients can be successfully treated with known treatment at that time. And it can now be extended to closer to 20,000 or 25,000 patients a year.

This means, Mr. Chairman, that 20-to-25,000 patients are dying needlessly in the United States simply because we cannot implement the program set out in the Gottschalk report or a program as envisioned by this addition to the regional medical programs, the program for kidney disease.

Now, it is interesting that what has happened in the past three years since the Gottschalk report was submitted, we have had to run in a patchwork quilt of financing, as was indicated, and we turned to third-party payments of insurance. And we turned to Title XIX and various private donations, even use of research dollars, to support activities in transplantations.

Despite this, as these programs have grown, in 1967, there were approximately 300 kidney transplants in the United States. Last year, in 1969, there were approximately 500 to 550 kidney transplants in the United States, an increase of only 250. And this means that there are 20-to-25,000 patients that are dying simply because there is no method of treatment available to them at the present time.

To my knowledge, this unconscionable situation has never presented itself to medicine before, when a treatment modality has been available and not been given to the people because of lack of funds to implement the programs envisioned by those who have studied the kidney disease.

Now, it is interesting to note from a pragmatic sense that kidney fits nicely in a regional medical program. Kidney disease affects heart disease. And, as Dr. Merrill pointed out, it has been a tremendous spin off in the area of investigation of cancer, affects strokes by hyper-

46-566—70——9

tension. And, in addition, it is the ideal disease to add categorically to the end of the diseases in the "RMP program."

The other thing important, as far as the RMP program is concerned, is at the present time we have regional programs, regional programs within our own five-State area of Minnesota, the Dakotas, Wisconsin, and Iowa, which allow us to keep approximately 100 to 125 patients on the artificial kidney at any time, all waiting as recipients for transplants when organs become available.

It is implemented by a system of helicopters, airplanes, ambulances, and cooperative satellite units.

This program extends even beyond the microscopic regions to the region of the whole United States. A classic example may thus be brought forth based upon a series of events that occurred just last week.

A young man died in Salt Lake City, Utah. And the survivors felt the patient wanted his kidney used for transplantation. And he was typed. And this was done through a computer in Los Angeles. The computer readout of the other 1,000 patients awaiting transplantation throughout the United States indicated the two closest patients to this patient were two patients located in Minnesota, one on dialysis at Mayo and the other in the veterans' dialysis unit in Minneapolis.

These kidneys were flown from Salt Lake City to Minneapolis, both transplanted successfully to these two patients. This shows the kind of regional and superregional representation that can occur with kidney disease.

To extend this even one step further, in Los Angeles recently a kidney was removed from a dog, placed in a container, and airshipped to Israel and placed in another dog and successfully transplanted. It is keeping the dog alive, which indicates the kind of progress being made in preservation and utilization of these organs for transplantation.

Now, kidney disease today and kidney transplantation is no longer experimental. It is therapeutic and is the best treatment for patients dying because their kidneys no longer function. This differs from other pilot programs in transplantation of heart and lung and pancreas and bone marrow, and so forth.

If this is true, what are the results? At the present time, if you receive a kidney from a blood relative donor, the chance of you being alive and well with a functioning kidney 5 years later is between 90 to 95 percent in the institution. If you receive a kidney from somebody recently dying, a cadaver, unrelated, the chance of being alive and well are 50 to 60 percent at 5 years in our own statistics.

What this means is a 100 percent fatal condition has been now reversed to a completely treatable condition as far as the kidney is concerned.

I think, as far as I am concerned, that there is to me a tremendous urgency needed for implementing this program.

What about cost analysis? Kidney disease and urological disease is the primary cause of loss of work for women, work hours, and the fourth leading cause of loss of work for men. So it does cause an economic loss as well as 25,000 patients dying needlessly because of lack of treatment.

What happened economically is the following:

Kidney work used to cost $25,000 because of research and other

developmental projects associated with it. At the present time kidney transplantation costs approximately $10,000.

It is my hope and aim in the not too distant future that kidney transplantation will not be any more expensive than that of any other major surgery. And these cost reductions have been made in a situation where we have rising costs in all other areas of health care.

How can we implement these programs? I think it is important that somehow or other the development of the kidney center concept as outlined by the Gottschalk report should be followed, and the training as exemplified by the two previous speakers, the training of personnel, can be implemented in these centers.

In addition, the centers can relate to large regional areas in keeping with the regional concept in this program.

In closing, Mr. Chairman, I would like to say I think the need is extremely urgent to recognize we are only treating one out of 20, or 5 percent, of the individuals that could be effectively treated for or are dying from kidney disease, because of lack of funds and facilities and personnel. There is no question that dialysis and transportation are most convenient methods of treatment that do save lives.

The tragedy of some 20,000 to 25,000 productive Americans who die needlessly each year continues to add fuel to public allegations against our health care delivery system of the most affluent nation in the history of man. I therefore strongly urge this committee to enact H.R. 17570.

I thank you, Mr. Chairman, Representative Nelsen, the Representative from Minnesota, for your courtesy.

(Dr. Najarian's prepared statement follows:)

STATEMENT OF DR. JOHN S. NAJARIAN, PROFESSOR AND CHAIRMAN, DEPARTMENT OF SURGERY AND DIRECTOR OF THE TRANSPLANTATION AND DIALYSES PROGRAM, UNIVERSITY OF MINNESOTA HEALTH SCIENCES CENTER, MINNEAPOLIS

Mr. Chairman: Thank you for giving me the opportunity to appear before your committee in support of HR–17570 and other companion bills to extend the Regional Medical Program and amend its title to read "Heart, Cancer, Stroke, Kidney and other Related Diseases" as well as earmarking other funds and adding Regional Representatives to the National RMP Council.

I am Dr. John S. Najarian, Professor and Chairman of the Department of Surgery and Director of the Transplantation and Dialyses Program at the University of Minnesota Health Sciences Center, Minneapolis, Minn. I have been concerned and active in the field of organ transplantation since 1954, when the first successful kidney transplant, using identical twins, was performed at the Peter Bent Brigham Hospital in Boston. At that time I felt that transplantation represented one of the brightest of all medical-surgical horizons and that it would be as vital a development as were the development of anesthesia and subsequently antisepsis.

The successful transplantation of a kidney between identical twins produced evidence that successful transplantation could be accomplished if the immunological barriers presented by the host during rejection of foreign tissues could be controlled. Therefore, I devoted the next eight years of my training to include not only surgery but basic science training in the rapidly advancing field of immunology. My primary research endeavors are documented in 130 publications concerned with control of the immunological response to allow successful transplantation. In addition, I am currently completing a standard textbook in transplantation. I was privileged to be a member of the Committee on Chronic Kidney Disease (serving under the Chairmanship of Dr. Carl Gottschalk) advising the Bureau of the Budget in the area of chronic kidney disease. I have been a member of the Scientific Advisory Council of the National Kidney Foundation for the past three years. I have been involved in finding methods to implement the tremendous potential of treatment available by dialyses and/or transplantation

and to improve the delivery of these measures of health care. At the University of Minnesota we are transplanting between 60 and 100 kidneys each year as well as 10–12 pancreases. Our pilot programs in heart, lung, intestine and bone marrow transplantation are progressing rapidly.

Mr. Chairman, I will direct my discussion to the field of transplantation while my colleagues and friends, Drs. Schreiner, Merrill, and Perry will elaborate on the subjects of renal dialyses, prevention of renal diseases and urological aspects for the proposed legislation.

It is an established fact that more than 8 million Americans are afflicted by diseases of the urinary tract. Approximately 50,000 of these individuals die of primary kidney disease each year. Between 1965 and 1967 the Gottschalk Committee concluded that *at least* 10,000 of these 50,000 individuals who would be ideal candidates for life-saving treatment from either the artificial kidney (dialyses) or transplantation. The ideal patient criteria established by our Committee was very limiting; it included only patients between the ages of 15 and 45 with primary kidney disease and no other systemic conditions. Since that time, in only two years, kidney transplantation has evolved to the point that we no longer set age limitations as were suggested in 1967. We now transplant children from the age of 6 months, as well as adults, 60 years and older. In addition, our transplant program accepts patients with diabetes, lupus, and a variety of other systemic diseases that cause chronic kidney failure. Even the extended criteria has produced most gratifying results. I would estimate that the number of terminally ill individuals who could benefit from either dialyses or transplantation today is about 25,000 per year if programs were available. Last year only 500 patients received kidney transplants and only 300 patients were placed on dialyses. To my knowledge, the unconscionable situation has never before presented itself in the history of medicine. A treatment modality *is available* and 25,000 lives could be saved each year but less than 5 percent of those who need this life-saving treatment are getting it. I sometimes wonder what the impact of these factors would be on our current socially active generation that desires and demands our extraction from South Viet Nam where, in fact, at the cost of $35–$40 billion a year we are deliberately taking the lives of thousands of Vietnamese soldiers and civilians, our own soldiers included. Yet, in the same context the most affluent country in the world has, in fact, overlooked the recommendations proposed in the Gottschalk Report that could potentially save 10 to 25 thousand lives a year for an extremely modest investment..

When the recommendations of the Gottschalk Report were presented there were misinterpretations of the figures. A total fiscal commitment of care was envisioned by some individuals. However, since the cost of dialysis and transplantation have not been implemented, a variety of institutions including the University of Minnesota, have gone forward with active programs in dialysis and transplantation, seeking funds from third-party insurance carriers, private donations, Title IXX beneficiaries, and utilizing the limited research monies to cover a small portion of clinical transplantation costs. These clinical-research transplantation programs have developed techniques of improved organ graft survival and at the same time have given the very distinct and tangible service of saving lives. Thus, transplantation and dialyses programs have had to evolve with a patchwork-quilt type of financing. Despite efforts by many centers to expand their capabilities, the increase in the number of kidney transplants performed is minute. In 1966, 300 transplants were performed—in 1969, 550 were performed, an increase of only 250.

Mr. Chairman: Another staggering fact is that approximately 70 percent of all individuals afflicted with primary kidney disease are youngsters or patients under the age of 35 years. These are individuals who's life is cut short in their prime only because their kidneys no longer function.

Kidney transplantation today is no longer experimental but is, in fact, treatment; the best treatment for terminal kidney failure. The established transplant centers schedule kidney transplants in the operating room as they would schedule appendectomies, removal of gall bladder, stomach or other elective procedures.

The success of kidney transplants are such that of the 3,700 patients who have received a kidney transplant since 1954, 62 percent of these patients are still alive and well today. If any of us in this room was to receive a kidney transplant from a blood relative, the chances of being alive and well with a functioning kidney 5 years later is close to 90–95 percent. At the University of Minnesota, our patients who receive a kidney from someone who has re-

cently died (cadaver) have a 50–60 percent chance of being alive and well with a functioning kidney in five years. Five years has been used as a biological measure because a patient who survives five years will usually follow normal life tables thereafter. To deny these lifesaving procedures to dying patients simply because there is a lack of funds, facilities, or personnel would be a modern American tragedy. We espouse the importance of health delivery systems and make platitudes such as "health care is the right of every American Citizen," and to quote Secretary Finch "As long as there are people in this Country who are denied essential health care services because of poverty, race or lack of access for any reason, we have fallen short of our promises as a Nation." Clearly, by not acting towards development of a kidney health care delivery system we have definitely fallen opprobriously short of our promise to one of the obvious and frustrating problems presented to physicians interested in patient care related to kidney disease.

I have a very pragmatic sense, the addition of kidney disease to the RMP Programs is a very obvious utilization and extension of the extremely important program. Certainly kidney disease does effect heart disease, cancer and, through hypertension, the development of strokes. Thus, kidney disease is most intimately related to the other three categorical diseases defined for the RMP Programs. The Regional aspect of this program in kidney disease is already being implemented in crude, poorly supported, yet enthusiastic programs. A classic example exists at the University of Minnesota Hospitals: In order to maintain adequate numbers of patients for transplantation it is necessary to keep a large number of patients on the artificial kidney, patients who will eventual recipients of cadaver kidney transplants. In recent years we have found it possible to match cadaver kidneys with the very best recipients and the results are markedly improved when such conditions are met. Thus, at the University of Minnesota we have developed a Center for "tissue typing." For patients who do not have a blood relative donors and must await a kidney from someone who has recently died. We have a method to find the very best kidney for a patient by tissue typing the recipients and matching a subsequent donor kidney to the closest matched recipient. To obtain the very best kidney transplant, it is necessary to have a large pool of potential recipients. We must maintain at least 25 patients on dialysis at the University of Minnesota Hospitals. At our County Hospitals and in peripheral hospitals throughout the five state area there are another 100 patients on dialyses who are potential candidates for transplantation.

A classic example of what happens when a cadaver donor kidney becomes available may be exemplified by an event that occurred last week: A man died in Salt Lake City, Utah; tissue typing on this individual was fed to a computer in Los Angeles which contained tissue typing on more than 1000 patients awaiting a kidney transplant. Two patients matched almost identical the individual who had just died. These two patients were available on dialyses at the Mayo Clinic and at our Veterans Administration Hospital in Minneapolis. The donor kidneys were shipped by air and transplanted successfully. We have received kidneys from as far away as Boston. In one instance a dog kidney was sent from Los Angeles to Israel and subsequently transplanted into another dog. The kidney survived, indicating that it is possible to ship kidneys or other organs over wide distances for purposes of transplantation.

This same program is used regionally in our own five state area; not only for obtaining kidneys from patients who die in that area but in addition we maintain patients on dialyses in so-called "satellite dialysis units" in small hospitals scattered throughout Minnesota, North Dakota, Wisconsin, and South Dakota. If a patient comes to us in kidney failure and has no immediate related donor, he is placed on dialysis first in our own institution and subsequently in the satellite unit closest to home. His life is maintained on dialyses twice or three-times weekly. When a kidney is available the patient is flown to our Hospital for transplantation. The current Regional Program underway in kidney therapy is working basically on shoestring financing and unfortunately lacks the concept of the kidney center approach as outlined in the Gottschalk Report. A Kidney Center should have a nephrology, dialysis, and transplantation unit as well as research and development endeavors based at a central hospital associated with peripheral subsidiary dialyses units.

With the increased experience in dialysis and transplantation during the past ten years, the cost of transplantation which initially was $30,000 per transplant has been reduced in our own experience to about $10,000 per transplant, despite rising hospital costs. It is our hope and our aim that in the not-too-distant future

the cost of kidney transplantation will not be any greater than that of any other form of major surgery and with the research developments that have occurred to date, I feel that cost of care should decrease. Subsequent reductions have already been made in dialysis. In basic economics, kidney disease and urinary tract disease is a major illness causing loss of work in women, and it is the fourth leading cause for loss of time from work for men. If these citizens who face death from kidney disease receive a transplant they could return to a perfectly normal life, taking a few pills each day, and return to their jobs, classes or house work.

Our inability to transplant more than five to six hundred patients annually, is obvious in several areas. *First and foremost:* inadequate financing necessary for the development of kidney centers. These centers should include dialyses units, intensive care units and operating rooms. Primarily, this would involve some degree of new construction money since most University Hospitals do not have the facilities necessary for dialysis or transplantation; reconstruction or new construction of currently overcrowded facilities for the development of these kidney center units could be arranged. *Secondly*, there is a great need for training personnel: doctors specializing in the field of transplantation, immunology, and nephrology. They, in turn, will establish new transplantation centers throughout the country in a regional sense and eventually transplantation can be expanded to meet the needs that are so currently evident throughout the country. *Finally*, there is a need for strong satellite dialyses centers to be established in community hospitals throughout the peripheral web of any large urban area, as well as our rural areas and we can then train patients for home dialysis as well as the support patients with terminal kidney disease who are awaiting transplantation. This too, by necessity, involves some renovation funds, monies for dialysis units and training of personnel for the units. Training dialysis personnel does not take away from the medical pool since most technicians and other technical help involved in dialyses are non-professionals and represent individuals whose background may be in another discipline including: mechanics, lab assistants, secretaries, service station operators, etc.

Mr. Chairman: In closing, I would like to say that: I feel that the need is extremely urgent to recognize that we are currently treating only 1 in 20 patients or 5 percent of the individuals who could be effectively treated, who are dying of kidney disease simply because of lack of funds, facilities and personnel. There is no question that dialyses and transplantation are proven methods of treatment that do save lives. The tragedy of some 20,000 to 24,000 productive Americans who die needlessly each year continues to add fuel to the public allegations against the health delivery system of the most affluent nation in the history of man. Are we incapable of delivering the needed health care to its citizens? I strongly urge this Committee to enact HR–17570 and its companion bills that can extend the Regional Medical Program by amending the title to read "Heart, Cancer, Stroke, Kidney and Other Related Disease" as well as earmarking other funds and adding renal representatives to the National RMP Council.

Thank you, Mr. Chairman, and Representative Ancher Nelsen, the Representative from my State, for your courtesy.

Mr. JARMAN. Thank you.

Dr. Schreiner?

STATEMENT OF DR. GEORGE E. SCHREINER

Dr. SCHREINER. Mr. Chairman, I am George E. Schreiner, president of the National Kidney Foundation.

Hardly a week goes by that I don't pick up a paper that is "doctor beating," the second most popular sport. And they say that physicians are really not interested in delivering the fruits of their research. And they point out that millions of dollars are spent, but there is a delivery gap to the people.

I think that we should pay some attention to a group such as this. These are the pioneer people who have spent their lives in research in this interesting field, and there is not a one of us that is not interested in seeing that the fruits of this research become delivered.

The first kidney patient was put on chronic dialyiss 10 years ago and is still living. This is a field that has been surveyed to death and has been demonstrated to death. Every time someone proposes a systematic, planned approach, we have another request for survey and another committee to look into the matter further.

I don't think you will find a group of doctors, such as the nephrologists, who feel so frustrated that there is not in this Nation a planned, systematic approach to the health field. Sweden has a national program, and Norway and Britain, for treatment of kidney disease. And the United States, which has been a leader in every other field of medicine and led in the research in this field, does not have at this moment anything like a systematic, planned approach to kidney disease.

Ten years have gone by, and we have watched it. Another 10 years will see the anniversary of a half-million Americans who have died unnecessarily.

Furthermore, as research develops, we find new uses for the previously developed things.

As Dr. Merrill pointed out, these can be roughly classified as the spin-offs. For example, one can treat malignant hypertension today by removing both kidneys. We had a patient at Georgetown Hospital who was a jet pilot. He was absolutely blind, completely crippled, and paralyzed in both extremities with malignant hypertension. We removed his kidney, placed him on dialysis and then transplanted him almost 5 years ago with a cadaver kidney, and he is now gainfully mployed and completing a computer programing school course.

We can literally save thousands of patients with hypertension, but we don't have the capability of taking care of patients with primary kidney disease, so we can't always go into new areas with these new techniques. And I think it is a frustrating situation both for patients and, of course, for doctors who have to be dealing with them on a day-to-day basis.

Now, you have heard the many surveys that have been done, the Gottschalk report being a very systematic and very thoughtful analysis. The Gottschalk report made one major political mistake. It was honest. It has an analysis of cost based on overall patient costs. We have had these numbers thrown back in our teeth day after day, week after week, by people who want to fasten on the numbers game and not pay attention to the realities of a situation.

The survey indicated that if the Federal Government were to take over in a hypothetical situation, all of the costs of treating patients, it would be a very big amount, indeed. But, as you have heard, that point in history is past. We now have the Veterans' Administration handling their group of patients. We have Blue Cross and Blue Shield plans generally handling their patients—we have some States with programs—this kind of thing is gradually growing, so that we have patient care costs taken care of by many different sources.

What is needed is a primary system, an organization that will sort of father this along, and, secondly, facilities and training money.

As we mentioned, we feel that kidney disease lends itself beautifully to the regional concept. Since Christmas at Georgetown Hospital, we have transplanted kidneys from Baltimore, Md., Atlanta, Ga., Charlottesville, and Richmond, Va. The one from Charlottesville was

flown in by the North Carolina University plane. They picked it up in Charlottesville and flew it to National Airport. The one from Atlanta—the patient died at 5:45 a.m. The cadaver kidneys were on a commercial airlines flight and in Washington Airport at 7:30, and the transplanted kidneys were working in the patient at Georgetown Hospital by 9 o'clock that morning.

She was a nightclub singer and is now back at work.

These things are no longer hypothetical, as Dr. Najarian mentioned. The people who have been working in the field know they are practical. They have problems of developmental research which have to be continuously worked on. But the basic theory is already here and now needs to be delivered.

Now, there are many spin-offs, as Dr. Merrill mentioned. And remarkably little credit is given, I think, to the kidney programs for these spin-offs.

Dr. Merrill mentioned the cancer breakthrough that was initiated by him. And many years ago we were interested in isolation, human isolation for the transplant program, and helped to design and develop an apparatus called "hylaphollum." The first successfully treated leukemia patient was treated in hylaphollum. Some time ago Mr. Walter Cronkite had a program on "20th Century Medicine," the opening shot was this, and no one mentioned that it was developed out of kidney research.

We have pioneered many of the basic equipment breakthroughs useful in other fields. Yet, because we have such a small foundation and because it is such a new field in medicine, we get a poor break when it comes to actual distribution of funds.

Now, I personally feel that there is no other area of scientific medicine which lends itself better to the regional concept than does kidney disease. I think many of the problems, to be blunt with you, that the regional program has faced in the last year or so, would be improved by having a model to work on in which the intrinsic content of the thing to be delivered lends itself to regionalization.

We have seen how the regional program has gotten watered down in some regions by natural, traditional competition. If you have two universities in a region and they both put in a request for the cardiac surgical service, the professional competition is such that they fail to reach a common denominator.

What happens is they fund a program of postgraduate lectures, which is the only thing both can agree on. What we have here is a situation which is almost a natural for regionalization, because there is no preconceived notion. We are able to train individuals who are not even in the health manpower field.

Dr. Scriber's technician was a service station attendant, and our dialysis man was a disabled Air Force electronics sergeant, and we are bringing people into the field which you couldn't do with another field simply because it is new and has no vested interests. We can set a model and a plan which I think is going to be applicable to the systematic delivery of medical care in other areas. And I look at it as kind of a working model which is much more widely applicable than just to the kidney field alone.

We don't have a big foundation to help. But, such as it is, we are committing all of our financial and human resources to this. We really

need help. And as far as I am concerned, the place to get it is from you gentlemen, and we appreciate your interest.

Mr. JARMAN. Thank you very much. I think you have made an effective presentation. I just wish we had more time for the questions that I am sure the subcommittee would like to ask in this important field.

It certainly is encouraging to hear what has been and is being done and what the possibilities are in the kidney disease field.

We have several other witnesses this morning. So the questioning will have to be held to a minimum. I, as the chairman, would like to ask a couple of questions and would simply leave to the panel who would like to respond on it.

In 1965, when this committee reported the original heart, cancer, and stroke program in the House, we did specify in the report, as you remember, that diseases closely related to heart disease, cancer, and stroke could be included under regional and medical programs.

There are some who might, as a result, wonder why it is necessary to specify kidney disease in this legislation. Would you have any comment to make?

Dr. SCHREINER. Yes, sir. The pragmatic facts are that last year less than one-half million dollars was spent in the kidney field out of all regional funding. I don't find that unnatural.

There is no one on the National Council of Regional Medical Programs at the moment with any real expertise in the kidney area. The directors that have been chosen around the country have been rightly chosen in the areas which were specifically mentioned in the original legislation—heart, cancer, and stroke. Each of these has advisory committees, and each has a chairman.

They have problems which we recognize, and they obviously would have to be very extraordinary people when caught up in their own programs to be also interested in another field.

I think one of the most important features of this bill, which we support, is to put people on the Council who have expertise in the kidney area. This will in itself encourage applications from this area of medicine.

Second, obviously, if no additional funds are recommended, then what you are doing is competing with already scarce funds, and we will get the natural defense reaction from the people primarily interested in heart, cancer, and stroke, which is perfectly understandable human psychology.

We feel therefore the only realistic way to do it is to add the kidney expertise to the council, give earmarked money in the initial years of the program until it comes up to the level—that is the level we had preexisting, and then we feel the programs will be funded properly.

You are correct, Senator Hill established the legislative record that the kidney program could be funded. But the facts are that it has not. And I think you gentlemen who are realists can see in the very RMP organization why it will never happen unless it is specifically organized into the program.

I also would like to extend, or I meant to extend, an invitation to any of the members of the committee to visit our unit at Georgetown. We would be happy to have you at any time to see some of the patients firsthand.

Mr. JARMAN. Thank you very much.

Yesterday Dr. Egeberg was asked by the subcommittee as to his own reaction to specific reference to kidney disease within the scope of this legislation. As you know, he suggested at that time an expansion of regional medical programs to cover all diseases.

What would be your reaction to that suggestion?

Dr. SCHREINER. My research—and I will ask Dr. Najarian and Dr. Merrill to add to it—is that the program is underfunded at the moment as far as its goals are concerned.

If you broadened RMP to some vague, ill-defined group of non-specified diseases—someone once jokingly said, no one dies of comprehensive health—you will have a difficult time and will spend another 2 or 3 years trying to define what is being covered by the regional medical program. And you won't get on with the areas in which the research expertise already has been developed.

So we think it would be a disservice to provide the same amount of money and then dilute it out so thin that nothing will be accomplished, and it will just really go out as a dilution rather than getting to groups with major problems.

Secondly, I think we have an honest case to make for practical expertise. It is one thing to say that if we get the money that maybe in 10 years we will be able to do something about cancer. It is another thing to be able to do something now and not have the organization to do it.

So we have arrived at a point in science which is an intellectual and scientific fact, that this is a ready-to-go item. It is on the firing line. And when this happens in some other field, we will be all for inclusion of that field in the program.

But I think it could be a great mistake to dilute the aims of the program in such a diffuse manner that no one could define the purposes or goals for which they are working.

Dr. MERRILL. I would just like to emphasize—I think both Dr. Najarian and I stressed this—this program that we are talking about is an on-going program. It is already underway. We have made great inroads in funding it from other than Federal sources. But we still need help.

It is as clinically feasible, certainly, between relatives as open-heart surgery. None can question the need for continuing that.

In addition to this, it is a program which has already begun to train and to spread. And it is a natural for the kind of thing that should be included in "RMP."

I think if one were to be vague about other kinds of diseases, you might, as has certainly been done—and I don't think I am telling you any secrets—you might spend 2 or 3 years in planning and neglect the specific delivery of services to patients for whom the services are now available.

Dr. NAJARIAN. I would just like to support what Dr. Merrill and Dr. Schreiner said.

It is true that this is a program that works right now and can work, and nothing in heart, stroke, or cancer, or any of the other diseases, such as arthritis and so forth, have treatment modalities that are not being given or extended to the public because of lack of funds. This is true, and we do have a treatment modality and have shown the works.

And we need implementation. And this is the reason that it should be there and not diluted, as has been said.

Mr. JARMAN. Thank you.

Mr. Nelsen, do you have any questions?

Mr. NELSEN. Thank you, Mr. Chairman.

These machines; do they last forever?

Dr. SCHREINER. No; they—well, of course, they are being revised, as every other kind of machine is in America. There is a certain technical obsolescence that develops by the improvements which come over a period of time.

Actually, some of the early machines can be used. But the improvements have proceeded at a fast rate. So I think a useful average life would perhaps be 3 to 5 years. Some of the machines are available through lease-purchase arrangements, so that individuals do not have to indulge in a capital expenditure.

One of the things that is being done by the National Kidney Foundation is the purchase of the machines and then renting them to hospitals or institutions, so the individual is not faced with the initial capital expenditure.

Mr. NELSEN. I have one question off the record.

(Discussion off the record.)

Mr. NELSEN. On the record.

May I say to Dr. Najarian from Minnesota, we are glad you came and we are proud of our medical school. I used to serve on the finance committee of the Minnesota State Senate, and I remember some of the early history of our medical school. We have had many famous doctors there, particularly in the area of heart disease. The University of Minnesota Medical School has been one of the leaders for many years. I want to say thank you for taking the time to come here to appear in support of this legislation which has such great merit.

Thank you.

Dr. NAJARIAN. Thank you.

Mr. SKUBITZ. Will you yield?

Doctor, a couple of weeks ago I read an article in one of the Washington papers about development of an artificial kidney that would sell for $5. Can you tell me what they were talking about?

Dr. SCHREINER. One of our minor publicity problems is the enthusiasm of the inventor. All inventors are enthusiastic about their wares when they first are made. Dr. Cole first invented the coil kidney. He said all you have to do is go down to the hardware store and buy a grapefruit can and wrap it up with sausage casing and put a window screen around it, and that is an artificial kidney.

It is true it works in the lab, but when you go to humans you have to be concerned with lead content and so forth.

Mr. SKUBITZ. Well, they said they developed a new sort of rubberized cement of some sort.

Dr. SCHREINER. Yes, is it theoretically possible. Mr. Skubitz, and what they are talking about is a sponge elastic capillary tubing which has the diameter of a human hair and the big problem with the tubing is with the problem with the end being straight, like your hair standing up on end, and there would not be blood clotting in the tubes and the gentleman who released that from Chicago feels they have been able to accomplish that in the lab.

I think it needs more confirmation, but it is an interesting idea and does hold promise.

Mr. SKUBITZ. I thought perhaps there was a kidney drive scheduled and you had to come out with something new.

Dr. SCHREINER. No, we don't have to. We are very interested. A lot of organizations are looking for programs. We are a program looking for more organizations and more money. We have so many things happening that we don't have to look for programs.

Mr. SKUBITZ. Thank you. That is all.

Mr. JARMAN. Mr. Rogers?

Mr. ROGERS. Thank you very much, Mr. Chairman.

Your presentation has been very impressive. How much money would it take to set up a program to treat the 20,000 to 25,000 that you say die? Is that the case, is that for the transplants?

Of course, I presume you wouldn't participate in all transplants, but what would be an estimated figure to save those 20,000 people?

Dr. NAJARIAN. I think the figure presented here is $15 million. What does it really mean? That figure was derived from a variety of things, including programs presented to RMP for kidney disease approved and not funded. In addition to this, when we talk about 20,000 to 25,000 transplants and $10,000 apiece, I remind you that we are currently getting most of that taken care of by third party payment, through title XIX, welfare, et cetera.

The problem that exists is that we don't have the organizational structure necessary to implement the kind of regional program that Dr. Merrill and I have spoken to. In other words, we have satellite units which feed into computers "tissue typing" and we retrieve all of these organs into one place and to train personnel so they can set up new units.

This can be done for a rather modest investment, an investment of $15 or $20 million in order to implement what is now in a patchwork quilt type of thing.

Mr. ROGERS. What is your manpower shortage in the field?

Dr. NAJARIAN. The manpower shortage exists only because of lack of trained personnel. One of the things we learned is the artificial kidney which people with the expertise of Dr. Merrill and Dr. Schreiner used to have to monitor and be with physicians well trained and now this is done by nurses and not only by nurses, but we have janitors, God knows what all, that are responsible for these machines, so we draw from the manpower pool of nonmedical and make them into a paramedical pool and these expand and control these units.

Mr. ROGERS What is the training period necessary?

Dr. NAJARIAN. It depends on what you want to do, and in training people for dialysis it can be a short period, perhaps 6 months, and if you are training people for nephrologists such as my colleagues, it may take a period of anywhere from 4 to 5 years of postgraduate training and for transplant surgeons, which are already obtaining training in surgery, it requires a minimum of 1 to 2 years, specific training in immunology and transplantation capabilities.

So I would say it depends on the personnel you are training. This is the kind of thing involved in the kidney center.

Mr. ROGERS. Out of the 20,000, how many probably would have to have a transplant?

Dr. NAJARIAN. The 20,000 I quoted you, sir, is a figure that all could and perhaps should. You see the ideal treatment is transplantation.

In your dialysis, you have another problem and you have a machine you have to have two or three times a week and certain devices and so forth, and you are never completely well on the machine so the ultimate goal is transplantation. All cannot be transplanted for one reason or another and some have to be maintained on dialysis.

Mr. ROGERS. Well, I understand the dialysis, but what is the life period once you go on dialysis? Is there an average?

Dr. NAJARIAN. Yes, there is. As a matter of fact, there is about 15 percent attrition the first year and 10 percent every year thereafter until the fifth year and levels off to about 40 percent; 40 percent of those you originally put on, 5 years later would be alive under ideal circumstances.

Mr. ROGERS. What are the major expenses, the devices, or services?

Dr. NAJARIAN. I would say for the most part it is services.

Mr. ROGERS. What is the average cost of the doctors' services, first, in the dialysis treatment and, second, in the transplant?

Dr. NAJARIAN. In the transplant as an average the services have been essentially zero and the only time the charges have been made by transplant surgeons is when there was a third party coverage.

Mr. ROGERS. Most of them, though, are covered by third party payments?

Dr. NAJARIAN. That is correct.

Mr. ROGERS. What would be the average cost?

Dr. NAJARIAN. The average cost, in other words, the price that the surgeon would charge?

Mr. ROGERS. Yes.

Dr. NAJARIAN. Approximately $1,000. That ranges anywhere from $750 to $1,000.

As far as the dialysis, Dr. Schreiner could probably answer that.

Dr. SCHREINER. Yes; this varies considerably with insurance payments. That is Blue Shield, for example, in Washington provides a professional fee of $150. With a proper organization, that is, and with the facilities set up properly, this can be markedly reduced and there are a number of physicians around the country doing it for much less because it is a volume proposition, how many you can do, depending on the kind of organization that you have.

I might mention that the home training takes a patient or spouse, if they have any mechanical aptitude, in our program, about 2 months. That if you do transplantation as a rough estimate, you need about a third as much dialysis capacity to maintain the patient around the house, a third to a half, and it has to do to carry the patient up to transplantation. And the longer the wait for a kidney, the longer a dialysis period that is required.

Let me give you an example. We have an ambassador who is one of our patients who was home trained and he wanted to go to France for the summertime and he offered to buy a kidney for a hospital in France. The French hospital said, "We can't do it, it is much too complicated and we don't have the necessary manpower, medical manpower."

He ran it in his farmhouse all summer long with his wife and came back to the United States after a summer in France. This is a mutual

patient of ours that Dr. Merrill trained in Boston, who now is living in Washington.

But this is an example of what can be done when it is necessary. We have a man who has psychiatric problems in his family and he is a very noted member of the Government and now contributing significantly in an important area, and we are having him at home next week with volunteers from Walter Reed, who are long-time patients in the hospital who are helping him at home to do dialysis.

It is possible under stress of need to do new patterns in manpower training. The thing that kills us is to have professional medical planner say you have one doctor in this unit for four patients and therefore, it will require 50,000 doctors to do 250,000 patients.

These kinds of figures are killing and they are untrue and simply obfuscating delivery of medical care. They are a smokescreen and under the stress of necessity with proper organization, these things can be done and can be done cheaply and with newly trained manpower, but what we need is leadership.

Mr. ROGERS. Let me conclude by saying this: As I understand it, you need membership on the Council?

Dr. SCHREINER. Yes.

Mr. ROGERS. How many?

Dr. SCHREINER. I would say at least three, possibly four.

Mr. ROGERS. Would this be consistent with the other diseases?

Dr. SCHREINER. Yes, sir.

Mr. ROGERS. And you need $15 million?

Dr. SCHREINER. Yes, sir

Mr. ROGERS. And what results can we get for $15 million and at what time?

Dr. SCHREINER. You can get model programs within a year. In fact, the Bureau of the Budget released just a few weeks ago $1 million in reserve funds and within hours a program was funded in the State of Wisconsin, which is going to be a pilot project that will cover the entire State of Wisconsin, so these results can be produced within months.

Mr. ROGERS. I think the committee would want you to keep us advised. I personally feel it does not make any sense to have spent money to find answers to problems and not use them. This is absurd and it is what we are doing in too many areas in medicine today.

I commend you and I am going to support it and I am hopeful the committee will.

Mr. JARMAN. Dr. Parry has a comment.

Dr. PARRY. May I, for the record, add that the greatest block to kidney function is obstruction in the urinary system and we are talking about renal failure, but I want to bring out there is a tract below the kidney and such problems as congenital abnormalities in children and stones in middle age and tumors in the older group, and trauma across all ages that end up in the paraplegic group and nephragenic bladder problem in paraplegics and their lives depend upon the kidney function and the problem of infection, and these are problems and obstruction within the renal area. These are all foes of kidney function, too.

When we are talking about kidney failure, I want to bring out that aspect because there are many things we can do in the urologic field,

are ready to do in the preventive aspect right now, but what we need to do is train clinicians to recognize these problems, to go back to their diagnosis, to treat them earlier, to cure them and prevent these costly procedures of dialysis and transplantation.

Mr. ROGERS. May I ask a question there?

This is what we set up the regional medical programs to do and this committee changed the thrust of the program as it came out from the Senate, to try to get the latest knowledge down to the most people in the fastest way.

Now, are there the regional medical programs—do you feel in functioning this way, they are functioning in this way to bring the information and get it out?

Dr. PARRY. Absolutely. I came to Oklahoma because I wanted to belong to the whole state and this regional program has given me the chance to do it. I have such a program going in Oklahoma right now.

This has been the fun of it, because my contract with each of the 152 hospitals and the 48 hospitals in my neighboring States, canvassing 133 of these, every patient, carcinoma patient, right now is to go back to these hospitals and give them this playback.

As a matter of fact, on one, I called out to a student 2 days ago in western Oklahoma to get a followup report to turn in, and he said, "I hear you are coming out to Shattuck, Oklahoma." I said, "How did you know that?" He said, "The word is out here you are going to come back and give us a report on the regional program."

That is part of our contract. In all of the 152 hospitals we are surveying right now, we have canvassed 133 of them and we have only one hospital that has refused to let us go through their records and this is a matter of miscommunication. I think we are going to solve this.

This is the kind of response we have had. We started out with a medical students, coaxing the physician. The physicians, the urologists, who worked with us, have then helped in that area.

In turn, we worked with the preceptor, the man who works with the medical school in training the student. He has been the next liaison officer. We move to the smaller communities where there is no neurologist, or preceptor, and we have been working with the hospital superintendent and interestingly one of the field workers is a wife—she is a nurse and wife of one of the hospital superintendents, and this is the way that we are moving out to all of the hospitals, so right now we have such.

Mr. ROGERS. I would like for you to furnish the committee, if you could, a rundown of your program in this particular field for the record, and you don't have to do it now, but for the record.

Dr. PARRY. This was my first presentation.

Mr. ROGERS. That is all right. I am sorry. I was late. That is all right, if you did it.

Dr. PARRY. We would like to and are happy always to come back with our information, because we have about 1,800 cases all on computerized data.

Mr. ROGERS. I want to take it up with the other regional programs to see if they have done anything.

Dr. PARRY. Three other programs have asked for this. This is what we hope if we set up the model in Oklahoma; it will be carried out.

The problem is we see no insurmountable difficulties in other areas.

Mr. ROGERS. Thank you.

Mr. JARMAN. Mr. Carter?

Mr. CARTER. Certainly I want to compliment the distinguished gentlemen upon your presentation. You have been very good. Personally I am for your integration into this program, authorization for funding, that is as far as we can go.

What is now the cost of artificial kidneys?

Dr. MERRILL. I think it depends on the kind of artificial kidney you buy. There are essentially two kinds widely being used now. One is the flat plate dialyzer and the other is the coil—I don't think the distinction is important.

The initial investment in one, the flat plate, is considerably more. With all the monitoring equipment, it is something like $15,000. The supplies for this subsequently are considerably less, so that the average for the first year or the average for the first 2 years is about the same.

The cost of the round equipment now is about $2,500 and the subsequent equipment gets up to $3,000 for all of the equipment that must be used and disposed of.

Mr. CARTER. The cost is going down considerably?

Dr. MERRILL. Yes. An example I gave you, one of the inserts for the round type, began at $82 and is down to $18.

Mr. CARTER. From $2,500 to $15 then?

Dr. SCHREINER. On the rental program it can be reduced. We require a patient for a year's rental around $900, which will take care now of the simplest console type of apparatus for a year. If they don't have the capital expenditure with the rental program or lease program, you can get the basic equipment needs for about $900 to $1,000. There are modifications in plumbing and so forth. I would say, to look ahead for a year on a home program, at the outside rental plus the plumbing changes and so forth, that may be a high figure, around $1,500.

Mr. CARTER. And that is the cost per year?

Dr. SCHREINER. It would be $900 a year thereafter. But that is a lot easier for a working man than plunking down $2,500 for a machine because he can do it as an ongoing thing and take it out of wages when he goes back to work.

Mr. CARTER. How many people per year are actually denied use of the kidney machine because of expense, or that now are available and people cannot be supplied with them?

Dr. SCHREINER. That is a difficult point for us to get over. It is really not the machine. American industry could turn out 1 million of these in a year if the market were there. The problem is, you might call it, the delivery organization. It requires a center to start with that would provide training for technicians, nurses, and doctors, it requires a central facility and satellite facilities in the community hospitals and they have to have places to refer problems.

They cannot exist in a vacuum. When the complications happen, it has to be built in a systematic way and what is missing is not just money, but a plan, the systems approach. We don't have a plan.

We simply said—just let this happen. We don't have an organized way to deliver it.

Mr. CARTER. You don't have the manpower?

Dr. SCHREINER. I think the manpower is achievable, if you say, or if I may, I mean, be informal to express myself, but we are really going about the whole thing in a "back asswards" manner.

Instead of saying, "Here, we have 100 sick patients, how can you deliver the best possible treatment for these patients at the lowest possible cost?" What we are doing is saying, "We have this program, and that program, how are we going to fit them in to take care of these 100 patients in other programs?"

You can do things very much more economically and much more efficiently if you approach it from a systematic planning way, because you can find that the ideal size of a dialysis center, for example, may not be four beds, it may be nine beds, and you may get more economical use of nursing manpower and technician manpower so you have to do analysis for the area to see what is the most efficient way of delivering care to that area.

There are parts of the country you can't train people or a high percent of people for the home because of educational background, economic problems, and obviously you can't put an artificial kidney in the home where there is no plumbing. So in those areas you are going to have to go to mobile units or a center dialysis in the community. This has to be adapted to the environment in which you are going to produce it.

Our problem is the rigidity we have in the programs. We don't have national planning and we have a rigidity which says we are going to find storefront centers, but they are no good in the hills of Kentucky, as you well know. This kind of thing that we would like to see is flexibility.

Mr. CARTER. In our hills we do have some. In Kentucky I have a veteran with an artificial kidney, an M.D., and I was fortunate enough to get him service connected.

Dr. SCHREINER. He is one of our patients.

Mr. CARTER. Dr. Asher?

Dr. MERRILL. He is one of our patients.

Mr. CARTER. Let's get back to my first question.

How many patients who need this treatment do not get it each year?

Dr. SCHREINER. Up until about 2 years ago, with the indications, using the strictest medical criteria, we figured about nine out of 10 of the people dying are not being treated. With the increasing number of applications as the use of it in hypertension and with stretching a little bit of the ability to transplant, it is more like 5 percent now, one out of 20 being treated, because the pool is larger and we have not grown in terms of development of delivery.

Mr. CARTER. Of course, we have noticed, I believe you mentioned, Doctor, effects of estrogen and which had been noticed, I would think, probably in cancer of the prostrate and, of course, we have had that for many years and a spinoff, I would think, and of course I believe one of your most noticeable effects is phlebitis.

Dr. PARRY. The Veterans' Administration study has brought to our attention that the patient receiving doses of estrogen in the range of 5 milligrams, that really is not a feminizing dose, but is a pregnancy level of the drug. They have more cardiovascular complications than a person on the prosebo-hyper compound.

That has brought this to our attention. In other words, in an older

person given a misdose of a drug seems to increase the rate of complications.

Mr. CARTER. There is increase also of phlebitis?

Dr. PARRY. That is one of the cardiovascular complications.

Mr. CARTER. Another interesting thing about cancer of the prostrate, which you mentioned, there is increased incidence as one grows older. Could you quote the percentage or give the incidence among people from 60 to 70 and 70 to 80 and so on of those having cancer of the prostrate, and are those figures available?

Dr. PARRY. Yes; I have figures here from our own study which I could give. It does increase with age. On the other hand, we are learning there is a certain virulence of this kind of tumor, too, so we have to put the two in balance. The older one gets, the incidence of this disease increases.

On the other hand, that does not mean that this is going to be the cause of death in this situation.

Mr. CARTER. Many times it is evident for years after diagnosis.

Dr. PARRY. May I answer Mr. Rogers in one of his questions?

I would like to go a little further in my presentation, because I didn't answer it correctly. We are going to have figures, I think, that you would be interested in which I didn't mention this morning. For example, how far does a person have to go to a physician? How far does he have to go to a consulting physician? What are the local facilities? Are they being used, such as the laboratory, such as X-ray? How many or is it any advantage for the one kind of patient with the same type of disease to see a doctor many times compared to another man in an outlying part of the State where physicians are not available?

Then we have the questions of cost. Do we need to do all of these X-rays at regular intervals?

We think this is ideal medicine, but is this necessary?

These are the kinds of byproducts that will come out of the program by being able to evaluate an area with no physician compared to an area with one and compared to another with a specialist and compared to another, say, with a medical center.

We have a whole spectrum of distribution of medical care in Oklahoma and we are trying to sample each one of these.

Mr. CARTER. Thank you. May I just ask this.

If you could submit for the record, if it is not already covered, and I would not ask you to comment on this now, but could you submit, if we include in this program the kidney diseases, what type of inter-regional and national information dissemination systems and cooperative organ banks could be implemented to improve the availability of transplants to those in need of them?

Could you just let us have your thinking on it? I think it would be helpful for the record.

(The following statement was received for the record:)

COMPUTER CAPABILITIES IN ORGAN RETRIEVAL AND TISSUE TYPING

Dr. Carter, in effect what we would propose to do is to expand the capabilities of existing computer tissue-typing-organ banks in addition to taking the necessary steps to add facilities, at other computer centers to cover the entire country. As you know, Los Angeles has an excellent system which could become the prototype for new centers. I would envision multi-regional centers, for example in Seattle to cover the Northwest, one or two in the Midlands, and so forth. It will be necessary to carefully delineate the geographic-medical services-population service areas of the centers. Finally, the prepared statements of Drs. Najarian and Parry cover certain aspects of organ retrieval and tissue typing.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. I have no questions, Mr. Chairman. I would like to say that it has been an excellent opportunity to hear the great pioneers in this field and as one who sits down at the foot of the table here and who hears this for the first time, I will say you have made a very powerful impression on me.

Thank you for your testimony.

Mr. JARMAN. Mr. Skubitz?

Mr. SKUBITZ. I have no questions, but I want to commend all of you today. I am for your program.

Mr. JARMAN. Mr. Kyros?

Mr. KYROS. Thank you. No questions.

Mr. HASTINGS. I have no questions. I will only say as one who sits at the other end of the spectrum, I agree with the viewpoints of Mr. Preyer.

Off the record.

(Discussion off the record.)

Mr. JARMAN. Gentlemen, we very much appreciate your being here and helping to make a record on this important subject.

Our next witness is Mr. Schlesinger, executive vice president, Community Health Information and Planning Service, appearing on behalf of the American Public Health Association.

STATEMENT OF RICHARD SCHLESINGER, EXECUTIVE VICE PRESIDENT, COMMUNITY HEALTH INFORMATION AND PLANNING SERVICE, INC., SYRACUSE, N.Y.; ALSO ON BEHALF OF AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. SCHLESINGER. Thank you, Mr. Chairman and members of the subcommittee.

I am Richard Schlesinger, executive vice president of the comprehensive health planning agency for Metropolitan Syracuse, N.Y. In addition, I have the honor of chairing the Community Health Planning Section of the American Public Health Association, the country's 26,000-member organization for professional and lay leaders interested in health matters. Thus, I speak to you today not only out of personal interest and concern, but also as a spokesman for my colleagues in the American Public Health Association.

Review and analysis of the original comprehensive health planning legislation, congressional hearing reports and Federal regulations guiding the development of the program reveal the goals which the framers had in mind. Primary among them were:

1. Developing and strengthening a planning process with basic roots at the community level;

2. Providing a mechanism for consumers and providers to work jointly in analyzing their community's health problems, in establishing priorities, and in devising appropriate and effective solutions to those identified problems;

3. Drawing together representatives of both public and private spheres in a working partnership to achieve health progress; and,

4. Encompassing an ecologic approach to the total spectrum of

health concerns: personal care and environmental health; physical health and mental health; services, manpower, financing and facilities.

Slightly more than three years have elapsed since the passage of that legislation, even less since its initial implementation, especially at the areawide (or community) level. In many ways, efforts to evaluate the program's productivity in contrast to its progress are misleading in judging the results of an organizational period. Nevertheless, it is pertinent to note that the early goals of the program remain relevant, and to question how best to promote continued efforts to achieve them. This question assumes particular importance in view of the differing pieces of proposed legislation currently under consideration here.

It is our impression that the administration-favored bill, introduced by the Honorable Mr. Staggers, makes provision for significant improvements in coordinating and correlating health planning activities now being carried out at State and areawide levels in a variety of administrative arrangements. Indeed, there is much in that proposed legislation which merits support. Yet, juxtaposed with the goals, several weaknesses and potential pitfalls in the legislation and/or its intent remain sources of anxiety.

For example, with respect to the first goal of strengthening the planning process locally, statements by departmental spokesmen are disquieting. I quote Dr. Egeberg: "Under a more complicated and dynamic approach, an areawide CHP agency could be given community responsibility for structuring the local health decisions." While this language is subject to more than one interpretation, the general thrust of the legislation, when viewed in the context of related remarks about the planing agency's role as "community trustee" and about its evolving "management" functions certainly appears oriented toward operational-type responsibilities. I submit that when the planning agency begins to assume responsibility as an arbiter of health services delivery and perhaps even to compete for service dollars, its planning role is compromised and the concept of partnership (goal No. 3) ceases to exist.

Again, redirecting the planning agency away from consensus-building into becoming an agent for achieving a federally predetermined objective—namely, development of an improved delivery system for primary health care—could conflict with the community self-determination implied in the second goal. Obviously, no one would want to quarrel seriously with the objective of improving and systematizing health care delivery. But concern should be expressed, I think, if the means of attaining that objective can be interpreted to include a change in the method of operaiton in which the planning agency is empowered to substitute legal sanction and statutory authority for the planning process involving all the parties at interest. The point is made cogently in a recent article by Dr. William J. Curran.[1]

The local planning agencies may become so involved in court-like decision-making in individual cases that the functions of overall planning will be compromised.

Gentlemen, I would like to interrupt the testimony for a moment,

[1] Curran, William J., "Health Planning Agencies: A Legal Crisis?" A.J.P.H. 60, 2: 359–360 (February), 1970.

because coming down on the plane this morning I was reviewing the text of an address delivered recently, an address entitled "Diagnosis and Treatment of Training," delivered by a friend in California. Let me read this paragraph, because I think it is pertinent.

Mr. Paley said—

> We must steer clear of casting planning as principally a regulatory mechanism. Planning and regulation are not the same. Their activities can and should be compatible, but probably not be vested in the same organization, because they are oriented to different ends. One establishes minima and assures conformance, and the second establishes goals and promotes and stimulates action.
>
> If we place our full emphasis in planning on regulation and control, I think we will achieve an irrevocable mediocrity, which will come back to haunt us in years ahead.

Few, if any, professional health planners would accept a definition of their major function as focusing on approval or disapproval of health projects. Such a definition carries too much inherent danger of smothering the agency's critical planning endeavors in mandatory public hearings, legal battles and debilitating interagency squabbling. It is my personal opinion that such approval responsibilities should rest with the existing regulatory and/or licensing bodies—most often at the State level—with the areawide health planning agency serving in an advisory, counseling role.

Finally, if the administration's proposals are taken at face value, it seems clear that concerns with the environment are to be demoted in favor of an almost exclusive attention to the personal care delivery system. The ecologic approach, which planners inferred from the earlier legislation and guidelines and which is implied in goal No. 4, will have to be abandoned—and the end result will be a more fragmented planning program than the emphasis on "system" would appear at first glance to promote. Unless the health care needs of man are seen in the perspectives derived from a knowledge and appreciation of the environment in which man lives, a necessary piece of the planning framework will be lost. Furthermore, the comprehensive health planning program requires in most instances a minimum of 50 percent matching funds derived from local sources. If the base of local funding is to be predicated on a broad enough foundation to avoid any possibility of undue influence on the planning program from one financing quarter, then the program itself should be encouraged to maintain the comprehensive scope envisioned in the original congressional intent. My own agency has already determined, through committee and board action, that environmental health planning must be a priority item in our regional program. Can you picture the reaction, after that soul-searching assessment and priority determination, when I go back to my board with the information that planning activities to improve our environment and its effect on the health of our citizens may still be permissible, but has been determined federally not to be a priority matter?

I should like to conclude these remarks on a more positive note. It is obvious that my reservations about the administration-sponsored bill more than counterbalance, in my mind, its advantages. This viewpoint is strengthened when one examines the alternatives—the proposals put forth by Congressman Rogers and his colleagues for extension and expansion of the existing legislation.

In the first place, Mr. Rogers' bill calls for certain changes which are designed to strengthen developing programs by promoting increased cooperation and coordination. The requirement for mutual representation from CHP and RMP on one another's advisory councils is a case in point. As the areawide health planning agencies move from their organizational phases to operational status and develop the competences that such growth implies, a review and comment function with respect to RMP projects and operations is no doubt justified, though one hopes that the two groups would have been working so closely and effectively together from the inception of the proposals that the review and comment activity would be largely pro forma in nature. The same comments apply to relationships between the areawide agencies and their responsibilities on the one hand, and the 314 (e) demonstration projects and their sponsors, on the other. Simple amendments I should think would make it possible to extend this review and comment function to other complementary programs, such as model cities, OEO, and capital financing for health and health-related facilities.

In the second place, again one might look to the possibility of concise amendments to incorporate some of the helpful provisions of the administration's proposals. For example, the concept of a National Advisory Council is not only sound, but indeed necessary to help bring a more integrated philosophy and policy to undergird the allocation of Federal resources. The function and composition of such a Council, however, deserve the most careful deliberation. Another illustration of a good element which can be incorporated is the administration's proposal for joint funding approval. Yet another provision of the administration proposal which deserves support is the effort to strengthen the States' vital statistics and information systems. Without adequate backup of valid and reliable data, planning will tend to founder in bewildering opinion and speculation. I suggest that Federal support of the burgeoning comprehensive health planning programs at both areawide and State levels will be enhanced if changes in the existing legislation are made within a framework of promoting a more rational health system (with effective and efficient delivery of both personal and environmental services) by means of a planning process which is oriented politically (in the generic sense of that word), and makes use of appropriate tradeoffs and accommodations.

When I see the administration stating in its briefing materials that "CHP has concentrated primarily on planning, rather than the development of health care systems," I am concerned that we may all accept this spurious dichotomy unthinkingly. Certainly we must all begin to approach the resolutions of many of our health problems from the vantage point of systems analysis. But just as surely, planning and an analytical method are not antithetical; sound planning will rely on systems analysis as one of its important tools to promote effective community action, without which planning would be useless.

One final comment. The proposals for extending present legislative authority for the comprehensive health planning program offer two other potential advantages over the administration bill. First, given the severe time constraints imposed by the expiration of current authority on June 30—a scant 4 weeks hence—it seems more likely that

action to extend can be achieved more readily than new legislation in time to prevent any destructive and unnecessary interruption in the programs involved. Second, the levels of Federal financial support recommended in H.R. 15895 come closer to reality in terms of national needs and demands to implement congressional intent than is true of current, inadequate appropriations or of the static amounts indicated in the administration's proposal.

To reiterate, I support legislative proposals, such as H.R. 15895, to extend authority for existing programs and enlarge appropriations to provide more realistic financial participation. At the same time, I suggest the advisability of adding to the proposals, via amendments, those features of the administration's bills—such a National Advisory Council, joint funding approval and strengthened State capability in data collection and analysis—which seem particularly meritorious and constructive.

I am grateful to you for the courtesy you have shown in permitting me to share these thoughts with you today. On behalf of the American Public Health Association I wish you success in your important deliberations, and I pledge you our continuing support in all reasonable efforts to make both comprehensive health planning and the regional medical programs viable partners in the unending search for ways to improve the health of our people and our country.

Thank you.

Mr. JARMAN. Thank you.

Mr. Rogers?

Mr. ROGERS. Mr. Schlesinger, I share the feeling you have expressed. It is not well to actually combine these programs too early and testimony has brought out, I think, that we have only 12 or 13 of the area-wide planning grants that are operational.

Mr. SCHLESINGER. Correct.

Mr. ROGERS. So we need to get this on the ground and I think your suggestion of incorporating some of the administration's proposals is a good idea. I am not sure about just the National Council, the one council; I think we still need to keep two councils.

Mr. SCHLESINGER. I agree. I think we need—well, obviously my preference would be for a National Advisory Council, which has a particular interest in comprehensive health planning since that is the program I am involved in and I am certain my colleagues in regional medical programs would prefer to have a council concerned with their activity.

Mr. ROGERS. I think this would be advisable.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Kyros?

Mr. KYROS. No questions.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. No questions. Thank you, Mr. Chairman.

Mr. JARMAN. Thank you very much.

Mr. SCHLESINGER. Thank you, sir.

Mr. JARMAN. Next is Dr. Letton, chairman, Medical and Scientific Committee, American Cancer Society.

STATEMENT OF DR. A. HAMBLIN LETTON, CHAIRMAN, MEDICAL AND SCIENTIFIC COMMITTEE, AMERICAN CANCER SOCIETY

Dr. LETTON. Mr. Chairman and gentlemen, I am pleased to appear in support of H.R. 14284 which was introduced by Mr. Staggers and the companion bill, H.R. 15135, of Mr. Cramer, which will amend and extend the current legislation for the regional medical programs and chronic disease control.

I am Dr. A. Hamblin Letton, and I serve as chairman of the Medical and Scientific Committee of the American Cancer Society and am acting as one of their representatives. My background includes my being the secretary-director of the Southeastern Surgical Congress, an organization of almost 2,500 of the leading surgeons of the southeastern United States; chief of staff of the Georgia Baptist Hospital in Atlanta; chairman of the cancer task force of the regional medical programs of Georgia; and president of the Atlanta Medical Center. I am a surgeon and my two younger partners and I have one of the larger private surgical practices in Atlanta. This background has afforded me a wide acquaintance with the functions of the regional program and the chronic disease control program, as well as of the comprehensive health planning program. It has given me an insight into attitudes and abilities of the physicians, the volunteer health agencies, and the public in this cooperative venture.

The American Cancer Society supports and encourages any program which demonstrates, or has promise of demonstrating effectiveness in the care of people with cancer—including diagnosis, treatment, rehabilitation and followup.

We believe that in their first 4 years of existence the regional medical programs have achieved their major objectives of shifting emphasis and accomplishment in health care planning and delivery to the local, practicing level; and that they have accomplished this through development of the "cooperative arrangements" as set forth in Public Law 89–239, and within existing patterns of medical care.

We fully support the concept of planning, programing and delivery of health care on a regional basis. Diseases, other afflictions and the capabilities to deal effectively with them know no political boundaries, nor can programs designed to meet the health care delivery of people be restricted to State or local boundaries. Most foci of health care delivery are medical schools, and the influence and service areas of these institutions transcend State and local boundaries. Therefore, the organization and funding of programs to accomplish the objectives of the RMP must be on a regional basis.

In analyzing the various bills which have been introduced, which bear on the continuation and future funding of the RMP and its areas of concern, H.R. 14284 most effectively meets what we believe are essential considerations.

However, it must be emphasized that we are testifying only as experts in the field of cancer—not on the drafting and formulation of legislation. This is solely the task of the Congress and the administration.

In addition, it should be understood that we can speak with authority only in regard to programs for cancer detection and control.

In our judgment, the RMP's have, in the relatively short period of less than 4 years, achieved amazing and gratifying results. There are now 55 programs—one in the early or planning stage; 54 of them are conducting operations programs—actually achieving the objectives of improving and increasing health care delivery. The credit for the inspired and innovative legislation which brought RMP into being belongs to the Congress. In its wisdom, it took the recommendations of the President's Commission on Hearth Disease, Cancer and Stroke, refined them to a workable, practical level considering all points of opposition and concern. As a result, this program has seen the required cooperative arrangements develop among physicians, technicians, hospitals, organizations, and go to work in the interest of the patient. This collective, cooperative approach has realized some very dramatic results in many regions.

Even within this short time, health care has improved significantly in many regions, and is programed for improvements in the others. We know you are familiar with many of these accomplishments from other witnesses you have or will hear from.

To arrive at this level of achievement has not been easy. Developing a working system of cooperation and mutually objective behavior among a wide variety of groups and individuals who had been working individually for so long—that it became tradition—took time. It is still taking time in some areas, but it is working.

There has been disappointment and some criticism of RMP's for not achieving the early expectations of success in some areas. One of the most persistent areas of disappointment has been the slowness with which RMP has moved in the major, and most problem-ridden urban areas. This has been emphasized by the speed and acceleration of success in other areas. Much of the difficulty here has been traced to the problem of getting RMP's organized in the big cities, such as Philadelphia, Chicago, New York where, among other problems, there are many health institutions, programs, activities, most of which are unrelated and uncoordinated. These failings are recognized and understood by RMP leadership, and stringent efforts are being made by them to resolve them, so the RMP's can be soon serving not just most, but all of the people of the United States.

Other areas of disappointment are usually not so well justified, not objective. It must be realized that to develop meaningful conclusive cooperative relationships takes time. It is a personal thing. It requires that old barriers, old boundaries, be torn down in a mutual, honorable, selfless effort. In many cases the varied, and sometimes contradictory elements of State, local, and county government protocol have had to be sidestepped, altered, or just ignored in order to achieve true "regional" character. This has been done.

I was just at the International Cancer Council in Texas and talking with Dr. Murray Copeland of the institute there, and he told me for the first time people in the Texas Medical Center are talking together, Baylor and the University of Texas are finally getting together and doing something through the regional medical plan.

The investment in development of regional approaches to better health care is now being realized through RMP. To dilute this pro-

gram, or blend it into other programs would seriously weaken it and perhaps mark the beginning of its demise. Maintenance of the cooperative arrangements called for and realized by RMP can only be accomplished through maintenance of the challenge, a most effective vehicle to meet this challenge. In this case, we are talking about the self-accelerating dynamism of approaching health care on the basis of the area within which people get their medical care, or the medical care "region."

That such regions exist, and conform to no prescribed boundaries or areas is dramatically evidenced in the way RMP regions have evolved. For example, some States, like New York, have a number of regions within the State (New York has five, with one overlapping a portion of Massachusetts; Ohio has four regions). The Intermountain Region encompasses all of Utah, and portions of Montana, Nevada, Wyoming, Idaho, and Colorado. California has accomplished RMP objectives by organizing itself into "areas" defined by the medical service areas of the State's eight medical schools. The Georgia Region in some locales extends beyond the State boundaries of the State of Georgia. For instance, in the Columbus area, the town of Phoenix City, Ala., which lies across the Chattahoochee River, is really a part of greater Columbus and it is included in the Georgia Region. The city of Aiken, S.C., is across the Savannah River from Augusta, and for years the medical practice of that area has been located in Augusta. The city of Aiken, S.C., therefore is in the Georgia Region. On the other hand, Rossville, Ga., which is over the mountains of Chattanooga, Tenn., is in the Tennessee region. Regions vary in size geographically from the several county northeast Ohio region to the four-State Mountain States region.

The number of people served by regions varies also, reflecting the best considered judgment of medical and community leaders within an area as to just what the most realistic medical service area is. The northern New England region, for example, has only 425,000 persons, while California's program serves more than 20 million people.

Regional emphasis on organizing for delivery of health care—for getting the latest medical facilities and capabilities to the most people—works. It has shown in a few years that it is the answer to our inability in the past to meet these important needs through traditional organization, and traditional geographical, and medical service area concepts.

THE IMPORTANCE OF THE CATEGORICAL EMPHASIS

The American Cancer Society is a categorically oriented organization. Therefore, we strongly endorse the categorical approach to health care. This does not, thereby, imply opposition to the comprehensive care concept. We believe that there are urgent needs for both approaches. We also believe that there should be, as the Congress has in its wisdom provided, separate legislation to provide for and fund both approaches.

Cancer is the second largest killer of Americans. It is a ruthless unforgiving enemy. Concentrated, imaginative efforts are required to conquer it. Roughly 30 percent of patients with cancer are now being cured while 50 percent could be cured by the use of the proper

treatment at the proper time. A recent report showed there is an average delay of 3.2 months on the part of the patient between the onset of symptoms and his visit to the physician. The same report states there is an average delay of the beginning of proper treatment of 2.8 months after a physician first sees the patient. This shows the desperate need of education of the patient and on the part of the physician, and here we would be able to cure 20 percent more of the people only by or through education of both physician and the layman. This is the aim of the regional medical program.

The broader aspects of health, such as problems of infectious diseases, environmental health problems, health education—problems that require monitoring, that have been with us forever, and which will require constant community and agency attention for many years to come in the interests of general health—need separate, but coordinated consideration, legislation and funding.

We believe it would be mutually defeating to remove, through formal amalgamation of the two efforts, the separate but essential initiatives of RMP and comprehensive health care programs. We do believe, however, that coordination is essential, and that this can be assured through existing provisions of both activities that they establish and maintain "cooperative arrangements."

Heart disease, cancer, and stroke are the active killers. Congress recognizes the need for a long-range, concentrated effort against them in the original legislation (Public Law 89–239). A very well-devised plan of attack on these major killers is contained in this law, and the good judgment of Congress is taking the categorical approach in the attack on them has been demonstrated many times since. In fact, Congress has expanded the categorical emphasis somewhat through greater attention to kidney disease, respiratory disease, diabetes and other diseases that fall under the "related diseases" portion of Public Law 90–574.

Again, with imagination and foresight, the Congress has made the RMP a living program in the sense that it is changing and growing as conditions change and new health priorities emerge—such as in poverty programs, renewal, et cetera.

The next logical step is to further strengthen the RMP and reemphasize, through carefully considered legislation, the position taken so wisely by the 89th and 90th Congresses.

The categorical approach caught the imagination and enthusiasm of all involved in developing new health care delivery programs. One of the principal reasons for this enthusiasm has been the ability to rally the forces of influence and capability—physicians, medical societies and organizations, hospitals, community leaders—around a focus, or a specific objective such as cancer or heart disease. We question whether it would be possible to gain the same kind or volunteered interest and participation if the rallying focus was "disease." Cardiologists are not particularly interested in virus pneumonia, or microbiology, et cetera. And this is true of others, not just the health care provided. The layman, the professional—no matter who it is—normally thinks in terms of category, when thinking about disease.

I think it was mentioned earlier today that they had not seen many people die of comprehensive disease and when we think of someone's

illness, we want to know what is wrong with him, what is his categorical status.

The regional medical program has progressed due to the fact that people can and do relate to specific categorical interests. This phenomenon has been used to build an overall improvement in the organization and the delivery of health care. To change the categorical approach, we fear, would be to destroy the very foundation of the whole program; therefore, we are convinced that the categorical approach should be preserved.

The categorical character of the RMP's has provided a focus of common interest between many of the RMP's and local divisions and other units of the American Cancer Society. ACS representatives are included on the regional advisory groups of many RMP's. Joint programs and programs developed out of close working relationships—the "cooperative relationships," if you will—have come into being primarily because of the mutual categorical interests. These interests are much more than simply matters of common interest. Many regions have been funded for specific programs in cancer detection, tumor registry development, cancer nurse, and other training programs—all on the basis of the authorization for categorical emphasis.

A few years ago, the Georgia Cancer Registry results showed that a certain cancer facility in our State had an increase in the death rate of cancer of the cervix, which is the mouth of the womb. This is an indication of the cooperative action of a categorically oriented registry with other agencies, which in all probability, could not be accomplished at this stage of sophistication by a comprehensive concept. We do not believe that the essence and true flavor of a concentrated categorical approach could develop under a general, comprehensive concept.

I might add, actually at that time the vast majority of these cervix cases were stage 3 type of cancers, quite advanced and at the present time 81 percent of them from this area are situs carcinoma, which can be easily cured.

H.R. 14284 provides the means of strengthening and enriching the RMP concept, and the most effective and productive approach—the categorical approach—the delivery of effective medical care.

CHRONIC DISEASE PROGRAMS

The American Cancer Society strongly supports the provision in H.R. 14284 that the chronic disease programs be continued, and funded as a division of the regional medical program. The cancer control program serves a critical need in the control of this disease throughout the United States. As a categorical program it blends meaningfully with the purposes and objectives of the RMP.

The American Cancer Society strongly endorses H.R. 14284 as the most effective bill concerned with regional medical programs, and urges the Subcommittee on Health to approve it and move it forward in the legislative process.

I heard criticism in the past from others that say the administration has more or less decimated the chronic disease program. I happened to talk to one of the division doctors a week ago today and he told me he knows where these people are and can get them back at

once if you make it possible for us to have this chronic disease program again.

Although not qualified to draft legislation, but only to comment authoritatively on the nature of legislation that bears on cancer and efforts to understand and combat this disease, we would suggest that the effect of H.R. 14284 would be enhanced by the addition of a provision authorizing construction—with appropriate review and approvals, of course—and providing a specific fund authorization for construction. RMP needs to be able to fund construction needs completely rather than on a matching basis. We suggest that a figure of approximately $50 million per year be authorized in the bill.

To provide money for the poor or the elderly people to buy medical services, where there are no facilities in which to receive this service, is a fallacy. Many communities desperately need help. Many patients cannot get good therapy. The proper facilities are just not available. In Atlanta, the regional medical program has a committee working on the regional radiation treatment center rather than having small and at times inadequate facilities. One of the major difficulties at this stage is the lack of construction money. Philanthropists are interested in certain institutions for personal reasons, but they are not easily interested in areawide facilities. Education of professionals and laymen alone cannot accomplish the task. Facilities in which to save lives are also needed in many locations.

Also, we believe that the effectiveness of having the chronic disease programs in the RMP legislation would be enhanced by providing for the conduct of cooperative clinical field trials within these programs. Through such trials, or demonstrations, new concepts in diagnosis and prevention of chronic diseases could be carried out, tried and evaluated, quickly and by those best equipped to do this. The result would complement the RMP concept of getting the newest medical capabilities into medical practice in the best and most rapid manner.

With the chronic disease programs as a major element of the RMP legislation, we suggest that a special funding program for them be amended to H.R. 14284. This would be most effective as graduated sum, authorized for the chronic disease division starting with $50 million in fiscal year 1971, $75 million in fiscal year 1972, and $100 in fiscal year 1973. As this legislation must go through the entire legislative process, i.e., through the Senate, to presidential approval, we believe that it is most important that all succeeding groups studying the legislation know the range of funding being considered as essential by the originating House and committee.

One more word on emphasizing the need to maintain a categorical approach toward the all-out attack on the three major killers: There is no question that the other major diseases can be brought into the RMP structure. However, it is useless to add kidney disease, arthritis and other major problems without providing sufficient funds over and above those approved for heart disease, cancer and stroke to support them. The funds appropriated for the RMP as it now stands are not going to be sufficient to carry out all of the programs which are badly needed now. However, we believe that if RMP is provided with the financial resources to do the job, it will do it to the great benefit of the American people.

Regional medical programs have done a great job in a short period of time. The success achieved thus far more than justifies the con-

fidence and support Congress has given this program. To underfund it at this time, just when the "break-in" period is concluding, would be a travesty and a waste. For the last 4 years the regional medical program has attempted to get the cooperation of professionals and laymen. This volunteer cooperation is the major means of gaining improvement. The curtailment in the budget, at the present time, has shown us that these cooperative aims are perishable if they are held in abeyance for too long a period of time awaiting funding.

These projects are agreements between people and facilities, local government, and others to perform in a given way. But where these agreements are slow to materialize, the people either move on to other concerns or they forget about them, and the planning must commence anew. Thus, planning dollars are being wasted unless action follows planning very closely. At the present time we have 10 approved projects in the Georgia regional medical program in the amount of $890,000, which have been held in abeyance now for over a year, but cannot be funded, and the chances are they will not be funded unless there is a change in the fiscal policies. We are having great difficulty in keeping the enthusiasm at a high level when the participants cannot move ahead. Adequately supported, RMP and its Chronic Disease Division will move forward in a synergistic manner.

Recently, Dr. James Grace of the Roswell Park Memorial Institute has recalled that our Nation made as its goal of the sixties, "placing a man on the moon." He suggested that our Nation should declare that our goal for the seventies be "the control of cancer." We could do it with the same amount of money and effort that we used to achieve our goal of the sixties.

Mr. Chairman, this would be a tremendous gift that the United States could make to the world. A gift with more far-reaching benefits to all the nations, to all mankind than the moon walk can ever hope to attain. I would ask you and your colleagues to seriously consider this challenge.

In the meanwhile, Mr. Chairman, the American Cancer Society urges the passage of H.R. 14284, with consideration given to the aforementioned recommendations.

Thank you for your patience.

Mr. JARMAN. Doctor, that is a strong endorsement of the regional medical program and the committee appreciates your specific and concrete recommendations as to bills before us.

Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman. I share the feeling of the chairman and we are grateful for your being here and letting us have this information. Thank you.

Dr. LETTON. Thank you.

Mr. JARMAN. Mr. Kyros?

Mr. KYROS. No questions.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. No questions.

Mr. JARMAN. Thank you, Doctor.

Dr. LETTON. Thank you so much.

Mr. JARMAN. Our next witness is Dr. Mack I. Shanholtz, State health commissioner, Virginia State Department of Health, appearing in behalf of the Association of State and Territorial Health Officers.

STATEMENT OF DR. MACK I. SHANHOLTZ, PAST PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Dr. SHANHOLTZ, Mr. Chairman, I am Mack I. Shanholtz, M.D., State health commissioner of the Virginia Department of Health. I am a past president of the Association of State and Territorial Health Officers (ASTHO) and it is on behalf of ASTHO that I am presenting testimony today.

Incidentally, you might be interested to know that I am presently a member of the National Advisory Council to the regional medical programs and also involved and active in both comprehensive planning programs and regional medical programs on the State level.

I think you will also be interested in knowing my presentation is quite brief.

First of all, I want to express the appreciation of ASTHO for the accomplishments and interest of this subcommittee in legislation to improve the health of our Nation. The most recent example of your constructive efforts is the extension of the Hill-Burton program for the construction and modernization of hospitals and other health care facilities. We are very pleased that the Congress did not agree with the recommendation of the Department of Health, Education, and Welfare to abandon the concept of grants-in-aid for the construction and modernization of public and other nonprofit hospitals, nursing homes, and extended care facilities.

The legislation before the subcommittee this morning deals primarily with the extension of the authorities for the comprehensive health planning and health services program and the regional medical program. Both of these programs have contributed in a positive way to improving the health of our Nation. We recognize the progress that has been made, but we also recognize that serious deficiencies continue to prevail in our health care system. They are reflected in soaring medical care costs, inequities in the delivery of health services, and relatively high mortality rates for infants, mothers, and the general population in comparison with other major countries.

To help combat these deficiencies, the Department of Health, Education, and Welfare has proposed a consolidation of the provisions of the Public Health Service Act in the case of the authorities for comprehensive health planning and services, regional medical programs, and health services and facilities research and development. This consolidation is provided for in H.R. 14960, the proposed Health Services Improvement Act of 1970.

Although it is difficult to disagree with the objectives of H.R. 15960 as set forth in the proposed section 900 of the PHS Act, ASTHO has serious reservations as to the potential that is promised and the performance that would be realized under the legislation.

The concept of preventive medicine, for example, figures prominently in H.R. 15960. This is the promise, but here are the facts:

1. H.R. 15960 states that it has as a purpose to "encourage and assist in the establishment and support of comprehensive health planning agencies at the State and areawide levels * * *." But the authorization for comprehensive health planning at the State level is $15 million for 1970. Only $10.371 million is available for that year and the budget request would reduce the amount to only $7.675 million for 1971.

2. H.R. 15960 states that it has as a purpose "* * * to assist in the support of State programs of public health services * * *." But the authorization for formula grants under section 314(d) of the PHS Act of 1970 is $100 million. Only $90 million is available for 1970 and the budget requests no increase for this program for 1971.

3. H.R. 15960 states that it has as a purpose "* * * to assist in the training of health planners * * *." But the authorization for section 314(c) of the PHS Act for 1970 is $7.5 million. Only $4.125 million is available and the budget request provides for no increase in 1971.

4. The legislation introduces the concept of preventive health services in the authorization for the regional medical program. But at the same time the Department has dismantled the chronic disease control program of the Public Health Service.

A consolidation of statutory authorities coupled with a reduction in Federal support for public health programs is not the answer to the prevention of disease and disability in this country. When the comprehensive health planning and public health services legislation was originally proposed in 1966, a total of $292.6 million for formula grants was proposed by the Department of Health, Education, and Welfare for section 314(d) of the PHS Act for 1970. As mentioned before, only $100 million was appropriated for 1970 and the Department plans to spend only $90 million.

Adequate funding for public health programs must be available if we are to reduce the toll of diseases that can be prevented and lower health care costs. Mere rhetoric is not enough. But I also want to assure you that ASTHO does not maintain that additional funding with no change in the status quo is the answer to our problems. Consequently, I would like to briefly mention the aspects of H.R. 15960, H.R. 14284, H.R. 15895, H.R. 14486, and H.R. 17570 that we endorse and strongly support.

ASTHO believes there should be closer cooperation and coordination between regional medical programs and State and local health planning agencies. We support the appointment of State and local health and health planning officials on advisory committees or regional medical programs as provided for by H.R. 14486, H.R. 17570, and H.R. 15960. We also support all three bills with respect to the requirement that proposals under the regional medical programs must be submitted for consideration to appropriate State and local comprehensive health planning groups.

By the same token, we agree that there should also be representation of regional medical programs on State comprehensive health planning advisory committees. This is provided for in H.R. 15895 and H.R. 15960.

H.R. 14284 provides authority for training and clinical demonstration programs in the diagnosis, treatment, and prevention of chronic diseases. This proposed authority is most important. ASTHO urgently recommends that it be adopted in the legislation that is approved for the continuation of the regional medical programs.

ASTHO also supports the provision of H.R. 15960 in its proposed section 922(a)(2) of the Public Health Service Act that would make grants for areawide health planning to State health departments in the case of areas not covered by areawide health planning agencies. It is not

feasible to duplicate areawide health planning activities in some of the smaller counties and communities of States.

We support section 3 of H.R. 15960 that provides for a cooperative system of health information and statistics in order to produce comparable and uniform data at the Federal, State, and local levels.

In concluding, I want to express again the appreciation of our association for the leadership in health legislation that has been demonstrated so many times by this distinguished subcommittee.

Thank you.

Mr. ROGERS (presiding). Thank you very much, Doctor. Your testimony will be valuable to the committee because this committee, as you know, has always depended greatly upon advice and testimony of our State health officers. We feel they are people in the field that know what is going on and we are very grateful to you for your testimony.

Dr. SHANHOLTZ. We certainly appreciate that recognition, sir.

Mr. ROGERS. Thank you very much.

Mr. Kyros, any questions?

Mr. KYROS. No, I just appreciate the testimony of Dr. Shanholtz, because I think he very specifically and succinctly indicates here the areas where we will have problems in putting together the best possible legislation before the committee.

Mr. ROGERS. The next witness is Dr. Eugene Guthrie, Chairman of the Board of American Academy of Comprehensive Health Planning, and he could not be here so his statement is being given to us by Edward Van Ness, executive director of the New York State Health Planning commission.

Mr. Van Ness, the committee welcomes you and will be pleased to receive your statement.

STATEMENT OF EDWARD H. VAN NESS, VICE CHAIRMAN, BOARD OF DIRECTORS, AMERICAN ACADEMY OF COMPREHENSIVE HEALTH PLANNING

Mr. VAN NESS. Thank you, Mr. Chairman and members of the committee.

I appear before you today as vice chairman of the board of directors of the American Academy of Comprehensive Health Planning to present the academy's views on the bills to extend the authority of Public Law 89–749 and 89–239. The burden of my brief statement deals with the bills affecting comprehensive health planning.

We welcome this opportunity to appear before this committee since the academy represents the State agencies responsible for comprehensive statewide health planning. The academy was established in March of 1969 in response to the needs of many official State agencies for an effective forum to focus on the concerns of statewide comprehensive health planning.

The members of the academy are convinced that the need for comprehensive health planning is just as acute and important as it was when the Partnership for Health Act was passed in 1966 and funded the following year. During this brief period of time significant steps have been taken to forge viable planning agencies and processes at State and areawide levels. We must continue in the development of

this program to serve the highly important purposes for which Congress enacted the law. Any digression from this major thrust at this time would, we believe, jeopardize the great potential that this program offers.

Our academy believes that the most prudent course of action at this time would be to simply extend the current legislation, which, in our opinion, is adequate to continue the development of the program. Such further needs as do exist can be adequately met by appropriate administrative measures.

One very serious handicap to the successful implementation of this program has been the inadequate funding of various sections of Public Law 89–749, particularly section 314(b) for the support of area-wide comprehensive health planning and sections 314(d) and (e) providing funds for public health services and health services development.

It is the hope of the academy that this committee will recommend the extension of legislation authorized under Public Law 89–749 and increase the authorizations for appropriations.

Thank you, Mr. Chairman, for your attention and the opportunity to present this statement.

Mr. ROGERS. Thank you, Mr. Van Ness, and we appreciate the thinking of the American Academy of Comprehensive Health Planning, and we do share the view that these are our needs to expand since we are trying to build a base to upgrade from and I hope the committee can do this.

Mr. Kyros?

Mr. KYROS. No questions.

Mr. ROGERS. Thank you so much.

The committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12:35 p.m. the subcommittee adjourned, to reconvene at 10 a.m., Wednesday, June 3, 1970.)

COMPREHENSIVE HEALTH PLANNING AND REGIONAL MEDICAL PROGRAMS

WEDNESDAY, JUNE 3, 1970

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. John Jarman (chairman) presiding.

Mr. JARMAN. The subcommittee will please be in order.

We continue our hearings today on bills relating to the heart, cancer, and stroke programs and also relating to the comprehensive health program.

Our first witness this morning is Dr. Sidney Farber, past president, the American Cancer Society.

Dr. Farber has been before this committee before and has helped us a great deal in past legislation and it is a pleasure to welcome you before the committee, sir.

STATEMENT OF DR. SIDNEY FARBER, IMMEDIATE PAST PRESIDENT, THE AMERICAN CANCER SOCIETY

Dr. FARBER. Thank you, Mr. Chairman, and members of the committee. It is a privilege to appear before this committee once more to speak in strong support of the House bill 14284 introduced by Mr. Staggers and Mr. Cramer which contains most of the features which the American Cancer Society as such and which our citizens and myself, as a citizen witness, would like to support fully.

I am Dr. Sidney Farber, immediate past president of the American Cancer Society and am here today as one of the representatives of the American Cancer Society. I am Wolbach professor of pathology, Harvard Medical School, chairman of the staff of the Children's Hospital Medical Center, and scientific director of the Children's Cancer Research Foundation in Boston. As a member of the panel on cancer of the President's Commission on Heart Disease, Cancer and Stroke, I had the opportunity to study the problems and try to find solutions with other members of the Commission which culminated in formation of the regional medical centers. I am at present chairman of the advisory committee on cancer to the tristate area of Rhode Island, New Hampshire, and Massachusetts of the regional medical programs.

The American Cancer Society gives full support to the goals of the regional medical programs and although we are speaking today in ref-

erence to cancer activities which are included in this program we would like to make quite clear that we support all of the aims of the regional medical programs as a whole.

We have defined them as the application and utilization of the knowledge and expertise available anywhere in the treatment of every patient in the country. The original recommendation of the President's Commission singled out heart disease, cancer, and stroke, because those words or terms were associated with over 70 percent of the deaths in the country. Inclusion of kidney disease, and a few other important causes of death such as cystic fibrosis and diabetes has been recommended, or has taken place. The eventual expansion of these programs to include all disease should occur after the administrative techniques have been perfected, and when resources sufficient for the task are at hand.

The regional medical programs were designed to develop and on a regional basis, connecting links between centers of expertise in university medical centers, teaching hospitals and research institutions with the extremely important community hospitals for the application of the results of research to the patient as quickly as possible, for the demonstration of new methods of treatment, for the continuing education of doctors in the community hospitals, and for the generation of new knowledge of importance to the patient.

These are extremely important goals. Correctly applied and adequately supported they will mark for the first time the availability of the highest degree of excellence in the care of all of our people. They constitute a device which permits the Federal Government to work with the private sector in a manner never previously possible for the improvement of the quality of health care.

With your permission I would like to speak specifically on a few points raised by this bill and by other bills which have been placed before you. Much has been said about extension of the goals. As a doctor and as a citizen I am of course deeply concerned with improving the lot of all patients, suffering from any disease, and much of my professional life has been devoted to planning in fields other than cancer. If there are sufficient funds added to the appropriation, I would be very much in favor of expanding the work on kidney disease, pulmonary disease, cystic fibrosis, and diabetes, all of which have been mentioned and are included in the present programs.

The only reasons for restricting this program to heart disease, cancer and stroke, and related disorders, would be the inadequacy of funds and the need for experience in the development of cooperation of many different agencies in a given region to achieve these goals. As soon as sufficient experience is attained with these programs it is my earnest hope that all diseases will be contained in the regional medical programs on the same basis, with financial support of sufficient magnitude.

Then cooperation between comprehensive medical planning with regional medical programs should be very close indeed.

Progress for the last 4 years may be described in ecstatic terms of achievement of regional programs in some parts of the country where nothing of this kind ever existed before, or we may lament the fact that there has not been far greater progress. Two reasons for failure of greater progress stand out. The first has to do with the introduc-

tion of a new method of planning and working together in a given region which transcends political lines and brings together the centers of expertise, in research and clinical achievement with the invaluable community hospitals which after all care for most of the patients in the country. There had to be constructed an effective administrative umbrella to cover representation from the public, the medical profession and universities and hospitals. There have been impressive achievements in many parts of the country, but not in all, but it now appears that solution of administrative problems is well within our grasp everywhere. This marks a great achievement in the history of medicine in this country.

The second reason for failure to make greater progress has to do with the amount of financial support. Far greater amounts of money are needed than have been available. As of February 1, 1970 more than $26 million in approved grants in regional medical programs of all kinds could not be paid because of lack of money. Four years ago it was the expectancy of a number of experts concerned with the regional medical programs and the original heart disease, cancer, and stroke commission that by 1970 requests in the regional medical programs would be worthy of approval would be at the $500 million level.

We are behind our schedule.

CONSTRUCTION AND REMODELING

I would like to urge the inclusion of funds for the construction of research facilities in the field of cancer and the other fields with which you are concerned in this bill. These funds would be in addition to those which are recommended already for grants and contracts. The studies of the President's Committees of the National Cancer Institute and the American Cancer Society have called for the recommendation of construction funds to expand present cancer centers, and to erect new ones in at least 20 locations in the country where there are important centers of population. Such construction should be additive where there are important centers of population and they should be additive to the facilities now available so that we will make use of those facilities which are already there.

Such construction support has been recommended by the American Cancer Society Citizens' Committee in speaking to the appropriation of funds for the National Cancer Institute programs for the past 5 years but unfortunately no money has been made available. The Hill-Burton-Harris construction funds have made a remarkable impact upon the country in providing funds for hospital beds, but there are no funds large enough in that program to meet the needs for construction in regional medical programs, too. Until such centers are built throughout the country the full force of the regional medical programs will not be brought to the good of the community hospitals and through them to all patients with cancer, to speak specifically to the problem of cancer and not to the exclusion of any of the other major disorders.

I should like to urge too the provision of funds for the construction of educational and ambulatory facilities as well as other clinical facilities needed for the regional medical programs in the community hospitals. The community hospitals cannot provide for themselves the

specialized clinical facilities needed to carry out the most expert forms of cancer treatment to the patient in their responsibility, nor can they provide for the continuing education of the doctors in these community hospitals if they're to use to the full this new relationship with cancer centers made possible by the extension and expansion of the regional medical programs under your bill.

Again I have mentioned cancer, but it is equally important for heart disease, stroke, kidney and other major disorders, which we have mentioned as they come along or as they are included in these programs when more money is available.

COMPREHENSIVE HEALTH PLANNING

May I say a final word about comprehensive health planning? The administration proposal that the regional medical program should be merged with comprehensive medical health planning is something which the American Cancer Society does not support, and I would like to speak against such a merger. The comprehensive health planning is a program of tremendous importance to the health of our people and must be supported in its own right. To oversimplify, there are several great programs, all of top priority. The first concerns the support of the research programs of the National Institutes of Health and the National Science Foundation. These have to do with discovery, with the generation of new knowledge of both basic and clinical importance. Without adequate support of research the problems of disease affecting our people will not be solved and terrific cost of medical care can only increase. The second concerns the regional medical programs which has as their goal the rapid application of the results of research. These are concerned with the saving of life, with the reduction of terrific tolls of these dread diseases, and with the provision of the finest care for all patients. The comprehensive health planning has to do with the delivery of medical services with great emphasis on primary care for patients suffering from many disorders including the vast number of illnesses which do not kill immediately but which interfere with normal, happy, gainful existence.

It is the stand of the American Cancer Society, and one that I heartily support, that merging of the regional medical programs with the comprehensive health planning can only result in dilution of the regional medical program's potential and submerge its aims with loss of its great potential. All three great programs should work closely with one another. Merging them can result only in far more loss than any possible gain.

With your permission I should like to add a final word concerning the support of the Chronic Disease Division which is included in the regional medical programs. Separate appropriations should be made for the cancer control program. As far as I know it is not provided for in any of the appropriations before the Congress. These have been and are today very valuable programs not only in cancer but in the chronic diseases as a whole, and we would like to speak strongly in behalf of the provision of adequate support.

Thank you very much, Mr. Chairman.

Mr. JARMAN. Thank you, Dr. Farber, I was particularly interested in your including in your statement the position of the American

Cancer Society on the proposed merger of the regional medical programs with the comprehensive health planning. You made it very definite in your statement.

Mr. Rogers, any questions?

Mr. ROGERS. Thank you, Mr. Chairman.

Dr. Farber, it is good to see you back again before the committee.

Dr. FARBER. I am happy to see you, Mr. Rogers.

Mr. ROGERS. We remember well your helpful guidance to this committee when the heart, cancer, and stroke program was initiated here. Of course, we value highly your opinions. I, too, am impressed with the fact you feel we should not have a merger. I share that feeling. I think it is much too early and, as you say, Ithink the comprehensive health planning, which was to originate from local area planning and come up, is what the communities need, going contrary to the philosophy of the regional medical program, which is to come from the research at the top and go down and filter down and out rapidly.

Dr. FARBER. I agree with you.

Mr. ROGERS. So then it does not make sense to combine them. I think the philosophy is almost opposite of what we are trying to get done.

Now I notice your statement about maybe not expanding at this time because of funds, other than heart, cancer, and stroke and the allied diseases, but we have been very much concerned about the kidney disease, and the testimony we had yesterday was very impressive and estimates show that there are 20,000 to 25,000 people whose lives can be saved, and, now, think of that, if we will allocate $15 million for a kidney program.

Now, it is my own feeling we ought to be getting on with this job. They currently feel they are saving about 20,000, but they could save an additional 20,000 to 25,000 lives if we included kidney disease and give them $15 million with 1 year's time to crank in the training of people. Don't you think that would be a wise expenditure for us to make?

Dr. FARBER. I agree completely with you, Mr. Rogers. I am heartily in favor and I would like to see the $15 million added to the authorization for the regional medical programs.

Mr. ROGERS. That is what I certainly shall support, an additional $15 million for this program. I think you have made a good point on construction of educational-ambulatory facilities as well as other clinical facilities.

Now we have just agreed in the Hill-Burton bill to allow funds to go, or additional funds to go to hospitals where there is an educational factor involved, in teaching, as well as to stress ambulatory facilities and I hope that this will help meet the need that you are talking about.

I believe it will. I think maybe the committee is somewhat still concerned about getting into the construction program of clinical research at this time. But we certainly understand your reasoning.

Now one thing that is concerning me very much and I would like your comment, and I notice you mention it somewhat on page 3, in talking about the programs, this first has to do with introduction of a new method of planning and working together in a different region

which transcends political lines and brings together the centers of expertise in research and clinical achievement with the invaluable community hospital which cares for most of the patients of this country.

I am very much concerned that we are seeing a pattern built for the first time since I have been in the Congress, seeing a political clearance injected into the health community, particularly in the Institutes of National Health.

Have you seen any of this yourself or have you heard of it?

Dr. FARBER. This is very much in discussion today and rumors are numerous. I am very happy to hear your point of view on this.

I thoroughly agree with your philosophy.

Mr. ROGERS. We have just understood that Dr. Yolles has resigned, head of the National Institute of Mental Health, and Dr. English, who has been an outstanding scientist and administrator. Dr. Egeberg, in his testimony here yesterday, said it was true in his own office, he is appointing only those of one political party.

He says they need to educate those in that party more. But I am not sure that this should be the basis for selecting those who will manage the health programs of the Government.

I regret this. I think it is unfortunate that politicians should be instructed and injected. I can understand the top appointees where the Secretary would want that. I have no objection to that. I think any administration would.

But when you begin going down into what should be career employees and injecting politics, I think it is a tragedy for medicine and health of the American people to put it on that basis.

Dr. FARBER. I am very happy to hear your views, Mr. Rogers. We have had a great tradition built up in the National Institutes of Health and National Science Foundation, the two programs of which I am most familar with. We have brought the finest minds as consultants on the Council and on the study sections and we have attracted and recruited the finest men for the Government as public servants.

We have been very proud of this tradition and I think the scientific community and the medical community would join with you in the hope that these traditions can be maintained and that only excellence in science and medicine and general concern for the welfare of the country be the criteria which will be used in selection of the men working directly for the Government or as consultants.

Mr. ROGERS. Thank you, Dr. Farber, I share your opinion 100 percent.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. I have no questions, Mr. Chairman. I do want to thank you, Dr. Farber, for a very clear and interesting bit of testimony.

Dr. FARBER. Thank you, Mr. Preyer.

Mr. JARMAN. We appreciate your being with us, Dr. Farber.

Dr. FARBER. Thank you very much, Mr. Chairman.

Mr. JARMAN. Our next witness is Dr. John Herndon, vice president for medical affairs, the National Cystic Fibrosis Research Foundation, New York.

STATEMENT OF DR. JOHN F. HERNDON, VICE PRESIDENT FOR MEDICAL AFFAIRS, NATIONAL CYSTIC FIBROSIS RESEARCH FOUNDATION

Dr. HERNDON. Thank you, Mr. Chairman.

Mr. Chairman and distinguished members of the committee, I want to thank you for this opportunity to appear before you on behalf of H.R. 14284.

With your permission, Mr. Chairman, and those of your associates on the committee, I should like to submit my entire statement for the record and to move the hearing along faster, I will provide what I think are the key parts of my presentation.

Mr. JARMAN. We will be glad to receive your statement in full and hear your comments.

Dr. HERNDON. Thank you.

The National Cystic Fibrosis Research Foundation endorses H.R. 14284, the bill to extend the regional programs for heart, cancer, stroke and related diseases for an additional 3 years.

We also believe that the modifications in H.R. 14284 significantly enhance the value of these programs. We especially commend the amendment of section 5, paragraph 11(c), which assures the applicant group seeking a regional medical program a fair decision by providing a mechanism of appeal to the council of the RMP.

As medical administrator for the NCFRF I have seen numerous instances in which new programs have encountered opposition from unsympathetic local advisory groups.

In many cases considerable time, effort, and scientific medical talent, aided by more than competent outside advisers, went into preparation of the regional medical applications which then received a negative response at the local level.

Inquiry into such actions revealed that often the local group did not constitute what could be termed a true peer group.

Indeed, authorities in all the medical disciplines or in the public health problems under consideration are not to be found in every community. Therefore, local advisory bodies may not always be qualified to judge the merit of appropriateness of a regional medical program application.

Medical political considerations are a fact of life. Individuals who have served a particular geographical area over the years tend to believe they have a better understanding of current needs in that area than anyone else.

They may not be correct, but they may have control of the situation. The April 10 issue of Science, looks into the trend toward decentralization being fostered in the Department of Health, Education, and Welfare by the present administration.

Weighing the pros and cons of this policy, which would transfer more authority to local groups, the writer observes * * * "Given his expanded powers, a politically motivated regional director might conceivably turn his region into a patronage fiefdom."

I would say that even where patronage is not involved, the local or regional group may be weighted with persons who believe that local problems are best served by reliance upon existing, long standing facilities, programs and standards.

New ideas or approaches—whether in pediatrics or preventive medicine, may receive less than due consideration.

Our Foundation has had knowledge of specific programs in connection with children's lung diseases where there was little or almost no local interest or understanding, and needed improvement could not be affected.

It is not my intention to pass judgment or apportion blame, but I feel I should back up my general observation by citing specific instances. In Albany, N.Y. for example an application for a regional medical program in pediatric pulmonary diseases was blocked by men whose orientation was to internal medicine.

There was an honest difference of opinion here based on a lack of insight into the need for a special pediatric program of this sort. Recently the local review body has indicated a change of heart and asked that the application be resubmitted.

Now, a couple of years have passed. As one of the internists remarked:

> We did not understand the importance of this sort of thing. Now that I have seen then what goes on in cystic Fibrosis Centers, I realize that these pediatricians deal with a greater variety of lung conditions than the physician in adult pulmonary disease.

In Durham, N.C., doctors associated with the Cystic Fibrosis Center at Duke University Medical School submitted an application for a regional medical program.

After some time, getting no reply, they investigated and finally learned that the application had been mislaid.

Now I have personal knowledge in working with the preparation of that, a lot of people's time and effort went into the application that was "mislaid."

Another example: four medical institutions in the Los Angeles area joined forces and submitted an application for a carefully considered cooperative program. This program would have shared facilities. And talk about the type of cooperation between facilities that you mention and intended in the first place and it was well enough regarded by the Medical Scientific Council of our Cystic Fibrosis Foundation for us to commit funds of our own to the project to help it along.

The local review committee, for reasons unclear to us, rejected it. Now it appears that if the individual hospitals decide to apply again for funding, they will do so separately.

If only from the standpoint of efficiency and economy this diffuse effort is clearly less desirable than obtaining support in a single package.

A first and then a second application were submitted to Minneapolis for an RMP in pediatric pulmonary diseases. The rejections seem to have been based on the local committee's assumption that these diseases too do not fall within the purview of the act pertaining to heart, cancer, and stroke.

I think they were willing to admit where it is related to introduction of heart disease it was reliable.

The fact is of course that the provision for related diseases is designed to include those in the pediatric pulmonary category. Again the soundness of the proposed program, according to expert judgment

is attested by our own foundation's investment of approximately $40,000 each year in the work being done in Minneapolis.

Gentlemen, it is a fundamental tenet of democracy that citizens are entitled to a hearing and in the event of an adverse decision to an appeal.

At the very least those whose applications are rejected should be able to clarify the question of whether such a rejection upholds or runs counter to the intent of Congress.

In creating the regional medical program services on a 3 year trial basis, Congress acted wisely. Thanks to this trial period, we have had an opportunity to detect a flaw in the system.

And I want to say, gentlemen, I regard this as a program that has a great deal of strength. I don't mean to emphasize the weakness. I think your purpose today is to continue to make this a stronger program and this is what I would like to address myself to.

We now know that too much local control can result in arbitrary disapproval of some meritorious applications.

It is only in the past few years that the magnitude and seriousness of pediatric pulmonary disease and its impact upon the national well being have begun to be recognized. The preponderance of adult respiratory cripples which takes up so much of our economics in terms of their disabilities and occupation of hospital bed spaces, could be prevented because many of those disease start in the lung.

Because of previous lack of awareness, as well as a general shortage of doctors there is a dearth of physicians qualified to diagnose and treat such diseases at the stages where you can do something about them.

The penalty in infant mortality, to say nothing of health deficits in later life, are obvious. That we have awakened to the problem, even belatedly, is due to the zeal of a number of distinguished men of medicine who have brought the facts to public attention—some by appearances before other congressional committees.

Doctors of the caliber of Giulio J. Barbero, Milton Graub, Paul A. Patterson, and LeRoy W. Matthews, all of them directors of cystic fibrosis care, teaching, and research centers in major cities, have offered expert and relevant testimony.

In addition there have been eminent witnesses not connected with our foundation such as Dr. Frederick G. Burke, professor of pediatrics at Georgetown University.

Their testimony has brought about the inclusion in the RMP of cystic fibrosis and other serious lung diseases. At the same time this was done, the scope of the Chronic Disease Control Center of the Public Health Service was expanded to cover the same spectrum of disorders.

Gentlemen, I have statements here from associated expert witnesses, Dr. William W. Waring, chief of the section of pulmonary diseases, Department of Pediatrics, Tulane University School of Medicine; Dr. Thomas L. Petty, associate professor of medicine and director, respiratory care unit, University of Colorado Medical Center, Denve; and Dr. Giulio J. Barbero, chairman, Department of Pediatrics, Hahnemann Medical College and Hospital, Philadelphia.

Mr. JARMAN. The committee will be glad to receive them.

Dr. HERNDON. Thank you, sir.

Dr. Waring speaks from his experience as a director of one of the pediatric pulmonary centers funded by the chronic disease program of the regional medical services. Dr. Barbero directs a cooperative effort in which three hospitals are serving the community under a combination of chronic disease and regional programs.

From all evidence, this prototype effort has been working extremely well.

The picture regarding both the regional medical programs and the Chronic Disease Center program would be wholly gratifying were it not for the administration's decision to phase out the Chronic Disease Center program.

The effect, already even being felt, is for each regional medical program to become a separate unit functioning in geographical isolation without the stimulus to productivity and creativity of coordination on the national level.

The comments coming to me from our experts in the field clearly express their sense of being cut off from their colleagues and from the benefits they experienced as partners in a nationwide endeavor.

I have mentioned testimony by several of these experts who have been submitted for including in the record. I should like to quote from the letter by Dr. Waring, whose regional medical program in pediatric pulmonary diseases is centered in New Orleans at the Tulane University School of Medicine.

Dr. Waring says:

> The decision * * * to discontinue the Chronic Respiratory Diseases Control Program and its parent, the National Center for Chronic Disease Control, in my opinion was unwise.
>
> This was the only federal agency that was responsible for clarifying knowledge of the incidence and types of chronic pulmonary disease and for supporting the studies designed to prevent, control or cure them.

In a reference to the National Cystic Fibrosis Research Foundation, Dr. Waring remarks that it "can be justly proud of its role in developing within medical schools regional centers concerned with cystic fibrosis and other pulmonary diseases of children.

"Their triple goal of care, teaching and research has encouraged the development of interest and skills in pulmonary diseases by full-time academic pediatricians.

"These individuals are beginning to produce others like themselves. Unfortunately, however, the magnitude of the problem far outweighs the resources of a relatively small private foundation. It seems to me that the greater resources of the Federal Government are needed.

"This was exactly where the former National Center for Chronic Disease of the U.S. Public Health Service was beginning to be so effective," says Dr. Waring.

After describing the progress achieved and the possibilities opened up under the auspices of the Chronic Disease Center, Dr. Waring asks:

> If the National Center is not reactivated, from what sources and by what means will such new ideas emerge and be funded?
>
> As good as the Regional Medical Programs concept is, it has deficiencies, and its decentralization may at times be one of them.

Near the close of his letter, Dr. Waring alludes to the local review process which must now be cleared by RMP grant applications:

I know of several instances in which local politics have absolutely stopped a good pediatric pulmonary center grant application initiated by a man of natural stature. Peer review is a good idea, but some of these grants have never reached a man's peers, because in a developing field the peers may not be on the local scene.

It is not my purpose to point out deficiencies in the RMP granting process with regard to children's pulmonary diseases. Rather I want to emphasize the need for a centralized governmental agency overseeing, but not controlling, the field of chronic pulmonary diseases.

I believe that this agency should be able to see the importance of the development of pediatric lung experts and children's pulmonary centers.

Adequately funded, this agency should selectively support projects that would help to insure the health of children's lungs.

He concludes by asking, "Wasn't this part of the purpose of the old National Center for Chronic Disease Control?" Should not this purpose now be reinforced and strengthened rather than phased out?

Dr. Waring's argument offers an authoritative and judicious opinion on what should be done. Adding my own thoughts to this, I wonder if, in reinstating the Chronic Disease Control Center, we might start afresh by renaming it the contract division of the regional medical programs.

This would describe its vital function, which is to provide on a contract basis for the funding of clinical, training, and research endeavors necessary to the basic operations of RMP.

So by renaming it the contract division it would carry out the purpose of the chronic disease center and allow the program to continue.

One more time, and for the last time, let me emphasize the importance of the amendment guaranteeing national review. The fact that there is some appeal to higher authority to redress a decision will encourage local groups to make further efforts. The opportunity to try again is all important.

Where a single individual can prevent an application from reaching the local advisory committee, as happened in at least one case, this safeguard is essential.

The amendment, Mr. Chairman, will discourage such obstructionism because local advisory groups will realize that their actions are subject to higher scrutiny.

We feel that the two elements of H.R. 12484 serve to complement and reinforce each other. Because the Chronic Disease Center is the major agency for the overall chronic disease program, it must not be abandoned.

In conclusion, I would make the perhaps obvious point that we are a United States, not 55 unrelated regions or separate regions. A local health problem is by the nature of our society a national health problem.

Conversely the skill and talent of one area should not be denied other parts of the country because of artificial geographical fragmentation.

Gentlemen, I urge you to consolidate and extend our hard-won gains in health protection by insuring continuation of the programs on which you have heard this testimony, for House bill 14284.

I thank you for the privilege of appearing before you.

(Dr. Herndon's prepared statement and the statements of Dr. Waring, Dr. Petty, and Dr. Barbero, referred to, follow:)

STATEMENT OF DR. JOHN F. HERNDON, VICE PRESIDENT FOR MEDICAL AFFAIRS, NATIONAL CYSTIC FIBROSIS RESEARCH FOUNDATION

Mr. Chairman, distinguished members of the Subcommittee, I am Dr. John F. Herndon, Vice-President for Medical Affairs of the National Cystic Fibrosis Research Foundation.

I wish to thank the Committee for the opportunity to testify on behalf of House Bill No. 14284. Our Foundation speaks for 5 million lung-damaged children and more millions of anxious parents, grandparents and kinsmen. Figures do scant justice to such a situation, for there is no way of calculating the statistics of pain and despair. Yet figures offer a yardstick of need—and on the basis several deserve to be cited.

In 1965, out of the 92,866 infants under one year of age who died in these United States, 28,881 or 31 percent succumbed to respiratory diseases. Severe respiratory disease often begins in the newborn period; acute respiratory distress in the first few days probably accounts for more loss of life than any other single cause. Our country's poor record in newborn mortality compared with other nation's is due largely to this high rate of pulmonary failure.

Although deaths taper off after infancy, respiratory disease through childhood and into adulthood remains common. During 1966–67, for example, 171 million school days were lost by children age 6 to 16, and 57 percent of these absences were the result of respiratory diseases. Much if not most adult respiratory disease has its origins in early life. Need I point out the savings, in both human and economic terms, if progressive, irreversible lung disease were to be slowed or forestalled while the patients are still young? All too often where this would be possible, the necessary facilities, medical programs and personnel are lacking.

Even for patients in whom the progress of chronic disease cannot be totally arrested, much more could be done to help in the attainment of the goal of fruitful lives.

For such reasons as these, gentlemen, the National Cystic Fibrosis Research Foundation endorses the bill to extend the Regional Programs for Heart, Cancer, Stroke and Related Diseases for an additional three years. We also believe that the modifications in HR 14284 significantly enhance the value of these programs. We especially commend the amendment of Section 5, paragraph 11(c), which assures the applicant group seeking a Regional Medical Program a fair decision by providing a mechanism of appeal to the Council of the RMP.

As medical administrator for the NCFRF, I have seen numerous instances in which new programs have encountered opposition from unsympathetic local advisory groups. In many cases considerable time, effort and scientific-medical talent, aided by more than competent outside advisors, went into preparation of the Regional Medical applications which then received a negative response at the local level. Inquiry into such actions revealed that often the local group did not constitute what could be termed a true peer group. Indeed, authorities in all the medical disciplines or in the public health problems under consideration are not to be found in every community. Therefore, local advisory bodies may not always be qualified to judge the merit or appropriateness of a Regional Medical Program application.

Medical political considerations are a fact of life. Individuals who have served a particular geographical area over the years tend to believe they have a better understanding of current needs in that area than anyone else. They may not be correct, but they may control the situation. The April 10 issue of *Science*, the official publication of the American Association for the Advancement of Science, looks into the trend toward decentralization being fostered in the Department of Health, Education and Welfare by the present Administration. Weighing the pros and cons of this policy, which would transfer more authority to local groups, the writer observes: ". . . Given his expanded powers, a politically motivated regional director might conceivably turn his region into a patronage fiedom." I would say that even where patronage is not involved, the local or regional group may be weighted with persons who believe that local problems are best served by reliance upon existing, longstanding facilities, programs and standards. New ideas or approaches—whether in pediatrics or preventive medicine—may receive less than due consideration.

Our Foundation has had knowledge of specific programs in connection with children's lung disease where there was little local interest or understanding, and needed improvements could not be effected.

It is not my intention to pass judgment or apportion blame, but I feel I should back up my general observation by citing specific instances. In Albany, New York, for example, an application for a Regional Medical Program in pediatric pulmonary diseases was blocked by men whose orientation was to internal medicine. There was an honest difference of opinion here based on a lack of insight into the need for a special pediatric program of this sort. Recently the local review body has indicated a change of heart and asked that the application be resubmitted. As one of the internists remarked, "We didn't understand the importance of this sort of thing. Now that I've seen what goes on in a Cystic Fibrosis Center, I realize that these pediatricians deal with a greater variety of lung conditions than the physician in adult pulmonary disease."

In Durham, North Carolina, doctors associated with the Cystic Fibrosis Center at Duke University Medical School submitted an application for a Regional Medical Program. Getting no reply, they investigated and finally learned that the application had been "mislaid."

Four medical institutions in the Los Angeles area joined forces and submitted an application for a carefully considered cooperative program. This was well enough regarded by the Medical-Scientific Council of our Cystic Fibrosis Foundation for us to commit funds of our own to the project. The local review committee, for reasons unclear to us, rejected it. Now it appears that if the individual hospitals decide to apply again for funding, they will do so separtely. If only from the standpoint of efficiency and economy, this diffuse effort is clearly less desirable than obtaining support in a single package.

A first and then a second application were submitted in Minneapolis for an RMP in pediatric pulmonary diseases. The rejections seem to have been based on the local committee's assumption that these diseases do not fall within the purview of the act pertaining to heart, cancer and stroke. The fact is, of course, that the rovision for "related diseases" is designed to include those in the pediatric pulmonary category. Again, the soundness of the proposed program, according to expert judgment, is attested by our own foundation's investment of approximately $40,000 each year in the work being done in Minneapolis.

It is a fundamental tenet of democracy that citizens are entitled to a hearing and, in the event of an adverse decision, to an appeal. At the very least, those whose applications are rejected should be able to clarify the question of whether such a rejection upholds or runs counter to the intent of Congress.

In creating the Regional Medical Program Services on a three-year trial basis, Congress acted wisely. Thanks to this trial period, we have had an opportunity to detect a flaw in the system. Now we know that too much local control can result in arbitrary disapproval of some meritorius applications.

It is only in the past few years that the magnitude and seriousness of pediatric plumonary disease and its impact upon the national well-being have begun to be recognized. Because of previous lack of awareness, as well as a general shortage of doctors, there is a dearth of physicians qualified to diagnose and treat such disease. The penalty in infant mortality, to say nothing of health deficits in later life, has already been noted. That we have awakened to the problem, even belatedly, is due to the zeal of a number of distinguished men of medicine who have brought the facts to public attention—some by appearances before other Congressional committees. Doctors of the calibre of Giulio J. Barbero, Milton Graub, Paul A. Patterson, and LeRoy W. Matthews, all of them directors of Cystic Fibrosis Care, Teaching and Research Centers in major cities, have offered expert and relevant testimony. In addition, there have been eminent witnesses not connected with our Foundation such as Dr. Frederic G. Burke, Professor of Pediatrics at Georgetown University.

Their testimony has brought about the inclusion in the RMP of cystic fibrosis and other serious lung diseases. At the same time this was done, the scope of the Chronic Disease Control of the Public Health Service was expanded to cover the same spectrum of disorders.

We refer this Committee to testimony by Dr. William W. Waring, Chief of the Section of Pulmonary Diseases, Department of Pediatrics, Tulane University School of Medicine; Dr. Thomas L. Petty, Associate Professor of Medicine and Director, Respiratory Care unit, University of Colorado Medical Center, Denver; and Dr. Giulio J. Barbero, Chairman, Department of Pediatrics, Hahnemann Medical College and Hospital, Philadelphia. Dr. Waring speaks from his experience as a director of one of the pediatric pulmonary centers funded by the Chronic Disease program of the Regional Medical Services. Dr. Barbero directs a cooperative effort in which three hospitals are serving the community under a

combination of Chronic Disease and Regional Programs. From all evidence, this prototype effort has been working extremely well.

The picture regarding both the Regional Medical Programs and the Chronic Disease Center program would be wholly gratifying were it not for the Administration's decision to phase out the Chronic Disease Center program. The effect, already being felt, is for each Regional Medical Program to become a separate unit functioning in geographical isolation without the stimulus to productivity and creativity of coordination on the national level. The comments coming to me from our experts in the field clearly express their sense of being cut off from their colleagues and from the benefits they experienced as partners in a nationwide endeavor.

I have mentioned testimony by several of these experts, which will be submitted for inclusion in the record. I should like to quote from the letter by Dr. Waring, whose Regional Medical Program in pediatric pulmonary diseases is centered in New Orleans at the Tulane University School of Medicine. "The decision . . . to discontinue the Chronic Respiratory Diseases Control Program and its parent, the National Center for Chronic Disease Control, in my opinion was unwise," says Dr. Waring.

"This was the only federal agency that was responsible for clarifying knowledge of the incidence and types of chronic pulmonary disease and for supporting studies designed to prevent, control or cure them."

In a reference to the National Cystic Fibrosis Research Foundation, Dr. Waring remarks that it "can be justly proud of its role in developing within medical schools regional centers concerned with cystic fibrosis and other pulmonary diseases of children. Their triple goal of care, teaching and research has encouraged the development of interest and skills in pulmonary diseases by full-time academic pediatricians. These individuals are beginning to produce others like themselves. Unfortunately, however, the magnitude of the problem far outweighs the sources of a relatively small private foundation. It seems to me that the greater resources of the federal government are needed.

"This was exactly where the former National Center for Chronic Disease of the U.S. Public Health Service was beginning to be so effective," says Dr. Waring. After describing the progress achieved and the possibilities opened up under the auspices of the Chronic Disease Center, Dr. Waring asks: "If the National Center is *not* reactivated, from what source and by what means will such new ideas emerge and be funded? As good as the Regional Medical Programs concept is, it has deficiencies, and its decentralization may at times be one of them."

Near the close of his letter, Dr. Waring alludes to the local review process which must now be cleared by RMP grant applications. "I know of several instances," he says, "in which local politics have absolutely stopped a good pediatric pulmonary center grant application initiated by a man of national stature. Peer review is a good idea, but some of these grants have never reached a man's peers, because in a developing field the peers may not be on the local scene.

"It is not my purpose," he continues, "to point out deficiencies in the RMP granting process with regard to children's pulmonary diseases. Rather, I want to emphasize the need for a centralized governmental agency overseeing, but not controlling, the field of chronic pulmonary diseases. I believe that this agency should be able to see the importance of the development of pediatric lung experts and children's pulmonary centers. Adequately funded, this agency should selectively support projects that would help to ensure the health of children's lungs." He concludes by asking, "Wasn't this part of the purpose of the old National Center for Chronic Disease Control?" Should not this purpose now be reinforced and strengthened rather than phased out?

Dr. Waring's argument offers an authoritative and judicious opinion on what should be done. Adding my own thoughts to his, I wonder if, in reinstating the Chronic Disease Control Center, we might start afresh by renaming it the Contract Division of the Regional Medical Programs. This would describe its vital function, which is to provide on a contract basis for the funding of clinical, training and research endeavors necessary to the basic operations of RMP.

Once more, and for the last time, let me emphasize the importance of the amendment guaranteeing national review. The fact that there is some appeal to higher authority to redress a decision will encourage local groups to make further efforts. The opportunity to try again is all-important. Where a single individual can prevent an application from reaching the local advisory committee, as happened in at least one case, this safeguard is essential.

Your amendment, Mr. Chairman, will discourage such obstructionism because local advisory groups will realize that their actions are subject to higher scrutiny.

We feel that the two elements of the bill you propose serve to complement and reinforce each other. Because the Chronic Disease Center is the major agency for the overall chronic disease program, it must not be abandoned.

In conclusion, I would make the perhaps obvious point that we are a United States, not 51 unrelated regions. A local health problem is by the nature of our society a national health problem. Conversely, the skill and talent of one area should not be denied other parts of the country because of artificial geographical fragmentation.

Gentlemen, I urge you to consolidate and extend our hard-won gains in health protection by ensuring continuation of the programs on which you have heard this testimony. I thank you for the privilege of appearing before you.

TULANE UNIVERSITY,
SCHOOL OF MEDICINE,
New Orleans, La., March 16, 1970.

Dr. JOHN F. HERNDON,
Medical Scientific Director, National Cystic Fibrosis Research Foundation, New York, N.Y.

DEAR DR. HERNDON: I am writing at this time because I know that the National Cystic Fibrosis Research Foundation has become increasingly concerned with diseases of children's lungs. The decision by the U.S. Public Health Service to discontinue the Chronic Respiratory Diseases Control Program and its parent, the National Center for Chronic Disease Control, in my opinion was unwise.

This was the only federal agency that was responsible for clarifying knowledge of the incidence and types of chronic pulmonary disease and for supporting studies designed to prevent, control, or cure them. Chronic pulmonary disease is not limited to the adult members of our society. There is no doubt that a substantial proportion of adult lung disease has its origin in genetic or childhood environmental factors that set the stage years before the disease appears clinically. More must be done to study the earliest stages of pulmonary disease during infancy and childhood. Diseases of the lungs of children are no more simply small versions of adult pulmonary diseases than are children themselves miniature adults. Their diseases are frequently qualitatively and quantitatively distinct. Respiratory distress syndrome of the newborn and cystic fibrosis are two diseases that most physicians handling adults do not know.

The subspecialty of children's pulmonary diseases is now emerging as a genuine part of pediatrics, just as pulmonology has become firmly established as a branch of internal medicine. The National Cystic Fibrosis Research Foundation can be justly proud of its role in developing within medical schools regional centers concerned with cystic fibrosis and other pulmonary diseases of children. Their triple goal of care, teaching, and research has encouraged the development of interest and skills in pulmonary diseases by full-time academic pediatricians. These individuals are beginning to produce others like themselves. Unfortunately, however, the magnitude of the problem far outweighs the resources of a relatively small private foundation. It seems to me that the greater resources of the federal government are needed.

This was exactly where the former National Center for Chronic Disease of the U.S. Public Health Service was beginning to be so effective. The directors of this program recognized the need for attention to lung diseases in children, both for children *and* for adults. As you know, by means of several contracts with medical schools in various parts of the country, including our own, pediatric pulmonary centers were established for a period of three years. Physicians in these centers are struggling with all the problems related to a developing subspecialty. These include, as examples, workable nomenclature that will serve to standardize disease names, new methods of teaching people about pulmonary disease through innovative audiovisual methods, training programs for pediatricians who wish to specialize in children's pulmonary diseases, and applications of computer technology for both case registries and teaching. The extraordinary things about these four centers is their healthy spirit of cooperation. The progress reports of each have been shared with other centers, so that each knows what the others are working on and exactly how far the job has gotten.

This splendid spirit has been aided in the past by the National Center for Chronic Disease Control, which fostered it by regular meetings of the center

directors, both in body and by means of telephone conferences. In addition, the statistical and bibliographic resources of the National Center were made available to pumonary program directors. The spirit of cooperation engendered by the National Center has led to the formal creation of an Association of Pediatric Pulmonary Centers. This new association has already invited non-contract center directors to join them in a united attack on pulmonary diseases. This association has met already in Los Angeles, where its members could study the operations of one member center, and will next meet in Cleveland at the time of the American Thoracic Society meetings. The U.S. Public Health Service should be proud of this tangible evidence of its ability to unite physicians in a common fight. I feel certan that the Association of Pediatric Pulmonary Centers will continue, regardless of whether the National Center for Chronic Disease Control is reactivated or not.

However, if the National Center is *not* reactivated, from what source and by what means will such new ideas emerge and be funded? As good as the Regional Medical Programs concept is, it has deficiencies, and its decentralization may at times be one of them.

Several pediatric pulmonary centers have been formed by RMP grants. Up to the present each of these centers has worked on its own with no network of communication informing others with similar interests of their goals and progress. This liaison was maintained by the old National Center for Chronic Disease Control.

As you know, RMP grant applications must clear a local review process. I know of several instances in which local politics have absolutely stopped a good pediatric pulmonary center grant application initiated by a man of national stature. Peer review is a good idea, but some of these grants have never reached a man's peers, because in a developing field the peers may not be on the local scene.

It is not my purpose to point out deficiences in the RMP granting process with regard to children's pulmonary diseases. Rather, I want to emphasize the need for a centralized governmental agency overseeing, but not controlling, the field of chronic pulmonary diseases. I believe that this agency should be able to see the importance of the development of pediatric lung experts and children's pulmonary centers. Adequately funded, this agency should selectively support projects that would help to ensure the health of children's lungs. Wasn't this part of the purpose of the old National Center for Chronic Disease Control? Should it not be re-established?

Yours sincerely,

WILLIAM W. WARING, M.D., *Chief.*

ABBREVIATED CURRICULUM VITAE: WILLIAM W. WARING, M.D.

I. *Born:* 1923.

II. *Education:* Harvard Medical School (M D., 1947).

III. *Postgraduate Training:* Children's Hospital, Boston, 1947–48; Johns Hopkins Hospital, Baltimore, 1948–1952.

IV. *Present Academic Appointments* (Tulane University School of Medicine): Professor of Pediatrics; Lecturer in Physiology; and Chief, Section of Pulmonary Diseases, Department of Pediatrics.

V. *Other Appointments:* Councilor at Large, American Thoracic Society: Chairman: Care, Teaching, and Research Center Committee; National Cystic Fibrosis Research Foundation.

[The following comments from Dr. Thomas L. Petty were reviewed by the Executive Council of the American College of Chest Physicians. The Council unanimously endorsed Dr. Petty's communication.]

WE NEED PROGRAMS FOR CHRONIC AIRWAY OBSTRUCTION!

To the Editor: It is well known that our nation's most rapidly growing health problem is chronic respiratory disease—most notably, emphysema and chronic bronchitis. Frequently published statistics document the magnitude of this problem.[1] For example, in the past 15 years new case identification, morbidity and mortality have doubled during each five year period for emphysema and chronic bronchitis together.[1 2]

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[1] Stone, R. W.: Magnitude for the Problem, *Arch. Environ. Health*, 6: 306, 1963.
[2] USPHS Publication, 1715, 1967.

This disease spectrum constitutes the second highest cause of social security disability payments which amount to some 100 milion dollars a year in the form of direct benefits paid to the patients unable to work because of disabling symptoms. It has been further estimated that more than 81,00,000 productive man hours are lost each year from chronic bronchitis alone. Each year other chronic respiratory disorders (including emphysema) cost more than 170,000,000 hours lost in productive activity or recreation This is a rough estimate of the social impact of this important disease spectrum. The magnitude of the total problem remains unknown but there are probably 14 million people with some degree of emphysema or bronchitis living in this country today. Many have only mild or *no* symptoms.[2]

In an initial step to acknowledge and stimulate efforts concerning the problem, the Chronic Respiratory Disease Control Program was established and funded in 1966. Over approximately three and one-half years this branch has supported public education in the form of pamphlets, monographs and movies, has aided in the development of intensive respiratory care units, and helped develop and sustain out-patient rehabilitation programs which also provided training for medical and paramedical personnel. In addition the program supported community identification and care projects of a varied nature. This has all been accomplished with a very modest budget. The overall social benefit of these programs will never be known, however, unless the effects are continued.

The various pilot programs have already demonstrated the short-term effectiveness of both intensive and rehabilitative care methods,[3] and many physicians, nurses, inhalation therapists, and physical therapists have received training under the program contracts and grants.

In addition, the Chronic Respiratory Disease Control Program sponsored research conferences in emphysema and related diseases such as the Aspen Emphysema Conference. Published proceedings of the conference were supported from 1965–1969.[4-7]

In the face of this small but important effort, the Chronic Respiratory Disease Control Program has now been curtailed, effective June 30, 1970. Thus, today, there is no specific coordinated federal effort directed against our problem of chronic respiratory insufficiency. This seems particularly lamentable in view of the early success of the small but growing programs initiated through the assistance of the Chronic Respiratory Disease Control Program and doubly tragic when one considers the immense social and economic impact of these important diseases.

It is therefore hoped that all organizations and societies interested in furthering teaching, research, patient care activities and training in the area of chronic respiratory disease, put forth a great effort to ask the Secretary of Health, Education and Welfare not only to reconsider continuation of the Chronic Respiratory Disease Control Program but also to expand the scope of this effort on a priority basis as an all-out attempt to stem the epidemic of chronic respiratory disease.

Respectfully,

THOMAS L. PETTY, M.D.,
F.C.C.P., Associate Professor of Medicine, Director, Respiratory Care Unit, University of Colorado Medical Center, Denver, Colo.

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[3] Petty, T. L., Nett, L. M., Finigan, M. M., Brink, G. A., and Corsello, P. R.: A Comprehensive Care Program for Chronic Airway Obstruction, *Ann. Int. Med.*, 70: 1109, 1969.

[4] Management of Chronic Obstructive Lung Diseases, (Conclusion of the Eighth Aspen Emphysema Conference), USPHS Publication, 1457, 1966.

[5] Current Research in Chronic Airways Obstruction (Ninth Aspen Emphysema Conference), USPHS Publication, 1717, 1968.

[6] Current Research: Chronic Obstructive Lung Disease (Tenth Aspen Emphysema Conference), USPHS Publication, 1787, 1968.

[7] Current Research in Chronic Respiratory Disease, (Eleventh Aspen Emphysema Conference), USPHS Publication, 1879, 1969.

Congressional Testimony on Pulmonary Disease

(Giulio J. Barbéro, M.D., Chairman, Department of Pediatrics, Hahnemann Medical College and Hospital, Philadelphia)

The Chronic Disease Control Program has developed a series of major efforts in childhood pulmonary disease which are going to have far-reaching impact in this important area of childhood illness. Out of the funding programmed for this field, the Chronic Disease Control Program section of the United States Public Health Service proposed in a very enlightened and forward-looking fashion the development of a network of pediatric pulmonary disease centers throughout the country. These were to serve as a backup to the primary health system in urban and rural communities in the area of pulmonary disease. Since the field of pulmonary illness in childhood was earlier presented to your committee on health and welfare appropriations as one of urgent moment on the basis of hard-core frequency statistics, and you directed that activities in the area be given essential support, the Chronic Disease Control Section went on to approve four initial projects of broad scope and promise. These were selected because they all possess elements offering the prospect of widespread application in the delivery of health care and in training of diverse disciplines. Also they provide a context in which data relating to treatment programs can be accurately evaluated.

Reference to the underlying concept of each of the four programs clearly indicates the wisdom of the Chronic Disease Control Section in supporting this total effort.

The program at Georgetown University in Washington, D.C. has concentrated on the development for a network of hospitals of a computerized case registry of children with recurrent or chronic respiratory problems. This system is now available for immediate retrieval in the emergency room when a patient arrives, supplying doctors with exact details of past history, previous laboratory tests and treatment. With this information the physician is able to make more effective judgments for his management. The data are available to all the participating hospitals in the area.

Tulane University in New Orleans has been in the process of development on an intensive care team at Charity Hospital for respiratory management of the suffocating child. This has become a major demonstration and training program in pediatric pulmonary disease in the South. Many educational and training tools have been designed for this project, all of which will have use throughout the country. Advanced procedures for the measurement of pulmonary function have been devised, permitting better evaluation of the pulmonary situation in infancy and childhood.

The group in Los Angeles at the Los Angeles County Hospital has developed the first acute respiratory unit, providing laboratory backup and modern methods of care for acute and chronic respiratory insufficiency in a major city situation where such resources have not previously existed. An intensive training program for all physicians and resident physicians has markedly increased the use of these services. A computer system has been set up for training. On the basis of its data, laboratory results can be predicted from the clinical appearance of children and accurate judgments can be formed regarding treatment needs for oxygen, medication, artificial breathing devices and resuscitation. Since these learning tools have been introduced, there has been far more precise moment-to-moment monitoring of the utilization of breathing instruments critical in bringing the vital oxygen into the lungs at appropriate pressures and exact rates.

In Philadelphia, three medical schools have combined their efforts to develop a series of tools of widespread application. A basic classification of all respiratory diseases has been designed; forms employed in patient care have been structured as a learning and care tool assisting the physician to follow a pattern of optimum assessment of the patient and improved judgment of therapy. A storage facility is being programmed to allow free and immediate accessibility of data to *any* physician or hospital, for the first time overcoming the lag in obtaining urgently needed information. A major standardization of the measurement of pulmonary function has been tabulated and published as a natural standard. It is anticipated that the classifications, the patient care forms, the data registry computer program and the standardization of normal values of pulmonary function tests will all have widespread use throughout the United States.

In all four pediatric pulmonary programs, training of new physicians, nurses,

physical and inhalation therapists and laboratory technicians is under way to increase the pool of personnel for this vital child health care area. Many programs for these groups and for practicing physicians have been presented by the center staff in local community hospitals; similar programs in the future will contribute further to the delivery of high-quality care related to the problem of pulmonary distress in childhood.

It is felt that this has been a most remarkable effort. Leaders of all four programs have met jointly on four occasions, visited each other's programs and held a number of telephone conferences forging national links among their various endeavors. A number of projects in common are in progress in the four centers. The concept of a national network of pulmonary pediatric centers is now viable and being actively promoted through these cooperative efforts. An example of such cooperation is the development of a series of audiovisual aids. These are going out to institutions across the country, offering them the most up-to-date information and ideas in the constantly changing area of respiratory disease. In addition, the network of four centers is now acting as an organized association bringing together other interested parties such as the centers of the National Cystic Fibrosis Research Foundation and the Regional Medical Program in a larger frame of activity.

The success of these programs strongly supports the wisdom of having undertaken the effort envisioned by the Chronic Disease Control Section of the United States Public Health Service and should be further supported and expanded.

Mr. JARMAN. Doctor, for your comprehensive statement we thank you. I think the specific reference you make are good evidence of the need for guaranteed national review of applications.

I regret that time aspects of this hearing and the number of witnesses who are actually appearing before the committee of necessity cuts short the question and answer period but let me now call on my colleagues.

Mr. Rogers.

Mr. ROGERS. Thank you, Mr. Chairman.

Thank you, Dr. Herndon, for your testimony.

I, too, am concerned with some of the things you say. For instance, we see in the NIH now an effort to decentralize so much. I am concerned about the continuation of the program. Going down to 12 regions now, as I understand, and just dissipating what has been gathered in our expertise here.

"Now a tie-in with this business," you say, "of a politically motivated regional director, he might conceivably turn his region into a patronage fiefdom."

This concerned me and the fact that I am not sure, well, I am not sure we have trained people to run 12 regional programs right now.

It seems to me you are going to have more people and the program will cost more, that there will be less coordination, that the greatest research will take greater time getting out and the cordination that has been developed will begin to be lost.

So I think you make a good point when when you say that we need some overall coordination by the Federal Government. We don't want all decisions here, but certainly in these areas where we need to get out research in the newest methods, it needs to be gathered and then dispensed, this looks to me like we are getting into maybe the opposite of that.

I share your concern about this chronic disease program and here again then it looks to me like it is being abandoned and the center is being taken away. I hope this committee can do something about it.

Thank you.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. No questions, thank you, Mr. Chairman, and thank you, Doctor, for your statement.

Mr. JARMAN. Doctor, thank you for being with us.

Off the record.

(Discussion off the record.)

Mr. JARMAN. Back on the record.

Our next witness is Dr. James R. Kimmey, executive director of Community Health, Inc., of New York City.

STATEMENT OF DR. JAMES R. KIMMEY, EXECUTIVE DIRECTOR, COMMUNITY HEALTH, INC., NEW YORK, N.Y.

Dr. KIMMEY. Thank you, Mr. Chairman, for the invitation to appear here today and talk in relationship to the bill to continue the RMP and CHP programs. Since a member of my board will follow me with another group of witnesses, I will keep my remarks short, and ask that my prepared statement be received.

Mr. JARMAN. It will be received, sir.

Dr. KIMMEY. Thank you.

I would like to summarize very quickly our concerns, and the reasons for our concerns, with the legislation that is currently before the committee. Community Health, Inc. is a nonprofit agency set up by the American Public Health Association and the National Health Council to carry out a 5-year followup on the work of the National Commission on Community Health Services.

The comprehensive health planning program, as we know it, grew out of the recommendations of the commission, and we at CHI put a high priority on working with and assisting planning agencies at the State and community levels as they develop their programs. As a result of these efforts, we have had an opportunity to observe many of the developments that are going on in various parts of the country in State planning agencies and areawide planning agencies; to observe relationships developing between such agencies and regional medical programs; and to develop a sensitivity to the feelings of the people actually working in the field at the State and community levels.

Briefly, I think there are two things about the proposed administration bill, the Health Services Improvement Act of 1970, that deserve special comment. One is that the single preamble that has been put into this bill significantly changes the focus of both regional medical programs and the comprehensive health planning. At the time the programs were passed by Congress in 1965 and 1966, they were directed toward rather specific targets, the regional medical program toward the improvement of organizational arrangements and continuing of education to bring the results of research in heart disease, cancer, and stroke to the people; the comprehensive health planning program to concern itself on a broader scale with personal health, environmental health, and mental health planning with broad community participation. I think Mr. Rogers put it well with the bottom-up, top-down analogy that he used here earlier.

Three years have passed since the legislation was activated. I was regional health director for the Public Health Service in New York during the first 2 years of the program and had considerable involve-

ment in its start in that particular part of the country. We have seen new agencies developed in both regional medical programs and comprehensive health planning. I think the major thing which I would want to stress is the degree of participation elicited from people not previously participating in these kinds of programs. In RMP, as other witnesses have pointed out, the practicing physicians, the hospitals, and the major medical centers are involved in establishing the network necessary for new cooperative relationships and improved communication. In the comprehensive health planning program, I think we have seen the beginning of a real partnership between the Government and private resources to plan not only for medicine, but for health. I would suppose, from Dr. Egeberg's testimony on Monday and some of the other statements that have been submitted on the administration-supported bill, that we are seeing some confusion between the two concepts, health and medicine.

Health is a broad social concept, and encompasses social well-being, mental well-being, and physical well-being. Medicine is a scientific discipline, which happens to be the one in which I was trained, which in part supports the overall concept of health. I think these two programs, comprehensive health planning and regional medical programs, have somewhat the same dichotomy of focus. It should be observed and respected as the programs are continued. The comprehensive health planning program should not be solely concerned with the planning for the improvement of the system of delivery of personal health care services. I think the impression that it shall do so comes across strongly in H.R. 15960 and in the testimony in support of that bill.

I think that the response on Monday to Mr. Rogers' question on the environment, that HEW is waiting for the Ash committee report, was a very unfortunate response. I think the environmental problem, particularly at this point in time when ecology is of more and more concern, and with the interest on the part of the press, on the part of members of this body, and on the part of the administration very active, is not a time to downgrade environment and community health aspects of environment as a legitimate function of the Comprehensive Health Planning Agency.

Many of the agencies have become involved in planning for the health aspects of environment. They are facing problems of coordinating these health aspects of the environment with transportation planning, zoning planning, parks and recreation planning, and many other kinds of planning going on in the community today. How can you keep a perspective on the fact that all of these types of environmental planning have health effects? Where can we find an agency that can function and assist and work with various environmental planning agencies? I think the CHP agencies in many communities have demonstrated they can serve the role. Mr. Schlesinger's testimony yesterday mentioned the priority given the environment by his committee in Syracuse, N.Y. I think we need new thinking to solve some of the ecological problems facing us today and I think the Comprehensive Health Planning Agency has a definite contribution to make.

I would like to make two or three comments on H.R. 15895, Mr. Rogers' bill to extend comprehensive health planning. I think our experience in the last year and a half in working with the agencies

around the country indicates to us some of their concerns. The map you have shows that only 11 of the 113 agencies are operational and the rest in a planning phase. Our experience with working with them has demonstrated that they would benefit from a continuation of the existing program and from an opportunity to go through and complete the organizational phases and begin the operational planning without a reorientation of objectives coming from above. H.R. 15960 would appear to reorient them from local priorities, with which they are now concerned, to a federally determined priority for personal health care services. I think, however, that there are two or three things in the administration's bill that could be added to H.R. 15895 which would be very helpful to the field.

One is the National Advisory Council. In this, I am speaking not of the National Advisory Council covering all of the programs that are covered in H.R. 15960, but rather a National Advisory Council for the comprehensive health planning program. The Congress did not put such into the original legislation, and the Department has made no move in the last 3 years to establish such a council. As a result, many of the regulations and policies emanating from Washington have been promulgated and carried out without review by outside individuals, either the affected individuals in the agencies or the various volunteer and professional organizations at the national level interested in comprehensive health planning.

I think the second aspect of H.R. 15960 of great value is the provision for joint funding. I can refer back to my experience as a Director of the kidney disease program in the Department of Health, Education, and Welfare 3 years ago and as a Regional Health Director, and comment on the need for joint funding of projects by HEW. This is a long overdue reform. At a point in time, if you were setting up a kidney project, you are faced with going to 314(e) funds, to vocational rehabilitation funds, and perhaps to Children's Bureau funds in order to put together your own funding package. The joint funding provision would allow the Secretary to name one agency as manager and allow an applicant to follow one agency's rules.

The third part of the administration bill that I think would enhance H.R. 15895 is the portion concerned with the program for establishment of a data base for comprehensive health planning. Many of the State and areawide agencies develop their own data programs today without provision for comparability of data from area to area and State to State. We feel the establishment of some national guidelines in this area is essential in order to make the data developed by each of the agencies usable for national purposes and for larger regional purposes. The National Center for Health Statistics has a plan to do this if they get the legislative authority.

I have two other comments. One is that there are a number of bills that have been before the Congress already, this year which have put new functions onto areawide comprehensive health planning agencies. I think as we look at the amount of money in this bill for 314(b) and we look at the rather sparse geographic coverage that you can see on the map, it is obvious we have only begun. I think the point was made the other day that 55 percent of the population is covered. Comprehensive health planning, however, is important for areas not heavily populated as well as for those heavy in population. It makes little dif-

ference if you can't reach a doctor because of the fact that there are no doctors in the ghetto or if can't reach one because he is 75 or 80 miles away and you can't get to him. Either way, you need some assistance from the type on planning process envisioned here.

There are, in H.R. 11102, the Hill-Burton amendments, some added functions to be assigned to the 314(b) agencies. We ought to look at how the agency will carry out the function without additional funding. Maybe the basic grant mechinism, under consideration here, would be the place to get additional funding.

Also, I think we need to look at the relationship of H.R. 17550, the Social Security Amendments of 1970 to the 314(b) agencies. The negotiated agreements between the Governor of a State and the Secretary of HEW to establish a planning agency to review the capital expenditure plans may also substantially increase their load and complicate their activities. There is a possibility that the language in Mr. Rogers' bill, giving the 314(b) agencies the responsibilities for assisting the hospitals to develop capital plans in the first place, will conflict with the approve-disapprove feature of H.R. 17550. This might raise a possibility of conflict of interest for the 314(b) agency.

Finally, on appropriations in H.R. 15895, we feel there is need to look at the appropriations authorized for 314(b) in light of these new functions. Certainly our goals should be to cover the entire country with functioning areawide health planning agencies responsive to the consumer interests and taking into consideration the providers' needs and interests. This is going to be a costly, but essential move.

We believe the authorization levels provided in H.R. 15895 for 314(e) should be reexamined in light of the administration's decision to transfer $30 million in OEO neighborhood health centers and the declining balance that is in there should be looked at.

Now, one word about 314(c), because I am afraid that other witnesses will not cover it. This is the training portion of the Comprehensive Health Planning Act. Under this portion, 18 programs have been set up around the country for training of individuals in health planning, not only to work with the 314(a) and 314(b) agencies, but assist hospitals, medical societies, and volunteer agencies, urban planning groups, and so forth in planning to meet their health responsibilities. Programs such as the one at the University of North Carolina, that at the University of Florida, and one at the University of Oklahoma are now training individuals in comprehensive health planning techniques. The 1971 White House budget does not allow for expanding the programs. I think we need to look again at the authorization in H.R. 15895 and consider that the support of training is a long-range investment in the success of the health planning program. I think I will pause here and will answer any questions you have.

(Dr. Kimmey's prepared statement follows:)

Statement of James R. Kimmey, M.D., Executive Director, Community Health, Inc., New York, N. Y.

Mr. Chairman and Members of the Committee--

I am Dr. James R. Kimmey, Executive Director of Community Health, Incorporated of New York City. I appreciate your invitation to appear here today to testify in support of an extension of the Partnership for Health, originally authorized by Congress in 1966, and extended in 1967.

Community Health, Incorporated, is a nonprofit corporation sponsored by the American Public Health Association and the National Health Council, and charged with securing widespread understanding, acceptance, and implementation of the recommendations of the National Commission on Community Health Services. The Commission--active from 1962 through 1966--was made-up of thirty-three Americans prominent in the fields of health and public affairs. It undertook an extensive study of health programs in the United States, and formulated fourteen major positions and ninety-eight recommendations often cited as "a blueprint for health in the Seventies". Its recommendations have gained particularly wide acceptance because the Commission studied the health structure generally rather than concentrating on an isolated segment such as manpower or facilities, and because it worked over a four year span and was able to observe health programs as dynamic systems.

Significantly, the National Commission on Community Health Services' first six recommendations were concerned with the need to develop a system of Statewide and regional health planning councils. They saw the establishment and activation of such a network as essential if needed changes in community programming for environmental, physical, and mental health were to be made. These recommendations from the Commission were a significant factor in shaping the concepts embodied in Public Law 89-749.

Accordingly, Community Health, Incorporated has given its highest priority to working with States and communities and with other, more specialized, professional and voluntary health agencies to further the advancement of the comprehensive health planning program. In the course of providing assistance to these groups, we have had an unusual opportunity to observe the development of the comprehensive health planning activity at all levels and in all areas of the country and to observe its relationship to other Federally-funded efforts such as the Regional Medical Programs. I would like to share our impressions with the Committee, and offer some ideas concerning the future development of this vital program.

The Eighty-Ninth Congress, in which most of the members of this distinguished committee served, established an unprecedented record for advanced legislative actions to meet some of the most pressing health problems facing this nation. Now many of the programs launched during that period are up for review, evaluation, and extension or modification. The legislation being considered today deals either collectively or individually with two of these programs.

The Regional Medical Programs for Heart Disease, Cancer, and Stroke and Related Diseases were authorized by Public Law 89-239. This legislation grew out of consideration of a report prepared by the President's Commission on Heart Disease, Cancer, and Stroke, though the program enacted differed in several respects from that recommended by the Commission. Directed toward establishment of regional cooperative relationships among research institutions, community hospitals, and practitioners, the Regional Medical Programs have concentrated on demonstration projects and continuing education and innovations in medical communications. The programs have developed a wide user constituency among medical personnel, and have become an accepted part of the medical structure in this country.

The Comprehensive Health Planning Act, Public Law 89-749, was a rather different type of legislation, but of equal importance. This Act provided for improved planning for health programs, for support of basic public health services, and for projects aimed at applying new health techniques to community problems. In the three years since activation of the programs, fifty-six States and territories and more than a hundred communities have begun the difficult task of assembling an organization to deal with the complexities of planning for health in a highly pluralistic structure. Such a task cannot easily be accomplished for it requires the patient development of cooperation between institutions which have been divided by their public, private, or private, nonprofit organizational objectives.

From the beginning of the implementation of the comprehensive health planning legislation, there has been concern expressed in several quarters that these activities were "duplication", and were on a "collision course". A whole dogma of dichotomies grew up about the two programs. The Regional Medical Program was "academic" while the Comprehensive Health Planning Program was "political". The Regional Medical Program was concerned with "quality" while the Comprehensive Health Planning Program was concerned with "capacity". The Regional Medical Program was "professional" while the Comprehensive Health Planning Program was "consumer" oriented. While these part truths were being marshalled as evidence for a mandated cooperation between the programs, extensive cooperative efforts were taking place in the community, on State and local initiative. Leaders in both programs were recognizing that their goals and constituencies--though different--were related, and a number of joint ventures were quietly launched. As the Congress approaches the question of continuation of the programs, it seems vitally important that they recognize that the progress of the past three years, and the growing cooperative relationships, could be severely compromised by major shifts in the goals of the two programs. The majority of the Regional Medical Programs have completed their planning phase, and are a part of the fabric of medical services in the communities they serve. The majority of Comprehensive Health Planning Programs are only midway in their organizational phases, but many are already cooperating closely with the Regional Medical Program in their area, just as they are with hospitals, health departments, voluntary agencies, and other operating agencies in their community.

The Regional Medical Program legislation, with its preliminary planning component, was not the only Federally-supported health planning effort to pre-date the system

envisioned under Public Law 89-749. However, all previous health planning activities represented specific problem-oriented approaches to a part of the communities' health problems. For example, the Hospital Survey and Construction Act of 1946 required that participating States establish a health facilities planning activity and the State mental health and mental retardation planning programs had been undertaken using Federal dollars. The Community Health Services and Facilities Act of 1961 authorized grants to public or nonprofit private agencies to provide facilities planning on an area basis. Although each of these programs had successes within the confines of their specific interest, it was obvious that none of these planning approaches had the scope to deal effectively with the whole spectrum of such problems.

The comprehensive health planning legislation seemed to have the capacity to deal with the larger problems of the health structure in this country. The preamble to Public Law 89-749 stressed the broad mandate of the new planning agencies and the need for wide participation by public and private interests in a new partnership to achieve effective plans. The substantive portions of the legislation were cast in very broad terms--allowing a desirable degree of flexibility to approach in a field where there was little dogma to guide community efforts. The experience of the past three years has demonstrated that--in a nation with great diversity of methods for solving health problems--a variety of planning structures and approaches were workable. Agencies have grown-up based in government and in the voluntary sector; some have strong directive boards and supportive staffs while others have strong staffs and supportive boards; some have moved quickly to operational status while others have pursued a more methodical consensus-building approach; some have attempted--with success--to tackle specific problems immediately while others have dwelled on long-range priority setting for health in general; and some have limited their geographic coverage to a specific political jurisdiction--such as a city--while others serve a number of jurisdictions crossing State boundaries. This high degree of diversity appears to us not a weakness growing from insufficient administrative guidelines, but a strength representing real commitment and concern that communities and States find the most effective health planning vehicle for their specific situation.

In considering Congressional action affecting the future of this program, it is important to realize that over 80% of the projects funded thus far for areawide health planning are for organizational grants. Given the need to secure the participation of diverse health, consumer, and local governmental interests, it is not surprising that most of these agencies are still involved in the often-difficult, always time-consuming effort to develop a workable structure for health planning in the community. Careful efforts on the part of the organizers in various communities have begun to forge new alliances among institutions and agencies, to introduce health consumers into the planning process, and to build a local financing base for the type of partnership suggested by the preamble to Public Law 89-749. A major reorientation of the program at this critical point would be likely to disrupt the process, and nullify the gains of three years of community effort.

The Committee is currently considering two bills that take rather different approaches to the continuation of the comprehensive health planning program. Each approach has advantages and disadvantages.

The proposed "Health Services Improvement Act of 1970", H.R. 15960, would combine the Regional Medical Program, comprehensive health planning, and health services research programs in a single Title of the Public Health Service Act, with a single declaration of purpose. To the field, this new purpose, with its emphasis on "efforts aimed at the organization and development of improved systems for the delivery of health care and services" as amplified by the Assistant Secretary for Health and Scientific Affairs in his testimony before the Senate on the companion bill S.3443, is a major shift in emphasis of both the Regional Medical Programs and the Comprehensive Health Planning Program. This shift gives rise to a legitimate concern for the ability of the agencies to retain the local or State initiative aspects of their programs. To what extent may the overriding health services systems development mission conflict with the types of programs being developed under RMP and CHP which are now considered to be responsive to local needs? There is no answer to this question in the wording of the legislation or the various supporting statements. To the extent that environmental health concerns have been incorporated into CHP activities, the virtual ignoring of environmental health in this bill and in Senate testimony might give some pause. The same is true of the degree to which this legislation might be used to move an areawide health planning agency into the role of a "community trustee"--with management responsibilities for the local health care "system". Assumption of this role would mark a major departure from the non-directive planning concept developed in the first 2½ years of the Partnership for Health. Among the examples of approaches to experimental combination of RMP/CHP activities cited in the Senate testimony, this concept of the areawide agency as "community trustee" is clearly stated as one alternative approach. This is the most serious and basic question to consider in relation to HR 15960. It is potentially most damaging to the continued growth of the programs as State and regionally-based efforts to develop State and regionally-determined priorities, plans, and programs.

There are really very few substantive changes in the operating programs of a RMP, a State CHP, or an areawide CHP agency incorporated in HR 15960. For the most part, the differences that do appear simply codify situations that are already widely prevalent. For example, decategorization of the RMP's has already been under way as the definition of the term "related diseases" has expanded. The interchange of advisory committee members between RMP and CHP programs is widespread. The advisory council for the areawide CHP that appears here was already a matter of policy and a requirement for approval. Other changes "enable" the Secretary to carry out and study coordinative activities that are already possible under existing authorities--for example, the studies in combination of RMP and CHP programs, or the review and comment by areawide agencies on RMP or health services development project grants. Three items deserve special mention as desirable additions to the law that should be considered for inclusion in any bill to continue this program:

National Advisory Council - Many groups have felt that a NAC for Comprehensive Health Planning should have been built into Public Law 89-749, and that the presence of such a forum for policy review and advice to the program's Federal administrators would have headed off many administrative problems that have arisen in the past 2½ years. A council, properly constituted, could provide an opportunity for consumer and provider input that has been lacking at the Federal level since the program's inception. Whatever the final legislation enacted, some provision for a national level advisory group seems badly needed.

Joint Funding - HR 15960 [Section 943] provides a significant improvement in the administration of projects receiving funds from more than one HEW source. This long-overdue reform permits the Secretary to provide regulations whereby a project receiving funds from several HEW sources can be administered by one of the funding agencies. The designated managing program's regulations, policies, and procedures would be followed by all, simplifying the problems of the recipient agency, which now must serve many masters in the joint funding situation.

Cooperative Information System - HR 15960 modifies the authority of the National Center for Health Statistics to permit research and demonstration projects relating to the design of a system for producing comparable and uniform health data at the Federal, State, and local levels. The NCHS has built a very effective cooperative network with States for collection of uniform vital statistics. Under the authority in this section, NCHS would refine and extend the data system to include other types of health data. Uniformity of data is so vital to successful planning at each level that this may be the most important single provision of HR 15960 as written. This proposed authority would allow the NCHS to provide leadership in a critical period in data system development. Without some form of coordination, the many approaches to data being undertaken by various agencies may lead to fragmented approaches that compromise the usefulness of the data.

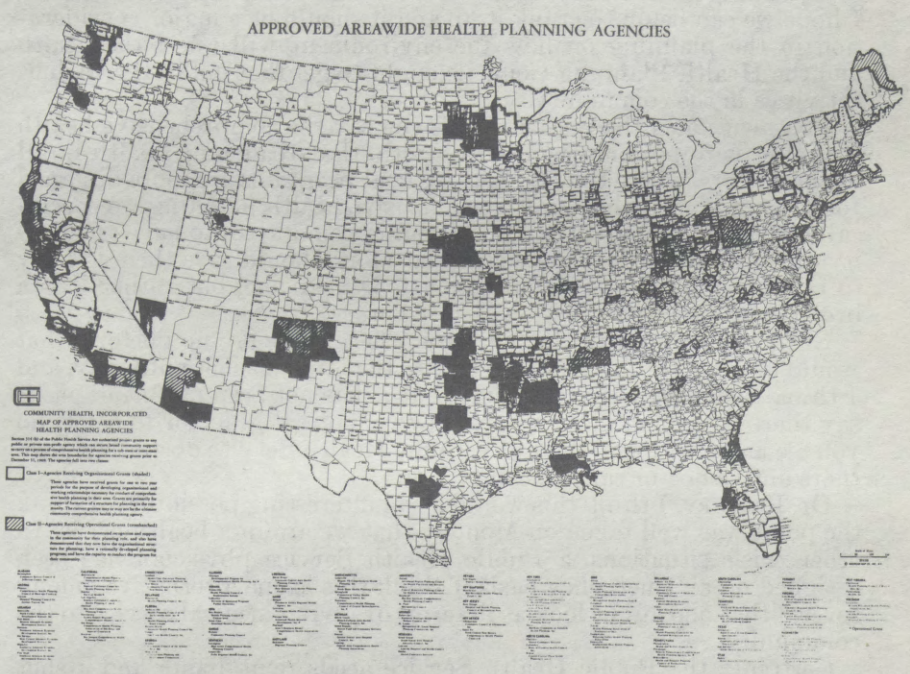
The proposed "Comprehensive Health Planning and Services Act of 1970", H.R. 15895, is the second bill I would like to discuss. It would extend--with slight modification--the existing authority for comprehensive health planning. In the present circumstances, this approach seems to offer major advantages in terms of consolidating the gains of the past three years, in allowing State and local program coordination to develop in patterns consistent with the traditions and motivations of each area, and in maintaining a broad approach to comprehensive health planning, encompassing the health aspects of environmental planning, and mental health planning, as well as personal health care services planning. In our view, it would be strengthened in these goals by addition of a National Advisory Council on Comprehensive Health Planning, incorporation of the joint funding language of H.R. 15960, and addition of the provisions of H.R. 15960 that relate to data systems development.

An additional area to which we hope the Committee might turn its attention is the role of comprehensive health planning agencies in planning for health aspects of the environment. In our view it is impossible to separate planning for the health aspects of environmental programs from planning for personal health services if we are to maintain an ecological perspective. Although those who have recently embraced ecology have a novices' tendency to simplify the conceptual tool as "concerned with the interface between man and his environment", ecology in the health sense involves looking at man and his environment as a continuous system. In this concept, a concern with the biological and pathological processes that underly the personal health services field is equally a part of ecology with the environmental contamination problems that are more often thought of in this regard.

Although many State and areawide health planning agencies have moved to incorporate a concern for health aspects of environmental programs into their planning, a clear statement of Congressional intent in regard to the broad scope of comprehensive health planning would seem particularly timely as national concern for ecology grows.

Thank you for the invitation to present these views before the Committee.

APPROVED AREAWIDE HEALTH PLANNING AGENCIES



Mr. JARMAN. You have covered a good deal of ground in a short period of time and we appreciate your giving us the benefit of your experience and comments on this legislation.

Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

Dr. Kimmey, we appreciate your coming here and your good advice. I agree with you, and I am concerned, too, about the down-play environmentally, the health factors of the environment in our planning and the fact that the response, as you mentioned was that they are going to wait until the ASH committee report comes up, I am not sure the committee is ever going to come up with anything, because we have been waiting on the ASH committee a long time in a lot of areas. So I hope we can begin to crank it up and it should be a major consideration in the planning on how the environment will affect the health and the Health Planning Councils ought to get that out to the various activities in the community.

You mentioned the reason—well, you say the comprehensive health planning is to be concerned with health, the broadening health in all of the factors, where the regional medical programs are more designed for the art of medicine. In Comprehensive health planning we specifically designed the advisory and planning committees to have a majority of consumers as members and that alone should give them the key to that. It is not just the specific art of medicine, but rather it is a broad health matter.

Now, you mentioned that in areas where there are no doctors what would be your feeling if we wrote into the law sufficient authority, and I think they may have it already, but it has not been used, and let us say there is a community where they cannot get a doctor to come, do you see an objection to having a Public Health Service doctor assigned there until a doctor can come in?

Dr. KIMMEY. I think this would be an interesting possibility. I think the point was well taken on Monday that we are in a health crisis. In other crisis situations, a Public Health Service physician has been assigned on an emergency basis. I think this is one alternative among several that one might look at in terms of giving medical service to the community.

Certainly the Public Health Service needs revitalizing and a shot in the arm. The morale is low. It might be that this kind of challenge to the corps would be very helpful.

Mr. ROGERS. I was hopeful that we could encourage them to use the medical corpsmen coming out and to tie them in with new career slots, I don't know why the Health Service cannot be used to develop these very effectively.

Thank you for your testimony.

Dr. KIMMEY. Thank you.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

Dr. Kimmey, I have just one question. Do you have any comment on the appeal mechanism as to whether it should come to the national level or whether it should be left to regional advisory groups?

Dr. KIMMEY. This is a question that was raised earlier. I will have to admit to prejudice on this, because I was, until 18 months ago, a regional health director for HEW and felt there could be significant

gains in terms of making our programs responsive to the public that lived in the area by having substantially increased regional administrative authority.

In terms of appeals on project grants, such as research grants and grants under the regional medical programs, I don't think this is a concern at this point in time. As I understand the review procedure for the RMP program, a demonstration project will be submitted to the regional medical program's regional level and the line goes from there directly to the regional medical program's headquarters in Rockville, Md. There is no intermediate stop at the regional office of HEW and never has been.

Whether, under the new regional organizations being proposed by HEW now, there will be a stop for RMP at the regional office or not, I don't know. We used to feel it would be important to have some overview of what is happening in terms of all Federal health programs, RMP, CHP, children's bureau, vocational rehabilitation, and so on. As you know, there are some 40 federally assisted health programs, some HEW and some in other Departments. We felt it was important at some level in the vertical line from the consumer in the community up to Washington that there be somebody closer to that consumer maintaining an overview of all Federal health dollars coming into the community. It does not exist now and none of the proposals we have seen here today would allow such a coordinative mechanism at this point in time. I think this might be important in terms of greater efficiency in terms of the use of these moneys at the community level. In response to the regional review question, I think in some of the project grant you do have an opportunity to appeal from a review of a regional body to a central body. This probably has some merit. The only question I would raise here goes back to the question that Mr. Rogers has raised before and that is, as politics gets more and more into the health aspects of Federal administration at all levels, it might distort the finding of a scientific panel if it were subject to review at the political level. This would be undesirable for scientists, who are really looking for the best possible review, the best possible projects, and the best possible expenditures for scarce research funds.

Mr. PREYER. Thank you, Doctor.

Mr. JARMAN. Thank you, Doctor, very much.

Dr. KIMMEY. Thank you, Mr. Chairman.

Mr. JARMAN. The next witness is Dr. Ivan F. Duff, University of Michigan.

Doctor, we appreciate your coming here.

STATEMENT OF DR. IVAN F. DUFF, PROFESSOR OF MEDICINE, UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Dr. DUFF. Mr. Chairman, gentlemen, I am an internist at the University of Michigan Medical School and I greatly appreciate the opportunity to appear before you today. I support broadening the scope and increasing the categorical identification in the regional medical programs.

In the language of the bill, in characterization of the phrase "major diseases," I recommend the explicit inclusion of "arthritis."

If my prepared statement may be filed for the record, I would like to summarize it.

Mr. JARMAN. Yes; your statement will be received in full.

Dr. DUFF. I make this recommendation because arthritis is the Nation's foremost chronic disease and No. 1 crippler. The statistics, as I presented elsewhere for you supporting this statement, are so overwhelming as to challenge perception.

The magnitude of the arthritis problem has never really entered the consciousness of the public.

This accounts, in part, for the fact that the arthritis victim gets the short end of the stick. He is shortchanged by a medical system that too often lacks appropriate orientation for treatment of chronic diseases.

The fact is, Mr. Chairman, that we can often bring about a favorable impact on the arthritic by utilizing contemporary forms of medical and physical agents and social support. The only way, however, that we can make full delivery of our present knowledge to these patients is through comprehensive and continuing care. What is required is giving urgent priority to fostering change in our health care system that will bring proper treatment to every patient who has arthritis and yet it has not been done. America, the most health-conscious nation in the world, is almost entirely without comprehensive programs necessary for treating arthritics.

In 1965, a surgeon general workshop urged that facilities for the diagnosis and treatment of arthritis be maintained, improved, and created and according to geographic population and community needs. Initiation was urged of a full-scale attack on arthritis that would reflect a real national commitment.

The 90th Congress, in translating into action its concern for the burden of arthritis and in endorsement of the demonstration concept as a method of attacking the problem, made an appropriation of $500,000 for a single, pilot arthritis demonstration center.

This appropriation was to the National Center for Chronic Disease Control, Diabetes and Arthritis programs. The availability of these funds on a competitive basis was announced early in 1969. On June 18, just about a year ago, the Public Health Service announced the center would be located in Michigan. On June 30, the contract negotiated between the regents of the university and the Public Health Service was signed.

The next day, the program, of which I have been the director, was activated, utilizing in a collaborative approach, the resources of the University Hospital at Ann Arbor and the Henry Ford Hospital in Detroit. Though the contract was for 1 year, there was a moral commitment for 5 years of support.

Not long after this program was initiated, evidence became apparent that it was in jeopardy. Background to this was the joining of the Division of Chronic Diseases with the Division of Regional Medical programs.

In September 1969 the announcement was published that budgetary restrictions made it necessary to phase out the activities of five of the chronic disease programs, including diabetes and arthritis. The Appropriation Committees, in restoring cutbacks in the 1970 HEW ap-

propriations for the chronic disease control program, indicated that it was disturbed by the proposals of the Department.

Being unable to accede to the elimination of ongoing chronic disease control programs of demonstrated value, the Appropriations Committee added $4 million to maintain these programs at their previous operating level and, furthermore, earmarked the funds so they could not be used for other purposes.

Eventually, of course, the bill was signed, but within a month it became apparent that the administration was unwilling to allow the funds appropriated to be utilized. This has been recently confirmed by the office of the regional medical programs with the statement that—

> The impact of the Revenue and Expenditures Control Act, which precludes our using 1970 chronic disease funds for these purposes, leaves us incapable of providing the continuing dollar support required for the pilot control program in Michigan.

The 1971 budget, as you know, eliminates all sources of chronic disease funds and positions for five of the operating programs, including arthritis and diabetes.

A further difficulty has been presented by challenging the legitimacy of supporting arthritis by regional medical service funds. In September, Dr. Stanley W. Olsen, then director of the regional medical program, stated that arthritis is not supportable under the current authorizing legislation.

Mr. Chairman, on the basis of the tribulations of this country's pilot arthritis control program in Michigan, and as friend of the arthritic, may I conclude as follows:

I would strongly recommend the explicit inclusion of "arthritis" in the language of the amendment of title IX. If it is appropriate, I would hope that this committee could recommend restoration of the second year of funding of the Nation's pilot demonstration arthritis control program in Michigan at the level originally contemplated and for 3 additional years.

Finally, in extending the regional medical programs through fiscal 1973, I strongly urge language which would establish additional arthritis control programs within the regional medical program service and the assurance of their continuity and adequate funding.

Thank you.

(Dr. Duff's prepared statement follows:)

STATEMENT OF IVAN F. DUFF, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Mr. Chairman, I am Ivan Duff, a Professor of Medicine at the University of Michigan Medical School. I greatly appreciate the opportunity today of appearing before the Committee. I support increasing the categorical disease identification for the Regional Medical Health Programs Service. I recommend the explicit inclusion of arthritis in the scope of "major diseases."

The "arthritis" problem is in reality a collection of the ramifications of several disease processes, all of which are in some way related to alteration in the structure and function of joints. The major diseases are rheumatoid arthritis, osteoarthritis and gout; but present day classification includes over 20 other illnesses in which joints may be and are often involved.

Unlike heart disease, stroke, cancer and kidney disease, the major forms of arthritis do not usually kill people. To the contrary, arthritis maims—it cripples and usually for life. The impact of each of these chronic diseases upon our

citizens is staggering. Bluntly stated—arthritis is the nation's foremost chronic disease and number one crippler.

The statistics are so overwhelming as to challenge perception; for some reason or other the magnitude of the arthritis problem has not entered the consciousness of the public.

Some 40 million Americans, or one in every five, have radiologically identifiable arthritis.

Almost 17 million persons in the United States are painfully aware of the disease with symptoms severe enough to need treatment.

As many as five million have rheumatoid arthritis.

3.3 million arthritics are limited in their ability to work, keep house or engage in scholastic activities; ten percent of all arthritics are homebound or unable to move about without assistance. At the lowest income level—less than $2,000 a year—seven times as many persons have arthritis severe enough to restrict daily activities as do persons having an annual income of $7,000 or more.

In wage losses, medical care costs, welfare and other support payments, the total annual cost of arthritis to our national economy is conservatively estimated to exceed 3½ billion dollars annually. Affliction of the wife and mother with these diseases and the resultant loss of homemaking services alone, costs the economy approximately $600 million dollars. In America there are 200,000 arthritics less than 25 years of age. The problems of long-term disability facing the family of the afflicted child and dependence are staggering.

Dr. William S. Clark, President of the Arthritis Foundation has stated the problem this way. "In America's health care system, the arthritis victim gets the short end of the stick. The poor with arthritis get the worst deal of all." Its victims are shortchanged by a medical system that is oriented to treating acute, not chronic disease.

"For the victims of stroke, cancer, heart and kidney disease and for the arthritic, there is no crisis treatment that dramatically reverses the illness. There is no sure return to the former condition of being well. The arthritis comes and often stays for years or forever.

"To treat this kind of disease, three requirements have to be met: treatment measures have to be employed to avert or limit the disease's impact or reduce disability; secondly, the treatment must continue indefinitely and thirdly, the victim must be assisted to live successfully with any damage that may ultimately prove to be unavoidable or irreversible.

"The aim of treatment is to keep him in society and in the working world. . . . What is needed to give this kind of care is a coordinated team of different specialists and facilities all working together *on each case* to provide long-term treatment. . . . The only way that we can make full delivery of our present knowledge to arthritis victims is through comprehensive care. . . . We would not have to revolutionize our system of medicine or invest tremendous sums in a new physical plant to create comprehensive care programs for arthritis. We could do it with our present plan and our present personnel." What is required is ". . . giving urgent priority to fostering changes in our health care system that will bring proper treatment to every patient who has arthritis.

"And yet it has not been done. America, often called the most health-conscious nation in the world, is almost entirely without the comprehensive programs that are necessary for treating arthritis. Because we do not have these programs, millions suffer who should not have to suffer, and millions are crippled and disabled who *could* stay in society and lead normal, productive and happy lives."

Current information indicates that total disability and crippling from arthritis can be reduced by the intelligent application of contemporary forms of therapeutic management. A 1967 study indicated that each $1 spent in an all-out program to attack arthritis could save the government $40 in terms of taxes generated and reduced health costs. The knowledge, techniques and drugs currently available, if correctly applied, can extend the working lives of rheumatoid arthritics by five years; victims of gout and osteoarthritis could gain at least one year of productive working time if current methods of treatment were broadly applied. (8)

In 1965 a Surgeon General's Workshop on Prevention of Disability urged that facilities for the diagnosis and treatment of arthritis be maintained, improved and created according to geographic, population and community needs. Initiation of a full-scale attack on arthritis that would reflect a real national commitment was urged; it was recommended that a substantial portion of Federal grants be earmarked for comprehensive community service programs for the arthritic.

The original recommendation visualized the establishment of a network of arthritis centers and satellite clinics. In the thinking behind the demonstration concept as a method of attacking arthritis, there was visualized the establishment and support of nine exemplary care centers for the prevention and/or control of crippling from arthritis to be distributed in each Public Health Service District. It was further visualized that each of these centers would eventually establish and support secondary arthritis service clinics which in turn would put to use the knowledge and competency acquired at the Center by the practicing physician and allied professional personnel. They would also act as a focal point for community programs of coordinated service and continuing care for the arthritic.

The 90th Congress in 1968 in translating into action its concern for the burden of arthritis, made an appropriation of $500,000 for a single arthritis demonstration center program to the National Center of Chronic Disease Control (Diabetes and Arthritis program) for the first year of a planned five-year program. The availability of these funds on a competitive basis was announced on January 13, 1969; on June 18 the Public Health Service announced the center would be located in Michigan. On June 30, the negotiated contract (Appropriation 759032; Contract HSM–110–69–417) was signed; on July 1, 1969 the contract was activated in force; protocol design was gotten underway and the nuclear staff assembled; on September 8 the first patient was entered into the program. As an addendum to this testimony there is included the complicated legislative history of the Center which documents its very precarious existence.

Forced phase-out of the program is to begin July 1, 1970. The combined impact of the Revenue and Expenditure Control Act which precludes using Fiscal Year 1970 Chronic Disease funds for those purposes and the Fiscal Year 1971 Administration Health budget which omits any funds for chronic diseases leaves the Public Health Service incapable of providing continuing dollar support for the Regional Arthritis Control Program in Michigan. An additional constraining influence has been lack of legitimacy, under existing legislation, for use of Regional Medical Program Service funds to support arthritis projects.

As Director of the country's first demonstration Arthritis Control Center I should like to briefly explain the work being done in Michigan and indicate our plans for the future, the achievement of which was contingent upon firm incorporation of our Program into the Regional Medical Program to be assured of a degree of continuity and adequate funding.

Our program is essentially a long-term research and development project in the delivery of health services to patients with the major forms of arthritis and related diseases. Its principal objective is to make certain that arthritics shall secure high quality health care; furthermore it provides for an analysis of cost-benefits in accordance with the concept that efficiency of delivery of health services must be done at a cost which bears a reasonable relationship to the benefits received.

The major goals of the Program are:

(1) The initiation of a demonstration that crippling from arthritis can be prevented, delayed or reduced by a method of delivery of medical care which provides for early diagnosis, comprehensive evaluation of the patient's total problem, efficient and knowledgeable use of today's treatment measures, and provision for continuing medical and social support. We have on board a multi-disciplined team of physicians, physical therapists, occupational therapists, public health nurses, social workers, counsellors in vocational rehabilitation and behavioral scientists, the skills and talents of whom are integrated to focus on the problems of the individual arthritic;

(2) To improve and expand the existing capacities in the four participating hospitals, i.e., University Hospital, Wayne County General Hospital, Henry Ford Hospital, and the Ann Arbor Veterans Administration Hospital, so as to provide optimum, comprehensive, continuing and exemplary care for adults and children with arthritis;

(3) To exert a greater degree of beneficial influence on the medical care received by arthritic patients in Michigan and adjoining geographical areas served by the participating institutions; a major mechanism for achieving this goal is close cooperation with the statewide Arthritis Consultation and Teaching Clinics sponsored by the Michigan Chapter of the Arthritis Foundation;

(4) To translate available advances in clinical rheumatology into productive educational programs for medical students, resident and practicing physicians, allied professional paramedical personnel, including nurses, social workers, physical therapists, occupational therapists, etc.. as well as the general public;

(5) To (eventually) assist state, regional (sub-state) and local health planning-action councils establish the best care for arthritics in their respective health care plans, and to establish and coordinate secondary and local arthritis care centers either within existing hospitals, as separate units or as part of comprehensive health care centers.

In Michigan there are already existent resources which make achievement of these objectives within our grasp.

The Michigan Chapter of the Arthritis Foundation (the President of which is a co-director of the Arthritis Control Program) has for several years sponsored statewide network of Arthritis Consultation and Teaching Clinics. These provide the Arthritis Control Program with a vehicle to pass on to practicing physicians and allied health professionals up to date information concerning the management and integration of care for arthritics. These clinics, located in eleven suitable cities in Michigan, represent a tremendous potential as locale for the development of satellite or regional arthritis clinics. They have been located on the basis of populations and geographic dispersion. They demonstrate, too, the active participation existing between the Arthritis Control Program and a volunteer health agency. The Michigan Chapter of the Arthritis Foundation subsidizes these Clinics in the amount of $60,000 per year.

For the design and success of this program of delivery of health services to arthritics, we combine the hospital and staff resources of the Arthritis Control Program, located in the area within which reside two-thirds of Michigan's population, the valuable resources within the University of Michigan's School of Public Health and the seven established out-state Arthritis Consultation and Teaching Clinics supported by the Michigan Chapter of the Arthritis Foundation. These clinics function within the setting of 12 community hospitals.

In the 10 months that this program has been in existence definite progress has been made toward the original objectives. In the two major participating institutions, the project has been staffed by gathering together a 32 man multidisciplined team, the talents of which are integrated to focus on the problems of the individual arthritic. There has been meaningful cooperation and working together of physicians, paramedical personnel and professionals in the University of Michigan's School of Public Health especially concerned with epidemiology, public health economics, community health services, evaluation of program effectiveness, biostatistics and program analysis. We have demonstrated that this method of delivery of medical care can work and that arthritic patients can be successfully enrolled into the program.

As was mentioned earlier, phase-out of this program is now required by circumstances which we have not been able to alter.

CONCLUSIONS

Mr. Chairman, I should like to conclude with the following recommendations:

1. I recommend the explicit inclusion of arthritis in the scope of "major diseases" in Title IX of the Public Health Service Act.

2. In extending the regional medical health programs through fiscal year 1973 I strongly urge that additional Arthritis Control Programs be established within the Regional Medical Programs Service and be assured of continuity and adequate funding.

3. I specfically urge resumption of funding of the country's pilot demonstration Arthritis Control Program in Michigan at the level originally contemplated: $500,000 for the first year and $543,000 for each additional year for a total of five years of Federal support.

Thank you.

IVAN F. DUFF, M.D.
Director, Regional Arthritis Control Program in Michigan.

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8. Correspondence, from Harold Margulies, M.D., Acting Director, Regional Medical Programs Service, received March 30 and May 20, 1970.
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ADDENDUM

The legislative history of the Arthritis Center documents its precarious existence to date.

In September 1968 the Division of Chronic Diseases was joined with the Division of Regional Programs to form the Regional Medical Programs Service.

During Fiscal 1970 budgetary restrictions made it necessary to phase out the activities of five of the eight chronic disease programs, including diabetes and arthritis. The Health Services and Mental Health Administration, in arriving at its allotment of the overall reduction made its recommendations on the basis of its own priorities.

The House of Representatives struck the $24 million in the 1971 HEW Appropriation for the Chronic Disease Control Program; the Senate, in restoring the cut, indicated that it was disturbed by the Department's proposal to make a $4 million reduction in chronic disease control programs. Being unable to accede to the elimination of chronic disease control programs of demonstrated value, the appropriation Committee added $4 million to maintain these programs at their previous operating level and, furthermore, clearly earmarked the funds so that they could not be used for any other purpose. The House accepted the Senate figure. Then came the President's veto.

On March 4, 1970, the House accepted the Senate amendments to the second House bill after the veto, including the amendment dealing with the mandatory authority allowing an overall reduction of two percent in the total amount of this bill, which the President later signed into law.

As of this date we are informed by the Regional Medical Programs: "Unfortunately, the combined impact of the Revenue and Expenditure Control Act which precludes our using FY 1970 Chronic Disease funds for these purposes and the FY 1971 Administration Health budget leaves us incapable of providing the continuing dollar support you require. The FY 1971 budget eliminates all sources of Chronic Disease funds and positions for the five operating programs of Heart Disease, Chronic Respiratory, Neurological and Sensory, Diabetes and Arthritis, and Cancer."

The legitimacy of supporting Arthritis by Regional Medical Program Service funds is discussed as follows by the former Director of that program, Stanley W. Olson, M.D.: "At the present time, however, we are faced with the dilemma that Arthritis is not supportable under the current legislation authorizing Regional Medical Programs. That legislation will be up for renewal prior to 30 June, 1970 and there is some indication that the categorical restrictions which limit the program to Heart Disease, Cancer, Stroke and related Diseases may be removed. It is possible, therefore, that what is not supportable in the current fiscal year may be supportable a year from now."

Mr. JARMAN. Thank you for your testimony, Dr. Duff.

The committee is very acutely aware of the arthritis problem in

the country and your recommendations will be given very careful consideration.

Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

Dr. Duff, I am very much impressed with your presentation. How many people do you think, by estimate, are effected by arthritis?

Dr. DUFF. 13 million people are estimated to have some form of arthritis or joint disease in this country.

Mr. ROGERS. How many chronic, would you say?

Dr. DUFF. I would think of that figure, that 5 million people have chronic rheumatoid arthritis, which is the greatest challenge of all, and over 250,000 of those are estimated to be under the age of 25.

Mr. ROGERS. Under the age of 25?

Dr. DUFF. Yes.

Mr. ROGERS. What about manpower? What is the manpower problem here? Just give it to us quickly.

Dr. DUFF. There is a very definite need for increasing numbers of qualified physicians and paramedical personnel in this field.

Mr. ROGERS. Could you let us have it for the record and you could supply it later.

Dr. DUFF. Yes, I will supply it later.

Mr. ROGERS. If you could, please do so. Tell us also what is being done or should be done in the area.

(The following letter was received for the record:)

REGIONAL ARTHRITIS CONTROL PROGRAM IN MICHIGAN
Ann Arbor, Mich., June 4, 1970.

Hon. PAUL G. ROGERS, M.C.
Room 2417, Rayburn Building, Washington, D.C.

DEAR REPRESENTATIVE ROGERS: Yesterday, at the conclusion of my testimony at the public hearings held by the Subcommittee on Public Health and Welfare, you asked to be provided with an estimate of what increase in manpower would be required to meet the challenge of the arthritis problem and what it would cost. I agreed to try and provide you with some information.

The fact is, Representative Rogers, that the manpower needs to do the whole or a part of the job are not known.

In respect to this, the 1965 Surgeon General's Workshop on Prevention of Disability for Arthritis concluded: "The recruitment, support and training of both medical and allied health professionals is inadequate. The sparse or nonexistent training in rheumatic diseases in the curricula of schools for associated professional personnel—contributes, substantially, to the present desperate shortage of physical therapists and to the scarcity of other health workers—all of whom should be instrumental in providing optimal care and education for arthritics. Because recruiting success is, in the end, largely dependent upon the excellence of education and training programs, the great need is for programs with the kind of built-in appeal that attracts medical students, well-trained physicians and associated professional personnel. For this reason exemplary, comprehensive care centers should be established in conjunction with medical schools. These centers would be multi-categorically oriented, but would focus on arthritis as a prototype of chronic disease."

Report of a cost benefit analysis of a control program in arthritis was prepared by Dr. Allan Wolfe in 1966 at the direction of the Secretary of Health, Education and Welfare. Amongst the areas of approach to arthritis in which critical gaps exist, various corrective programs were suggested. In regard to these it was commented that sufficient hard facts were lacking on the basis of which to warrant an all-out massive attack on the arthritis problem. What was obviously needed was an arthritis control program with a substantial pay-off, the cost of which would be modest, and which would provide for the accumulation of data upon which to make subsequent decisions.

Highest priority was given to a seven year arthritis program whose objectives were:

I. To establish and support nine centers for the prevention and/or control of crippling from arthritis:

A. To demonstrate the essentiality of early diagnosis and early treatment to prevent crippling.

B. To provide excellent continuing education in arthritis for practicing physicians.

C. To provide support in clinical research for long term studies evaluating different therapeutic regimens in relationship to prevention of crippling.

D. To provide excellent postgraduate training of allied professional personnel.

II. To establish and support 180 secondary Arthritis Service Clinics.

A. In which practicing physicians and allied professional personnel would put to use the knowledge and competency acquired at the center.

B. To act as a focal point for community programs of coordinated service and continuing care for the arthritic.

The nine centers established in the first year were to be federally supported for 5 years; through this program it was estimated that the following personnel would be trained:

112 Clinical fellows, 1800 Physical therapists, 1800 Private physicians, 1800 Occupational therapists and 1800 Nurses.

In all, 7312 medical and paramedical personnel would have been trained in the techniques of arthritis treatment. In these centers and their secondary clinics, it was estimated 56160 new patients would have been seen.

An arthritis center, it was estimated, would cost $725,480 the first year of operation and $768,480 each additional year. During the first year of operation, the nine centers would have cost a total of $3,264,660; in each additional year the total would be $6,529,320. The total cost of 5 years of federal support was to have been $30,542,940.

As I stressed yesterday, the 90th Congress in translating into action its concern for the burden of arthritis, and in endorsement of the demonstration concept as a method of attacking the problem, made an appropriation of $500,000 to the National Center for Chronic Disease Control, Diabetes and Arthritis Programs, for a single arthritis demonstration center program.

The pilot program in Michigan is a collaborative project between the University's Arthritis Division (Medical School), School of Public Health and the Arthritis Division, Henry Ford Hospital. There are as of this writing 35 professional persons concerned with this project. In my detailed testimony I described the goals and achievements in the first 10 months of the program. We have, I believe, made good progress in moving toward the objectives for which we made a commitment.

The contract negotiated between the Regents of the University and the Public Health Service was for 1 year; there was a clear commitment however, for 5 years of support.

Representative Rogers we have been caught in two traps. The one is represented by the impact of the Revenue and Expenditure Control Act which obstructs the clear intent of Congress to maintain chronic disease control programs, as the one in Michigan, at the previous operating level, 1970–1971. I believe it has now become apparent that there is no reasonable possibility of continuing federal support after July 1, 1970; we are seeking permission to utilize uncommitted funds which will hopefully carry us through August 31; the light of this, however, I am forced to begin phase-out of the program as of July 1, 1970.

The other trap exists because of circumstances whereby the Michigan program eventually came to be located within the Regional Medical Program Service. This office argues that it cannot support arthritis under the current authorizing legislation. My prime reason in testifying Sir, was to urge that the term "arthritis" appear somewhere in the legislative history of HR–17570 and HR–14486. The clear intent that these funds were to be available to support arthritis control programs would thereby be established and this obstacle removed to the establishment of future arthritis control programs.

Representative Kyros commented, in the light of limited monies, upon the necessity of giving support of arthritis less priority than heart, cancer and stroke. As a physician, I would agree that arthritis does not kill; it does, however, result in an unacceptable degree of dependency and it costs the national economy 3.5 billion dollars annually. I should have referred to some of

the statistical details appearing in my testimony, namely that in the United States 3.3 million arthritics are limited in their ability to work, keep house or engage in scholastic activities; 10% of all arthritics are homebound or unable to move about without assistance.

Representative Rogers, I appreciated your courteous attention to my testimony. It is a pleasure to provide you with this additional information as you requested. I hope that it serves your needs.

Sincerely yours,

IVAN F. DUFF, M.D.,
Director, Regional Arthritis Control Program in Michigan.

Mr. ROGERS. Now, how much money will it require to carry on an adequate program here, do you think?

Dr. DUFF. The program, of which I have been director, was supported at a level of $467,000 for the first year. I would recommend that there be funding so that there could be an additional three such programs started elsewhere in the country.

Mr. ROGERS. What gains have been made? Are you now being able to actively treat and relieve such diseases?

Dr. DUFF. Yes, indeed. Ours is a collaborative program between not only physicians and paramedical personnel, but also experts in our School of Public Health who are interested in medical economics. A very important part of their contribution to the program is to prepare an analysis of costs versus benefits.

In the 10 months that our program has been functioning, we have demonstrated that these rather diverse groups of people can work together. A substantial number of men, women, and children are being actively and effectively treated.

Mr. ROGERS. Yes; what about actual medical gains in treatment? Have there been advances?

Dr. DUFF. Yes, sir; I believe we have demonstrated that patients can be incorporated into such programs and that the approach in delivery of medical services to these people can pay off.

Mr. ROGERS. Well, now, the administration is not continuing your program; is that it?

Dr. DUFF. That is right. I am faced with the rather dismaying job at the moment of phasing out this program.

Mr. ROGERS. What is your time element? When would you need additional funds?

Dr. DUFF. We have some funds that remain that would allow us to continue the program at its present level for 2 months.

Mr. ROGERS. Two months?

Dr. DUFF. Yes. My hope in appearing before you today is that you could, by including "arthritis" in the bill's language, make it legitimate to support this form of chronic disease. If this could be done in the ensuing time perhaps other sources of funds could be found to keep our program going. In the ensuing years, hopefully, renewal of Federal support could be arranged.

Mr. ROGERS. Thank you.

Dr. DUFF. Thank you, sir.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. I have no questions, thank you, Mr. Chairman.

Mr. JARMAN. Mr. Kyros?

Mr. KYROS. I have just a couple of questions, thank you, Mr. Chairman.

Of course, one of the problems in a regional medical program is the attempt to catch the chronic diseases which can be fatal unless we act on them, particularly in rural areas; isn't that correct?

Dr. DUFF. I would quite agree with you.

Mr. KYROS. And with only so much money to go around, although arthritis certainly is a major disease, it could not come ahead of heart, cancer, and stroke and kidneys or lungs, could it?

Dr. DUFF. I think the concept that arthritis does not kill people in general is true. But the fact is that, as a cause of disability in this country, it is No. 1 after heart disease.

Mr. KYROS. And you said 13 million people are affected?

Dr. DUFF. Yes; with some type of joint disease.

Mr. KYROS. Well, how much money would you require appropriated in the regional medical programs, for example, in H.R. 14486, in order to bring arthritis within the scope of the program, do you know?

Dr. DUFF. I am not prepared to answer that question at the moment. I believe the approach that was visualized in the demonstration center concept is a realistic one and I would recommend funding to allow three additional programs be established in the country.

Mr. KYROS. If there were a choice between arthritis, lungs, or kidney ailments being included, or between those three, which one would you choose as a priority if there were limited funds?

Dr. DUFF. If there were limited funds on these three diseases, I could agree.

Mr. KYROS. Kidney and lungs?

Dr. DUFF. And cancer.

Mr. KYROS. There is no question in my mind arthritis is a crippling thing and I know somebody that has been playing paddle ball, about 45 years old, real hard with the right shoulder and it can cripple you—that is me actually. I just worry if we get just so much money to go around, what priority we must give.

I say this to you truthfully because I am in agreement with you and I have seen a lot of workers in my State of Maine, in rural areas, whether it is fingers, elbows, knees or shoulders, there is nothing more horrible than a man old and crippled with arthritis and I would like the program extended to that, but I think we must realistically examine how much money we are going to have this year and it is going to be a very, very hard puzzle.

I commend and support the statements you make, but I want you to know I think the problem is going to be money and it is your job to get back out into the country and turn on everybody in every single State on arthritis for us.

Dr. DUFF. The tragedy is most of our efforts to do so have been frustrated.

Mr. KYROS. How?

Dr. DUFF. By nonavailability of funds that will let us continue into the second year of our projected plans.

Mr. KYROS. I wish I could tell you right now something that would be helpful, but I am sure the gentleman from Florida, Mr. Rogers, who was instrumental in beginning the program and who has tried to include other programs, will try to do somehting, as well as the chairman.

Dr. DUFF. Thank you sir.

Mr. JARMAN. In the treatment of arthritis, is it still almost a matter of trying to arrest or alleviate?

Dr. DUFF. Yes.

Mr. JARMAN. Are you actually making progress in the sense of a cure for the disease?

Dr. DUFF. Mr. Chairman, you are entirely correct. For these chronic diseases, per se, there are no cures. The approach is, and hopefully early in the disease, to alleviate and to halt the basic inflammatory process; we do have measures of considerable value in allowing us to do that and in allowing us to proceed with rehabilitation so that the person with arthritic conditions can get back into the mainstream of life.

Mr. JARMAN. Thank you very much, Doctor.

The next witnesses are four gentlemen who constitute a panel on the regional medical program: Dr. J. Gordon Barrow, director of Georgia regional medical program, Atlanta, Ga.; Judge Stephen L. Maxwell, St. Paul, Minn.; Dr. H. Phillip Hampton, Tampa, Fla.; and Dr. Billy D. Dotter of Okeene, Okla.

Gentlemen, we are pleased to have you with us this morning. The committee will be glad to receive your statements for the record.

You may proceed in any order you have in mind.

STATEMENTS OF DR. J. GORDON BARROW, DIRECTOR, GEORGIA REGIONAL MEDICAL PROGRAM, ALSO REPRESENTING REGIONAL MEDICAL PROGRAM DIRECTORS; JUDGE STEPHEN L. MAXWELL, CHAIRMAN, REGIONAL ADVISORY GROUP, NORTHLANDS REGIONAL MEDICAL PROGRAM, INC., ST. PAUL, MINN.; DR. H. PHILLIP HAMPTON, TAMPA, FLA.; AND DR. B. D. DOTTER, OKEENE, OKLA.

Dr. BARROW. Thank you very much.

We will submit our full statements for the committee's consideration and limit our comments to a short summary.

I am Dr. J. Gordon Barrow, director of the Georgia regional medical program since inception and I am also representing here today all of the 55 directors of the regional medical programs in that I speak for them and have been authorized to speak for them in what I say today.

I do not feel I have to justify the extension of RMP to you. We included information about that in our statement and we assume you agree it should be extended for at least 3 years. We feel that the authorization level for the extension should be at $150, $200 and $250 million. We feel this will be adequate, considering the present fiscal situation that the country is in.

We feel that the categorical emphasis should be maintained, Mr. Chairman. We feel that the combination of RMP and CHP, and the other two programs into a single program with a single council would be disasterous at this point. We feel strongly that we have a strong appeal to the voluntary sector of medicine by reason of this categorical emphasis and would like very much to see this kept.

We do not object to seeing other diseases, such as kidney disease, included in this, as you see fit. We feel that the National Council has

been very important in the determination of the processes under which the regional medical program has operated and we feel this should be kept as a single national council for regional medical programs.

Now, if the Secretary wishes a larger council to advise him and coordinate, we have no objection to it, but we feel the RMP council should be kept.

We feel that construction authority, which has been testified to already today, probably would not be wise at this point, The coordinators are very aware of the need for construction in some of these areas. There is no question about this. We do not at this time feel that we have the staff or the competence to administer a construction program of any magnitude and we do not feel that now is the time to include this type of authorization in our bill.

We would like to comment on the contract authority that is mentioned in one of the bills. We feel this may be an important mechanism, but you will have to realize that the granting mechanism should be the keystone of regional medical programs and if contract authority is granted, we would ask it be limited to no more than 5 percent of the total of the funds available for the grants mechanism of RMP in order that the local determination of priorities shall continue to be the motivating force behind the RMP's in this country. We think this is very important.

The review process, of course, is undergoing some present modifications. The administration is now allowing development of what is called "developmental awards" to the regions which gives us authority to get awards from the National Council of up to 10 percent of our current awards for developmental purposes, without having to come back to Washington every time we want a new grant under that, so this is giving us a considerably greater leeway in rapid turnover of projects.

This will allow us to cut the review mechanism from about a year, as it is now, down to about 3 months, which will be very effective, I think, in helping us to keep interest at the local level. We are afraid, if the review and comment by CHP that has been proposed by several of the bills is kept in, this will delay the review process. And while we are trying to do everything to shorten it, we think this would be bad.

I personally feel that this relationship with CHP should begin long before it is a finished project. We feel it should begin in the beginning plan of the project and continue throughout the planning for the project and the review and comment, if it is done that way, is not necessary. Most of us are doing it that way now and do not feel that the review and comment is appropriate.

One other comment, and I will turn it over to my compatriots here, the joint funding provision of section 943 of H.R. 15960, the administration bill, is probably one that should be included. We have found considerable difficulty in arranging joint funding of projects with several Federal health agencies because the guidelines of each agency are different and it is hard to meet the guidelines of each of these.

This particular section will allow us to jointly fund a project using the guidelines of one of the agencies involved and I think this would be a good thing, Mr. Chairman.

Thank you very much for allowing this brief statement.

(Dr. Barrow's prepared statement follows:)

STATEMENT OF J. GORDON BARROW, M.D., DIRECTOR OF GEORGIA REGIONAL MEDICAL PROGRAM AND CHAIRMAN OF NATIONAL RMP COORDINATORS STEERING COMMITTEE

As Chairman of the National Steering Committee of Regional Medical Program Coordinators, I represent the majority views of the 55 RMP Directors who have the primary responsibility for administering the Heart, Cancer & Stroke legislation at the local level on a day-to-day basis. We appreciate this opportunity to present our views concerning the extension of this legislation.

Experience to date leads us to be enthusiastic concerning the accomplishments and future potential of the Regional Medical Program. All but 2 regions are now operational and the core staffs that have been employed across the country represent an exceptionally talented group of health professionals.

During the past 3 years the unique ability of RMP to develop effective cooperative arrangements between medical schools, community medical institutions and organizations and health professionals for the purpose of higher quality and better organized health care in the categorical diseases has been demonstrated.

For instance, in the area of coronary disease, with which I am most familiar since I am a cardiologist, more than 25,000 patients have been treated in coronary units supported in part by the various regional medical programs. It is estimated that this activity above has resulted in the saving of more than 2,000 lives this year. In cancer, approximately 46,000 persons have been screened for one kind of cancer or another through projects funded by RMP. Information available pertaining to screening and detection indicates that about 90 abnormalities are found for every 1,000 persons screened. It can be estimated therefore that more than 4,000 unknown cancers have been detected. Most of these are early and can be cured. In stroke, New Mexico RMP is involved in a stroke rehabilitation project which utilizes an innovative visiting team approach. The major efforts here are concentrated on encouraging community hospitals to develop rehabilitation programs with guidance and supervision from the stroke team. To date 200 stroke patients in hospitals, nursing homes, and outpatient clinics have directly benefitted from the teams' efforts. Many other regions have developed similar programs. In my own region we are asserting groups of smal rural hospitals, which have never offered rehabilitation services, to enter joint agreements sharing the services of a physical therapist. More than 140 patients have received rehabilitation services near their own homes during the past 4 months as a result of this program.

One very important facet of many RMP operational activities is the indirect results and benefits flowing from them. An excellent example of this "spin off" phenomenon is the coronary care network established with the financial and other assistance of the North Carolina RMP.

The direct and immediate beneficiaries to date have been the 300 patients who received coronary care service in the isolated Appalachian Region of Western North Carolina known as the State of Franklin because they had available to them a newly established network of coronary care units, including 13 monitored beds, located in 8 hospitals. These small hospitals—all are under 50 beds—are linked to each other and to the Bowman Gray School of Medicine by telephone lines for transmission and analysis of EKGs, as well as for other types of immediate consultation. Supported by physicians and nurses recently trained in modern coronary care techniques, as well as two mobile intensive coronary care ambulances with drivers trained in cardiac resuscitation techniques, this experimental program is beginning to show results; preliminary data reported by the region indicatees a 67% reduction in mortality from acute myocardial infarction, as well as overall improvements in the handling of shock patients from ambulance to emergency room. In addition, the feelings of professional isolation have been diminished because of the communications hookup with Bowman Gray.

This coronary care network and activity, moreover, appears to have had considerable indirect effect and impact. Many of the physicians in the area are increasing, where indicated, referrals of patients to the one cardiologist in the area, Similarly the eight small hospitals are beginning to think in terms of some degree of differentiation and division of labor in fields other than coronary care, since clearly no one of them can be truly self-sufficient. Thus, the hospital which has the services of the area's only physical therapist is becoming the locus for physical therapy and rehabilitation services for all. Several years ago all of the hospitals were threatened by the possibility of non-accreditation. Now there is the definite prospect that they will receive a joint accredi-

tation by the AHA as a "single" hospital. There is little question in the minds of the physicians and hospital administrators in the area that these developments will help raise the level of care and make that care generally available to all the people throughout the State of Franklin; and that this has been aided and abetted in great measure by the efforts of the North Carolina RMP and the coronary care network which it helped to establish in that area.

Because of this and similar examples across the country, the coordinators feel that the potential of RMP is for even greater effectiveness in the future.

When all is said and done everything hinges upon the involvement of people and their commitment to do certain things. We have been able to develop this commitment through RMP largely because of the local control that the Regional Advisory Group in the regions have had over the expenditure of the money. The recent decision by the RMP Service to award "Developmental Component" awards to the regions of up to 10% of the previous year's funding will allow even more flexibility. The decisions on how this money will be spent will be made entirely at the local level, thereby not requiring the review in Washington prior to the awards. This will reduce review time and enable us to make an award within three months instead of a year as is now the case.

This involvement of people in our Program is essential to its success. For the first time in a federally-funded health program the private sector (including both health professionals and institutions) is not only deeply involved in RMP but is committed to a future role in improving the quantity and quality of the Health care delivery system. For example, we in Georgia take pride in the fact that the physicians of our state through the Medical Association of Georgia took the lead in the formation of the Georgia RMP and today it acts as our fiscal agent in the expenditure of funds. Like most mature regions, we have a Regional Advisory Group which is broadly representative of all health interests of our region; we have Local Advisory Groups of physicians, nurses, administrators and laymen in almost every hospital in the state, and we have seventy-two members of special task forces developing programs in specific areas and serving as our local review groups.

The coordinators have studied all the bills which have been introduced for the purpose of extending the RMP law and we feel that each of the bills has its good points. Rather than testify for one particular bill, we would like to make certain pertinent comments concerning important points of difference in the bills and how they would affect the day-to-day operation of RMP.

First, let me say that an authorization level of $150,000,000, $200,000,000 and $250,000,000 for the three years could be wisely and effectively used. I believe that by now each of you understands the reasons why the RMP appropriations during its first two years were not completely used. The cooperative arrangements necessary for carrying out these complex programs required considerable time to effect and it is only in the past year that RMP is beginning to reach its full potential for moving ahead rapidly. We now have more than $20 million in approved but unfunded projects. The interest of people at the local level is at a peak now and we feel that authorizations of this level would be effectively used in carrying out our program.

The Coordinators feel that the original purposes for which RMP was created, namely the promotion of quality care in the enumerated diseases, should be continued and remain substantially intact. We recognize however that we certainly do contribute to improving the organization and delivery of health care services as proposed in H.R. 15960. Further, broadening the categorical nature of the program is quite acceptable to us. We also believe in fostering closer coordination of our efforts with Comprehensive Health Planning agencies, which incidently we hope will be continued as in Mr. Rogers' bill, H.R. 15895. Although we are in favor of the creation of a National Advisory Council to advise the Secretary on national health policy, we do feel that the identity and integrity of our own National Advisory Council, which has served so effectively, must be preserved.

We would also like to comment about provisions dealing with construction. We recognize the *need for* additional construction of new facilities, and for extensive renovations and alterations of existing facilities. However, our funds will be limited, and to obligate a substantial portion of these limited funds for construction will preclude us from doing the very things we feel the Congress would like us to do. Therefore, we would request that the law remain the same in regard to this item, namely allow RMP money to be used only for minor renovation and alteration procedures.

Another specific item we would like to call to your attention concerns contract authority of RMPS. If it is desirable to include contract authority in the law, limitation of this authority to an amount not to exceed 5% of the total RMPS grant authority should be specified.

The review process deserves comment, since several of the bills require review of RMP projects by other planning agencies. Let me say first that in the past year there has been a shift in emphasis from project review to program review in RMP, and in the future it is the entire program which will be reviewed annually. The review process with its local review mechanism, its Regional Advisory Group approval, and then the Regional Medical Programs Service review mechanism at the present time takes about one year and we do not feel that mandatory review by another agency would be wise. It would lengthen an already long review mechanism and separate projects cannot be completely understood without complete review of the total program. We do agree, however, that all Regional Medical Programs should take cognizance of any comprehensive health plans in their area and work cooperatively with CHP (b) agencies in all phases of their program.

The coordinators would also like to urge the committee to consider carefully a provision which would allow for joint funding of programs which could be administered under the guidelines of a single federal agency. As you know, the various federal agencies each have their own guidelines and we are finding it more and more important to utilize multiple sources of federal funding as local programs become more complex and organized. As we try to do this, we are finding that the guidelines of the various agencies often conflict with one another and that authorization to administer jointly funded projects under the guidelines of a single agency would be highly desirable as set out in section 943 of H.R. 15960.

Finally let me say that RMP, with its unique relationship to the private sector, and its ability to "bridge the gap between science and service", and to serve effectively as the catalytic agent to promote regional cooperative arrangements for the furtherance of higher quality and more efficient innovative patient care closer to the patient's home, can do the job, and we ask for your support and confidence to allow us to continue to serve this desperately needed function by extending the law for another three years.

Thank you for allowing me to present the views of the RMP Directors to the committee.

STATEMENT OF JUDGE STEPHEN L. MAXWELL

Judge MAXWELL. Mr. Chairman, my name is Stephen Maxwell, St. Paul, Minn., judge of the district court there, and I appear not only as chairman of the regional advisory group of the Northland Regional Medical program. which comprises the State of Minnesota, but appear as a consumer and also apparently as having my feet held to the fire by Dr. Herndon earlier in testimony regarding some program that apparently, I don't remember, the regional advisory group in Minnesota did not fund or recommend.

So, appearing here as a consumer, I am concerned basically over two things. First, I am concerned over the urgent needs of increased delivery of health care service of a high quality. Now, admittedly, I live in an urban area with many physicians where I am only 15 minutes from the University of Minnesota Medical Center and about one and one-half hour's driving time from the Mayo Clinic, if I don't drive too fast and get arrested, and I have become well aware of the problems of medical care for the rural residents as a frustrating complex thing and in face of the national shortage of 50,000 physicians, small towns from Maine to California not only compete with each other for physicians, but with larger cities, research laboratories and even medical school facilities.

You know that the problem is acute and in all probability will

get worse. It appears that the days are over where every small town has a doctor and, therefore, alternative solutions must be investigated.

Now, solutions that will only produce more physicians, I think, would be something way in the future, but the problem that we could maybe control today or do something about is to provide better health care for rural residents. I say this because it is my firm conviction that the regional medical programs are today one of the best approaches toward bringing about improvement in delivery of the quantity and quality of health care service.

This carrot approach of incentive motivation can accelerate momentum now started in regional medical programs and additional subsidization is absolutely necessary.

Second, being a consumer, I am concerned over the specter of socialized medicine. Rigid laws might simply and more rapidly bring about response to public demands, but such would result, in my opinion, in irreparable harm due to reduction of capacity for increasing the quality of health care services.

Therefore, in my opinion, I would like to see, and Dr. Barrow said that it apparently is already going to happen, to see an extension of the regional medical programs. In my prepared statement which I left with the committee I have set out some recommendations in a more detailed way and it is a pleasure to appear before you gentlemen today.

Thank you, Mr. Chairman.

(Judge Maxwell's prepared statement follows:)

STATEMENT OF JUDGE STEPHEN L. MAXWELL, CHAIRMAN OF REGIONAL ADVISORY GROUP—NORTHLANDS REGIONAL MEDICAL PROGRAM

I am Stephen L. Maxwell, Judge of the District Court in St. Paul, Minnesota, and Chairman of the Regional Advisory Group of Northlands Regional Medical Program, Inc. I have been a member of this regional advisory group since the beginning of the program in Minnesota, and its Chairman for the past one and a half years.

Northlands Regional Medical Program is a separate nonprofit corporation with a Board of Trustees containing one representative from each of nine health related organizations. These are: the two Medical Centers—the University of Minnesota and the Mayo Foundation; the State Medical and State Hospital Associations; the State Department of Health; the Heart and Cancer Societies; the American Rehabilitation Foundation; and the State Medical Association Foundation.

The Regional Advisory Group includes 42 members from throughout the State of Minnesota. Except for eight members at large, the group consists of leaders chosen and assigned by designated organizations. Fifty percent of the Regional Advisory Group members are practicing and academic physicians—the rest might be classified as knowledgeable consumers. It it a truly democratic organization with diversified, equal representation of multiple agencies, presenting many differing points of view.

Northlands Regional Medical Program operated under planning grants for two years from January 1, 1967, to March 1, 1969, with awards of $344,998 and $424,039. The operational phase of the Northlands Regional Medical Program started on March 1, 1969, with an award of $1,189,964, which provided reduced funding for five operational projects. The second year starting March 1, 1970, was funded with an identical award, based on the flat funding principle. Two supplemental applications have been submitted, and seven additional projects in these applications have been approved. Three of these projects have recently been funded. The remaining four projects were not funded due to insufficient Regional Medical Program funds.

Initial emphasis in Northlands Regional Medical Program, like most regional medical programs, was limited largely to the categorical diseases—heart, cancer, stroke and related diseases. However, in November, 1968, at a two day retreat of the 18 Trustees and Alternate Trustees, the goals were broadened. A consensus was reached for major emphasis on the functional problems of continuing education, health services development and health manpower distribution and services. The concept was emphasized that the problems affecting health care services for 70% of all deaths (heart disease, cancer and stroke), are the functional problems of the system as a whole. Initial antagonisms toward Northlands Regional Medical Program as a "foot in the door" toward socialization of Health Care Services has now been largely dispelled. We are making real progress toward improvements in the health care system.

Northlands Regional Medical Program has developed a capacity to bring about greater equality in the delivery of health services in Minnesota—both in quality and availability. Like most other states, rural areas and poverty areas are deprived as to the quality and quantity of health services. Mr. Ancher Nelsen's home district contains some of those rural deprived health services areas. Northlands Regional Medical Program has initiated several program activities which are beginning to exert influence for better cooperative arrangements in subregional areas, and between the subregional areas and the Medical Centers. Northlands has recently employed five prominent physicians, practicing outside the metropolitan centers areas, to spend one-fourth of their time as community coordinators of the Core Staff. In Mr. Nelsen's district, Dr. Olaf Heiberg at Worthington serves in this capacity, and Dr. Charles Sheppard at St. Peter served last year. The program has successfully enlisted the help of four former presidents of the State Medical Association. It now has support, and active participation and commitment, by leaders from multiple professions and institutions.

1. It is my firm conviction that the regional medical program is one of the best approaches toward bringing about improvements in the complex and fragmented health care system. Rigid laws might more simply and more rapidly bring about response to public demands but with attending irreparable harm due to reduction of the capacity for increasing quality. In my opinion, high quality professional and personal services cannot be stimulated by dictum. Improved cooperative arrangements under motivation by federal subsidy incentives have succeeded in many types of programs in America. It can succeed, and indeed it is beginning to succeed in the health care system, in regional medical programs. So, I urge you to renew the regional medical program legislation and expand the subsidy appropriations progressively during the extension period. If the "carrot approach" of incentive motivation is to accelerate the momentum now started in regional medical programs, added subsidization is an absolute necessity. Moderate annual increases such as proposed in H.R. 14486 (Mr. Rogers), and in S. 3355 (Mr. Yarborough) Bills are a minimum to maintain this momentum during the period of tight budgets.

2. The existing health care components in rural areas and in poverty areas are extremely weak in development of cooperative arrangements among themselves, and, in development of an organized front. In extending the expertise of the medical centers to the periphery, the large medical centers cannot deal effectively with multiple, small peripheral units. A great deal more emphasis on subregional organization is necessary. If we are to develop a more effective health care system, the large medical centers should not be called upon to do for peripheral units what they could and should do for themselves if subregional cooperative arrangements were fully developed. Therefore, I urge you to strengthen the section on subregionalization in the renewal of regional medical program legislation.

3. The country is engaged in extensive changes in the value judgments of a large and complex health service system. The magnitude of the total effort is comparable to the interstate highway system, and will probably require comparable time and financial support. To change the basic plan or curtail support at this stage is like changing or curtailing the interstate highway system after the first four years of construction.

The regional medical program represents the most extensive cooperative health care provider program ever developed in this country. This accomplishment and the developing potential for effecting progressive changes in the delivery of health care services must not be weakened by making the program subservient to, or diluted by, any other program. Health care providers have begun to regard regional medical programs as a mechanism for regaining lost

prestige in solving health care problems. This desirable attribute will suffer seriously from legislative rebuff. Achievement of desired goals will almost certainly be delayed by any reduction in emphasis. Therefore, I urge you to renew the present regional medical program legislation, expand the appropriations and introduce changes which will specifically strengthen Regional Medical Programs.

4. Conflicts between regional medical programs and comprehensive health planning are more imagined than real. Furthermore, the theoretical conflicts seem to be given much more publicity on the national level than on the regional level. Area-wide health planning councils have developed slowly in Minnesota, as well as elsewhere. Northlands Regional Medical Program is trying to help develop strong area-wide planning councils, and to cooperate with them as completely as possible. Northlands Regional Medical Program and the State Agency of Comprehensive Health Planning have developed close cooperative arrangements. The Director of the State Agency of Comprehensive Health Planning, and the Associate Director of the Northlands Regional Medical Program at the University of Minnesota Division, both physicians, are wife and husband respectively. We do not expect that the mythical "collision course" will bring them into my divorce court!

The North Central Group of fourteen regional medical program coordinators adopted the following recommendation with regard to RMP–CHP relationships: "Since the need for greater consumer orientation of the provider system is recognized and accepted, it is . . . recommended that the bill include a restrainer clause requiring regional medical programs to cooperate with comprehensive area-wide health planning agencies developed under P.L. 89–749, and take cognizance of the comprehensive health plans of those agencies." I support this recommendation and urge that you give serious consideration to this approach. Regional Medical Programs should be cooperative with Comprehensive Health Planning Agencies and the National Center for Research in Health Services Delivery, but not diluted by combination of these agencies into one administrative unit.

5. The clause prohibiting "interference with the patterns, or methods of financing of professional practice or with the administration of hospitals" has not been an impediment in the Northlands Regional Medical Program. The reassurance provided to health care professionals and institutions, more than offsets the nebulous advantages of omitting this clause. I recommend its retention.

6. Throughout this country emphasis on categorical diseases has been a strong tradition for many years. Health care organizations dedicated to specific categories have achieved significant advances in health care knowledge and service. In Minnesota, as in many other regions, the regional medical program has realized that its goals are broader than heart disease, cancer and stroke. But important categories of disease, disability and death obviously deserve specific emphasis. Categorical emphasis has stimulated productive cooperative arrangements between specialists and generalists. To eliminate all emphasis on disease categories will weaken the support given to the programs by specialists personnel and by voluntary health organizations dedicated to specific disease categories. Contrariwise, the addition of other categories will strengthen the program. Diabetes, emphysema, kidney disease, traumatic iniuries and addictions to alcohol and drugs are logical examples. Therefore, I recommend that the disease categories in regional medical programs be broadened to include other major disorders which have significant importance in the overall problems of improving the quality and quantity of the delivery of health care services.

7. Inordinate emphasis on hospital care is one factor which has thrown the health care system out of balance. New emphasis, with tangible support, needs to be addressed to comprehensive ambulatory health care. Evidence is accumulating rapidly on the potential benefits to be achieved by coordination and integration of the multiple components of primary health care. The addition of a charge to regional medical programs to strengthen comprehensive health care services could accelerate the improvement process. Comprehensive ambulatory health care is most easily accomplished in group practice by physicians. In Minnesota, the Regional Medical Program has just reported that 52% of practicing physicians now belong to groups of three or more. There has been an increase in group practice of 11% in the last three years. Projects to objectively analyze the results of comprehensive ambulatory care programs in private group practice would be appropriate additions to regional medical program activities. I recommend that a section be added to the regional medical program legislation to emphasize strengthening of primary health care programs, ambulatory health care services, and evaluation of comprehensive health care services in private group practice.

In summary, I recommend:

1. Renewal of regional medical program legislation with minimum of appropriations as proposed by HR14486 (Mr. Rogers) and S3355 (Mr. Yarborough) Bills.
2. Legislative addition emphasizing subregionalization and maximum stimulation of subregional cooperative arrangements.
3. Legislative changes to strengthen local decisionmaking responsibility of the health care providers.
4. No forced interdependence of the regional medical programs with any other programs.
5. Required regional medical programs cooperation with comprehensive health planning and the recognition of health plans developed by area-wide health planning councils.
6. Expansion of the categorical disease to include other major disorders.
7. Legislative addition to strengthen the development of primary, ambulatory and comprehensive health care services and the capacity of existing health manpower to meet the needs of the public.

STATEMENT OF DR. H. PHILLIP HAMPTON

Dr. HAMPTON. I am Dr. H. Phillip Hampton, a physician in private practice of medicine in Tampa, Fla., and I appreciate the opportunity to again appear before this committee concerning health care problems requiring legislative remedy. As a member of the American Medical Association's Council on Legislation, I presented earlier in this session recommendations of the AMA for continuation and modification of the Hospital Construction Act.

In addition, I am State chairman of the Florida regional medical program which had its inception while I was president of the Florida Medical Association. However, today I do not speak as a representative of any of these organizations, but wish to present my personal views on some existing problems and opportunities in health care delivery as they relate to the regional medical programs.

A nonprofit corporation was created to be the grantee for the Florida regional medical program composed of representatives from the practicing physicians, medical schools, hospitals, voluntary health organizations, State government and the public. We have a central office and district offices distributed throughout the State and at the medical schools. The core staff works closely with hospital directors of medical education and with existing community health planning councils. We also have operational projects mostly centered about a medical school.

I would like to emphasize with illustrations the opportunities for regional medical programs core staff to engender and aid the development of programs that will improve the ability of physicians to deliver better health care in their community, facilitate the dissemination of medical knowledge and enhance the training of additional health manpower.

A "Crisis in Health Care" has been generally proclaimed to exist in America and in July 1969 the President announced appointment of a task force to consider the crisis especially in relation to medicaid and medicare. During the 10 months of intensive investigations by the Secretary's task force ably aided by the staff of Health, Education, and Welfare, I have been convinced that a crisis in health care does exist and solutions to the dilemma must be found. This year we are spending well over $60 billion for health care services including $26 billion from

tax sources. Two-thirds of health care costs are paid through public and private third party payment programs.

As a member of the task force, the development of an adequate medical care information system has been my primary objective. I found the Florida regional medical program core staff a readily available source of expertise to aid the preparation of a plan whereby the Florida Medical Association and the Department of HEW are jointly involved with private enterprise in developing an adequate medical information system for efficient management of health care financing and effective peer utilization review.

Without additional Federal appropriation, Florida Regional Medical program core staff, with the support of a large public communications utility, developed a kidney matching program which is now operational in the southeast. The program, using computer technology, enables all of the kidney transplant centers to store in the computer's memory bank the tissue type of each of the potential recipients of a kidney transplant. When a donor kidney becomes available, it too is tissue typed and the data fed into the computer through a terminal at each center, instantly locating the recipient who offers the best tissue match for the donor kidney.

Just this one project carried on entirely by core staff will through the benefits it creates more than pay for the cost of Florida Regional Medical program's core staff for many years to come, as well as providing many dividends other than those which are economic.

Several other projects are in the process of development by Florida Regional Medical program's staff in conjunction with private industry and the private medical sector to improve the efficiency and quality of health care delivery.

Amendments to the Social Security Act, H.R. 17550, recently reported by the Committee on Ways and Means and passed by the House, offer an opportunity to appreciably improve medical and paramedical educational activities under the section entitled "Payments for Physicians' Services in the Teaching Setting." The education of interns and residents and paramedical personnel in teaching community and medical school affiliated hospitals has grown like Topsy, been poorly organized and dependent on chance voluntary efforts of the practicing medical profession. It has often been used by local government to provide free medical care to the indigent.

This private sector medical education effort can be greatly improved by the Ways and Means Committee's recommendation to reimburse teaching physicians on a cost or salaried basis, thereby providing support for this important education process from funds appropriated for health services to those who receive them in the teaching environment.

In Florida a plan proposed by the State Board of Regents and approved by the Florida Medical Association to improve health manpower production by providing the fourth year of medical education in teaching community hospitals in being implemented. The proposed method of "Payment for Phvsicians' Services in a Teaching Setting" could be a means of providing financial support for this valuable educational enterprise in the private medical sector. Regional medical programs are particularly well suited to administer and supervise this funding method for medical and paramedical education and re-

gional medical programs should be authorized to particiapte with other administrative agencies in performing this service.

The mammoth $60 billion rapidly growing medical care enterprise needs the catalytic influence of regional medical programs to foster innovations that will improve the efficiency and quality of health care delivery. To be effective, the regional medical program must retain its identity and ability to aid and encourage the private medical sector and private enterprise in developing improved medical servicing methods. It must overcome physician apathy, avoid medical school domination and abstain from providing medical care.

I am further convinced that solutions to the many problems in health care will not be found through legislative action, but will depend upon cooperative developments in the private sector to improve the efficiency of health care delivery and the production of health manpower. Regional medical programs can be a valuable agent in promoting these urgently needed developments.

And I submit a one-page summary of my remarks which I hope will be included.

Thank you.

(Dr. Hampton's summary follows:)

STATEMENT OF H. PHILLIP HAMPTON, M.D.

SUMMARY RECOMMENDATIONS

Therefore, I would recommend that legislation to continue Regional Medical Programs provide for:

1. Regional Medical Programs which are independent and free to cooperate with any governmental agency, educational institutions, practicing physicians, hospitals and private enterprise.
2. Emphasis on core staff activities and facilitating funds.
3. Participation in additional cooperative arrangements required to implement the plan for "Reimbursement of Physicians' in a Teaching Setting" proposed by H.R. 17550.

STATEMENT OF DR. B. D. DOTTER

Dr. DOTTER. As a recipient of the effort of the regional medical program, I would like to respond as a physician from a town of 1,200 in Okeene, Okla. We serve approximately 8,000 people within 15 to 25 miles of our town. We have in the past year instituted two major programs under regional health, and one is a coronary remote monitoring system, and this has been mentioned in the report, and the other is a continuing education, teleconference, which occurs one to three times a week. It involves 13 hospitals in northwest Oklahoma and it has been exceptionally well received.

I would just like to emphasize a few basic points that have been made here today. First of all, as far as the basis of education, when we train young physicians and give them 4 to 8 years of the finest medical knowledge of the great centers and ask them to go into rural areas and practice quality medicine without proper equipment and without available followup education, you are just not going to get physicians to go into rural areas.

You can train them with the fine lab facilities and then asking them to go into rural areas without these, obviously they will stay in the city. We can only retain a small amount of the massive knowledge presented to us without relearning constantly and updating and reviewing the common problems with new solutions.

MANPOWER DEPRECIATION

If you were to double it overnight, double all of the available physicians and nurses and paramedical personnel and even double the research centers, in 10 years you would be back where you started with physicians under the existing plan who have depreciated some 50 percent within 10 years because of the new knowledge coming on and anything other than a continuing educational program to make new information available in all parts of the country without them leaving their practice, we are just going to be in 10 years with more out-of-date physicians.

The isolation in the rural area can only be avoided by some means of regional medical programs in order to bring this delivery of new information to us. I think the most important goal of the regional medical program is not in bringing up-to-date information to the physicians in the rural areas, but in developing innovations in teaching, innovations in delivery of information.

In all truthfulness, if we have a goal in the 1970's to overcome the health crisis, it is not in learning anything new in medicine. If we can in all truthfulness administer all of those things that are known since 1950, all good quality medical care now available, and the knowledge that is available, if that is delivered properly, then we have quality care throughout the Nation.

(Dr. Dotter's prepared statement follows:)

STATEMENT OF B. D. DOTTER, M.D., OKEENE, OKLA.

I am Dr. B. D. Dotter of Okeene, Oklahoma. There are 1,200 people in my town. With two other doctors, I serve about 8,000 people who live within 15–20 miles of Okeene.

Our situation is similar to that which exists in other sparsely populated areas of Oklahoma and other states. In relation to the population we serve, there are only about half as many physicians as in the cities. We also have a shortage of nurses, technicians, and other health workers. We recognize the increasing importance of continuing medical education in improving medical care, but it is difficult for us to leave our patients to attend the postgraduate courses in the major medical centers. It is often uneconomical and sometimes impossible to provide locally certain kinds of services which require expensive and sophisticated equipment. Sometimes it is feasible to send patients fifty miles of Enid, Oklahoma, or eighty miles to Oklahoma City so that they may receive these special services. On the other hand, the health, and occasionally even the survival of our patients, sometimes depend on the *immediate* availability of advanced methods. A life-threatening irregularity of heart action, for example, may require immediate treatment if our patient is to have a chance for survival as good as that of a patient in a large metropolitan hospital.

The people in our community have not usually looked to the Federal Government to solve their problems. Rather, there is a tradition of local responsibility and local action. We have, however, welcomed the opportunity to participate in the Oklahoma Regional Medical Program. From the beginning we have been favorably impressed by policies which permit us to determine our own local needs and priorities. Also, we recognized the opportunity this unusual program provides to improve medical care *in our community* through cooperation with institutions, organizations, and specialists in other communities. For instance, we have developed an arrangement by which our patients with acute heart attacks will receive superior treatment in our own hospital at a reasonable cost. This will be done using electronic devices which make it possible to send to Enid, Oklahoma, a continuous electrocardiographic recording. This arrangement will take advantage of the availability of highly trained nurses in Enid who will instantly call us if the recordings show the need for emergency treatment. This sharing of service and expertise will improve the quality of service, increase survival rates, and reduce

costs. Some of our own nurses are capable of performing this monitoring, but it is feasible and much more economical for a central nursing facility to monitor several patients at the same time. Thus, a nurse in Enid will be able to monitor simultaneously our patients, those in other small towns, as well as patients in her own hospital. Our own nurses will then be free to perform other urgently needed functions. The ORMP will help us to meet some of the initial costs for installing this system, but the system will become economically self-sufficient within a year or two. Patients are now being monitored by this new system in 14 small Oklahoma towns, and within the next year about thirty of our rural communities and a dozen of our larger towns will be participating. This same project has also improved the efficiency and effectiveness of coronary care services in the hospitals of our larger communities such as Oklahoma City, Tulsa, Ada, and Lawton. These larger hospitals serve as central monitoring stations for both the small towns and their own patients. The University of Oklahoma Medical Center and the Oklahoma Heart Association provide back-up resources and training programs which support both the development and operation of this system.

The same telephone lines which carry these electrocardiographic signals can be used to improve communication among health professionals in our area. Under auspices of the Oklahoma Regional Medical Program we now have regular telephone conferences relating to selected problem cases. This permits those of us in Northwest Oklahoma who are "country doctors" to confer with each other and with specialists in Enid. Such consultation and continuing education has several advantages for us. We don't have to leave town, we lose very little time from our busy practices and the discussions have special interest and relevance because they involve our own patients. Finally, these weekly conferences provide us with a regular and continuing stimulus to bring to our patients the best of modern care. These telephone connections are also being used, in a similar way by the nurses, laboratory technicians, and medical nutritionists in our part of the State.

One of the major problems of this and other rural areas is the recruitment of doctors and other health workers. We believe that cooperative programs of the kind I have described will be of assistance to us in attracting health personnel since these activities mitigate our isolation and make it possible for us to provide a quality of care for which we need make no apologies.

I appreciate very much the invitation to appear and the opportunity to relate these experiences to you. There are, of course, certain aspects of these Regional Programs concerning which I have only limited knowledge, but I would be glad to try to answer any questions concerning the potentialities and implications of such programs for small town physicians and the people they serve.

Dr. BARROW. Thank you, Mr. Chairman, we will be glad to answer questions of the committee.

Mr. JARMAN. Thank you very much for your presentation, gentlemen, and for your statements. We regret that the time factor prevents much more time to explore your ideas and then hear comments and compare the views on the legislation before us.

Let me ask one question. In H.R. 14284, as you know, a provision does permit appeal to the National Council in the event an application is not recommended by a local advisory group. We have had testimony before the subcommittee in favor of that part of the bill.

Would you have any expression to make as to your own opinions as to the practical effect of that provision if it is enacted into law?

Dr. BARROW. Yes, Mr. Chairman, I would be willing to comment on this. I think most of the coordinators feel the review mechanism we now have has been fair and appropriate. It is a review mechanism at the local level, then it has to go through the regional advisory group which has to approve the decisions and it has to be approved nationally.

It is a tough review process and only about one out of five projects submitted to us for consideration actually clear our own review process at the local level. If we allow this review or appeal mechanism, I

am afraid you will overload the National Council to such an extent with these appeals from disgruntled people who have been turned down for reasons they cannot always understand, that it will just overload the mechanism and be completely inefficient then.

I think that most of the time there is an excellent reason why the local review turns down a project. Most of the time this is on the basis of priorities which are set on the local level and, of course, people who are interested in a very narrow area like cystic fibrosis, for example, are not concerned with priorities overall.

I think we in the regional medical program have tried to look at the overall problem and magnitude of each and tried to divide the funds as equally as we could according to the magnitude of the problem.

Judge MAXWELL. Mr. Chairman, may I add a comment there?

Beside my duties on the Regional Medical Advisory Group of Northland, I am also chairman of the Criminal Justice Advisory Committee for an eight-county area in metropolitan Minnesota. This is another regional advisory group under the omnicrime bill.

We are a group that does similar work as the regional advisory group in the medical programs, but we do not have a final say-so on review. There is always a chance of appeal to the metropolitan council and then to go up to the crime commission, and the crime commission can just disregard everything we have done.

I found out from the type of people that are serving on that committee that many of them become very frustrated and take pretty much the attitude that "If we cannot make the decision and make some recommendations that they will hew to, and they just turn some down, grant some, and grant some that were not even recommended, there is just no sense in being on the committee."

So this ought to be resolved. I feel that especially the regional advisory group, because of its makeup of consumers and other different types of people all over the State, does an adequate job of reviewing.

Mr. JARMAN. Thank you.

Mr. Nelsen?

Mr. NELSEN. Thank you.

I want to welcome Judge Maxwell from Minnesota, a longtime friend of mine. I appreciated listening to your comment, Judge, and I note also in your written testimony a reference to my district as being part of the area which is deprived of health services.

One of the problems that we face is that many times a rural community which has a small hospital is having difficulty through a State plan of continuing to exist on the premise that distances no longer mean anything and they are expected to go to a larger center for care.

I have been involved many times in trying to help a small hospital to even get approved to operate. Actually, sometimes these areas are deprived because of a plan that is supposed to be coming from experts in the health field. I want to call attention to our having just finished with the conference committee on the Hill-Burton bill. Some members on the conference committee recommended facilities that are less complete in some areas because of distances so as to give men immediate care in the less complicated cases. I want to add this comment that while there may be areas that are not served as well as we would like,

there are also areas that are not served because the plan that has been advanced does not include them as requiring an approved facility.

Offhand I could name two or three communities I have worked with in trying to get some kind of consideration for them and we have usually been somewhat successful.

Would you comment on that?

Judge MAXWELL. I think that this truly is the purpose of regional medical programs. Dr. Dotter talked about 10 years. You can take a physician and put him through school and his wife does not want to go to the rural areas because the life is not there, so if you double the output of the medical schools, you will still get the same distribution.

I think the regional medical program has a purpose of seeing that the physicians that are there deliver a better quality of health care services.

Now, this other problem of just getting more physicians, I think this is something else that, at least in my opinion, and remember I am not an M.D. but a judge, and I think this is not part of the medical program, but it is the delivery of the health care services and the innovations, and when you get into the rural areas, as Dr. Dotter indicated he is, you want to get things to the point where the physicians can come to the Mayo Clinic, the St. Paul-Ramsey Hospital, University of Minnesota Medical Center, and others, to get updated in their training so that they can go back and do a better job and also to be able to encourage other doctors possibly to go into same type of clinics so they can develop different types of expertise, and, yes, there are not more doctors, but those that are there can then do a finer job and a better job, and this is the purpose, in my opinion, of the regional medical program. Maybe I am wrong.

Mr. NELSEN. I noticed you mentioned Dr. Charles Sheppard and Dr. Olaf Heiberg, both of whom are personal friends of mine. I know them very well.

Yesterday, as I recall, I mentioned the same point when Dr. Egeberg was here and he commented, "Remember that distances now have changed the need for a hospital every 25 miles, because you can actually drive 75 miles in less time than you formerly had been able to drive 10," the move has been away, then, from providing complete health services and hospitals in smaller communities, but it seems to me that all parts of our State have available services through the University of Minnesota and other health facilities in the Twin Cities area. I am trying to find out what you mean here by "denying the health services in such a community."

Judge MAXWELL. Speaking as a layman, I think it is a misconception or an alibi, the rationalizing, or saying, "Let's change the distance," that you can drive a distance, and that is because the question still arises as far as the availability of health care services.

Say, if you live right within the Twin Cities, and because of the factors of economic conditions or ignorance, or what have you, you can't get across town only 2 miles, for instance, and you have to get medical attention, thus it makes no difference if you have to drive 50 miles in a rural area, but I say updating it in the rural area as well as we can through the regional medical programs so that the services that are there will be of a higher and better quality.

Mr. NELSEN. Thank you.

Mr. JARMAN. Mr. Rogers.

Mr. ROGERS. Thank you, Mr. Chairman.

Gentlemen, I, too, welcome you to the committee, and your ideas I think have been clearly stated on what you think should be done with the program; particularly I am pleased to see my old friend, Phil Hampton, here, who has done a great job in medicine in Florida and the Nation, he is president of his association and was chairman when we first got the program going in Florida.

I notice in some of the testimony which was not read you do give examples of specific and concrete benefits that have come from the regional medical programs. I think any information like this is helpful and if you have any additional information that can be supplied for the committee records, I think this would be beneficial.

(The following information was received for the record:)

EXAMPLES OF REGIONAL MEDICAL PROGRAM ACTIVITIES THAT HAVE A DIRECT EFFECT UPON THE AVAILABILITY OF PATIENT CARE, THE QUALITY OF THAT CARE, AND THE COST OF MEDICAL CARE IN GENERAL

In response to the request for examples of Regional Medical Program activities which are having a direct effect upon the availability of patient care, the quality of that care, and upon the cost of medical care in general, I would offer the following:

In Maine one of the major projects supported by operational funds to Maine's Regional Medical Program, is the Upper Kennebec Valley Regional Health Agency. Located in Waterville, and originally organized as a voluntary service under a local board of trustees, that Agency was given a new outlook and purpose by the infusion of Regional Medical Program leadership and funds in 1968. It now coordinates an ever expanding number of health related planning and operational activities.

On the planning side it not only serves as the base for Regional Medical Program activities in that area, but is the officially designated Comprehensive Health Planning Areawide agency serving exactly the same sub-Region. Two examples of a growing number of activities already in operation with a combination of Regional Medical Program and local funds are:

A Home Health Care Service staffed by 14 full and part-time nurses, as well as other health professionals, is operating out of the local community hospitals and effectively providing skilled home bedside nursing care to supplement physicians' services. This not only gives additional service to those patients, but frees the physicians for the care of their more acutely ill patients. Established in 1968, this service, which includes not only the Waterville area but that of adjoining Augusta and Gardner, has served more than 700 patients to date and currently carries a case load of some 1,000 visits per month. By shortening their hospitalization and cutting down on physicians' visits, this service not only provides more extensive service to patients, but does so at less cost to the patients, either directly or through third-party payors.

A Regional Blood Bank which now serves 8 of the 10 hospitals in the Kennebec Valley was established in June of 1969. During its first year of operation, this service drew and distributed over 3,000 units of blood to some 600 patients at a cost per unit of only $13.50. This 24-hour seven-day-a-week service negates the need for each of the cooperating hospitals to maintain and pay for expensive space, facilities, personnel and a 35% waste caused by outdating of blood, thereby saving considerable costs which can be passed on to the patients.

It should be noted that both of these activities are expected to be self-supporting within the next year.

In addition to moving into other similar operating activities, as noted, this Agency is also developing its own Areawide Comprehensive Health Planning Program under Public Law 89-749. This reflects cooperative arrangements not only among those who deliever health care through the Regional Medical Program concept, but those consumer groups who are responsible for long-range planning of health care in that area.

In the Pittsburgh area, the Western Pennsylvania Regional Medical Program recognized the need to improve the availability of quality care in the nursing homes and other extended care facilities of the area. To achieve this goal, the Program has started to bring together the people who represent such institutions. Already, some 60 people from 20 of the institutions have been brought together. As a result of this intial effort:

Administrators, nurses, social workers, and other people directly concerned with patient care and patient care costs are meeting with an interdisciplinary group of medical and health care experts to learn new techniques of care for chronically ill patients, and the administration of these concepts of care. These same "faculty" visit the institutions involved and work directly with the people on the scene.

Constructive changes in some of these institutions have already resulted in new nursing procedures for cancer patients in five institutions; two facilities have been able to free patients from use of geriatric chairs; three facilities have established positions for directors of nursing service; two others have replaced their directors with better qualified nurses; two have established directors of in-service education and four others have established such committees; six have developed job descriptions for special nursing jobs; and four have instituted methods for evaluating nursing personnel.

Similarly, in the area of social services three institutions have begun to develop a system which will include a social history of all newly admitted patients; two facilities are making such information part of their patients' case records; three institutions are actively looking for medical social work consultants and one facility is already involved in referring such cases to such a person; and five institutions are planning the employment of full-time caseworkers.

Administratively, four facilities are planning to provide additional services; six are reviewing their organizational structures; ten are routinizing the collection, summarization and reporting of statistical data; four are now carrying on departmental meetings; and eight have revised and updated their existing policy manuals.

Also, as relates to cost, eight of the institutions have initiated a budget process for the next fiscal year with a Certified Public Accountant working with the Director of Nursing.

It is planned to continue this activity for two more years with funds provided through the Western Pennsylvania Regional Medical Program. At the end of that time, it is expected that nearly one-half of all nursing homes and extended care facilities within the Region will have been involved in this process.

In Indianapolis, Indiana one of the prime objectives of the Indiana Regional Medical Program, that of improving the quality and availability of health care for the urban poor, is underway and beginning to show results. To accomplish this objective a multi-phasic screening program designed to identify the early stages of health abnormalities for the city's urban ghetto residents has been established:

To date, the project has screened over 2596 persons. Of these, 1588 have been found to have abnormalities or conditions requiring care or treatment. These persons have been referred to community hospitals and private physicians for follow-up care.

Within this project some 22 community residents have also been trained as screening technicians. As a direct result, the interest and help of the city's Model Cities and the OEO Health Programs are recommending additional applicants for this training.

In addition to the obvious benefit of the people screened and subsequently treated, this total effort has had a beneficial effect in bringing together community institutions, agencies and groups which never before had worked so closely in a cooperative project. Several organizations have provided personnel for training the workers in the project. The participating hospitals and a private foundation have cooperated in helping to set up the two facilities where the screening is done. The hospitals involved have adjusted their outpatient and clinic facility procedures to accommodate referrals from the project on an appointment basis. Other resources have made transportation available for persons who need further examinations or treatment at the hospitals and clinics.

Finally, the medical school faculty and private physicians have cooperated to supervise the work of the screening technicians, and consult with them about refinements in the procedure.

This entire project is actually only in its beginning stages, and more specific results are expected over the next several years.

In Washington, D.C., the major programmatic emphases of Metropolitan Washington, D.C. Regional Medical Program is to improve the general level of patient care being made available to the people of that unique Region. Within this general area of concern, a comprehensive stroke activity has been established by the Program in cooperation with Howard University at Freedman's Hospital. Included is a Stroke Station which is being operated with a team approach for both the acute and long-term management of stroke patients. Concurrent with its clinical activities, an evaluation of this team approach is being carried out.

To date, the data shows actual changes in the condition of patients accruing as a result of this Stroke Station in that a significant lowering of the mortality rate from 65% to 43.3% has occurred. The professsional staff and consultants have attributed the reduction to improved medical, diagnostic, and nursing techniques which were made available as a result of this Regional Medical Program-supported project.

In the Intermountain Region, which includes the State of Utah and adjacent parts of Wyoming, Montana, Idaho, Colorado and Nevada, one project of that Regional Medical Program headquartered in Salt Lake City is involved with developing a computer system for expert monitoring of physiological data from patients in remote hospitals and relaying diagnostic and treatment information back to physicians in these hospitals for their use in caring for their patients.

Results to date are already exceeding expectations. For example:

The demand for services of the experts in the University of Utah Medical Center from the first four hospitals in the system has accelerated far beyond the anticipated level as the benefits of the system have been demonstrated, and many other hospitals have already requested participation in the network.

Over 4,000 patients have been monitored.

More than 15,000 electrocardiograms have been processed.

Four heart catheterization laboratories have been made part of the system.

This type of electronic automation coupled with the maximum use of experienced personnel has reduced the cost of an electrocardiogram from $11 to $2 each.

Much more can be expected of this system in the future, and it can also be expected that it will provide a model of similar systems in other Regions.

Mr. ROGERS. Now, for instance, in Florida, your kidney program, could you tell us how many maybe have been benefited in Florida?

Dr. HAMPTON. This program has been just in existence for 2 or 3 months.

Mr. ROGERS. So you have not had a chance to do that?

Dr. HAMPTON. No. What it enables now is that every kidney patient who is a prospective recipient for a kidney transplant is typed and their immunological data recorded in the computer and then when a prospective donor appears in any part of the country, and right now it is operational in the Southeast, his immunological data is put into the computer and you immediately get the best match in the whole country for that prospective donor within the range of distance that can bring the two together.

So, this can be a great aid to those needing kidney transplants, and has already been a great aid and has been used, but it has been used in only a few cases so far.

Mr. ROGERS. That is excellent, and I commend you on that.

Did any RMP funds go into that or was it done in the private sector but with your leadership?

Dr. HAMPTON. The corps staff of RMP did the work and no operational funds were needed. We sold private industry into putting up the facilities and their services in developing the program, so the thing was developed without any additional funding at all and with the cooperative approach of private enterprise and our people.

Mr. ROGERS. That is wonderful, and it ought to be a great example for other parts of the country.

What about your computerized health information system?

Dr. HAMPTON. This is an activity in which I became involved in the task force, the Secretary's Task Force on Medical and Related Problems. It is quite obvious in this $60 billion health care industry today we are in great need of information about the delivery of health care that can be used for more efficient management of the third-party payment mechanisms, both Government and private, which are paying for two-thirds of the cost of health care today.

We need to have a more efficient management system, and I would estimate that about $10 billion is being spent this year just in the management of health care financing, the administration of health care financing.

If we can do this through application of electronic data processing, it could be done more efficiently and more effectively, and at the same time it would establish data that can be used to improve the peer utilization review mechanisms that are greatly needed and that the medical profession is anxious to develop and perfect in order to guide the delivery of health care of all types.

Mr. ROGERS. In other words, what you tell me is this would not only be more efficient but a savings, and would enable you to more effectively operate a peer review system as well?

Dr. HAMPTON. Yes, sir.

Mr. ROGERS. That is excellent. What are the outlooks for this?

Dr. HAMPTON. The outlooks are very good. The computer program has been practically completed. The Health, Education, and Welfare Department is participating with the Florida Medical Association in development of this program. The American Medical Association has appointed a task force to observe the development of this program. I hope we can now begin to extend it to other areas in model demonstration projects in the very near future.

Mr. ROGERS. The committee would be interested in following the progress of that. Will you keep us advised?

Dr. HAMPTON. Yes.

Mr. ROGERS. Thank you. Your testimony has been most helpful.

Mr. JARMAN. Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

I would like to ask this question, and I am glad to have the opportunity to ask it of men who seem to, from the testimony, know more about the regional medical programs than anybody before.

The question is, and I don't have it precisely in mind as a committee member, but why should we not pass H.R. 15960? What specifically is it in there that makes you so concerned about, as you call it, integrity and dilution of the regional medical programs, and I want to know, specifically, why, why is the administration bill not the vehicle to utilize?

Dr. BARROW. If I may try to answer it, the administration bill changes the purpose of the regional medical program from the improvement of the quality of medical care and delivery of the greatest quality medical care as near to the patient's home as possible, which we consider our goal now, to simply delivery of a high quantity of medical care without the mention of quality.

We feel that it also negates the difference in purpose of CHP and RMP.

We believe, with Mr. Rogers, both of these have separate and unidentical purposes and should be maintained separately because this is the only way they will be effective.

Mr. KYROS. What is the sharp difference in the purpose?

Dr. BARROW. Let me express it in a way I have not heard it expressed before the committee. I look at CHP as being the voice of the consumer in expressing the health needs of the community. I look at RMP as being the mechanism through which the profession can organize itself to meet these needs of the community.

Mr. KYROS. Can you make it more specific? I don't understand that.

Dr. BARROW. All right. Let's say that the community feels that they need better health care in a ghetto area of downtown Atlanta. The community is not able, and CHP with its present staff is not able, to plan the details of how it should be done. It does not have expertise on its staff among the professionals at this time.

It is primarily consumer oriented.

Now, RMP, on the other hand, can be in touch with CHP, learn of these concerns of the community, and begin to work with the physicians, the medical schools, the other medical organizations of the community, to see how the professionals can react in providing these services that have been expressed as a need by the community.

Mr. KYROS. But aren't these limited to heart, cancer, and stroke? How can they do all of those things?

Dr. BARROW. I do not see how, although we have emphasis on heart, cancer, and stroke, and, as I have testified, I think it is important emphasis, I do not see how you can separate it from the system of medical care.

Let me give you an example. You can't say we could give the highest quality care to a coronary patient without being first concerned with the quality of total ambulance services in the community, and then emergency room services, how are they organized in our community and the allied professional training in our hospitals and, lastly, organization of the coronary unit itself.

You have to look at the whole system. We found more and more as we dealt with heart, cancer, and stroke, we had to concern ourselves with the entire system. We looked at it from the standpoint not of the consumer but the standpoint of the professional and how we meet the needs of the community in this way.

Mr. KYROS. How do you answer the point of Dr. Egeberg, for whom I have great admiration, that really there is a lot of fragmentation and cumulative effect that should kind of be brought together, not kind of, but rather be brought together under the Health Services Improvement Act, H.R. 15960?

How do you answer it? We have only so much money to go around, and the administration's proposal has the same objective as yours, although you say yours is quality and theirs is quantity of delivery of medical care, and, namely, for the fixed amount of money to bring health care to America. How do you answer the arguments here that this coordination is now required because the programs are too fragmented and sometimes they serve not contiguous areas but congruent areas?

Dr. BARROW. Absolutely. We found the difficulty and apparent fragmentation you speak of is in fact mostly at the national level. The relationship between CHP and RMP at the local level has been excellent throughout the country with few exceptions. There are a few exceptions, yes, but mostly it has been good.

You will have to realize there are few B agencies as yet in operation, but where they exist, there is good coordination.

Mr. KYROS. Very few what?

Dr. BARROW. B agencies, 314(B) agencies, the local health agencies in contradistinction to State agencies, which are the A agencies, excuse me.

The fragmentation has been primarily at the national level, as we see it, where there has been more or less a conflict over the role of these two organizations, not at the local level.

Now, we do not see that the administration bill provides any degree of better coordination the way it is written. We feel that a single council, for example, cannot understand the problems of each of the four programs. We think it could do some coordination and, as I said earlier in my testimony, we would have no objection to a single council for overall coordination, but we feel that a RMP council to determine policies of RMP is very important and for men to be on that who are knowledgeable in RMP and its problems.

It takes a while to develop this knowledge, gentlemen, and these men who serve from 3 to 5 years on this national council are very valuable to us, and we would hate to lose them at the present time.

About the money, if you will look, the administration bill has separate line items for each of the things, it does not decrease the money at all. We do not see that it will save money.

Mr. KYROS. What about permitting the joint funding of projects and transfers of funds between programs?

Dr. BARROW. In my testimony, I say this is part of the administration bill that I heartily approved of and all of the coordinators support this part of that bill.

Mr. KYROS. What about authorizing contracts for research so that they are correlated between the programs?

Dr. BARROW. As I also said, we are agreeable for up to 5 percent of the RMP funds to be in contract funds which can be nationally determined as to their priorities. But we do think it is important for the majority of RMP funds to still have the local determination that they have now. We don't want this to be a national program handed down by a few Federal bureaucrats to tell us what to do locally. We feel that the local determination of priorities is an important facet of this program.

Mr. KYROS. Let me ask you this question since you brought up the last point. Are you suggesting that H.R. 15960 will lose some of the local innovative effort if it is put into effect? H.R. 15960, the administration bill?

Dr. BARROW. The directors of the RMP feel so; yes.

Mr. KYROS. Tell me specifically, using the words of this bill, how it does that, or you can write a letter and tell us.

I think that is a very serious defect. I remember that all of the testimony on the regional medical program and why it is such an excellent program and liked by doctors and legislators and every-

body is that it allows local initiative and innovation, but it concerns me you suggest that H.R. 15960, which I think has many things that are commendable economically, and if coordinated would nevertheless strike against the local effort, which I think is the key to your program.

Dr. BARROW. I will be glad to write you a letter and append it to the record. It is a little too complicated to discuss it now, and I would like to submit it.

Mr. KYROS. All I would like is an explanation.

(The following letter was received for the record:)

GEORGIA REGIONAL MEDICAL PROGRAM,
Atlanta, Ga., July 17, 1970.

Hon. PETER N. KYROS,
Cannon House Office Building,
Washington, D.C.

DEAR CONGRESSMAN KYROS: This is in reply to a request made by you during my testimony before the Subcommittee on Public Health and Welfare at its hearings on extending the regional medical program, commonly known as the "heart, cancer, and stroke" program. As I understood your request, you were interested in our reasons for opposing H.R. 15960 (administration bill), especially from the standpoint of its alleged capability of better coordinating various federal health programs thereby lessening duplication and fragmentation.

Based on my experience in public health programs over the past 25 years, I believe it is fair to state that there has been greater involvement of health professionals on a voluntary basis in the regional medical program than in any other Federal health program of which I am aware. This involvement of professionals from all segments of the private sector of the health field has been paramount in whatever success RMP has been able to attain so far, and is crucial to achieving the objectives and goals outlined in the RMP law. I cannot overemphasize this point about involvement of the private sector in RMP, because without the voluntary cooperation and support of the private health sector which still delivers more than 75 percent of all health care, no Federal health program is going to succeed. The foundation upon which RMP is based, regional cooperative arrangements, with its implicit local planning to fit local needs with involvement of those in the private health delivery system at the local level, is what lured many of us to RMP in the first place. To do anything which might destroy these relationships with the private sector would be disastrous. Testimony before your committee has made clear that many voluntary and professional organizations as well as all RMP coordinators feel that the administration bill might well destroy these relationships which have been so painstakingly developed.

The administration, in reviewing the proliferation of health programs that took place under prior administrations and in its desire to save the taxpayers money by making health programs more efficient and effective, made an honest but serious mistake in judgment by assuming that coordination, efficiency, and effectiveness could be achieved by merging programs that on the surface looked as though their function or purposes might overlap.

The key questions then that arise are, "Do the functions of the four programs being placed under a single advisory council in H.R. 15960 overlap?" and "Would the programs operate more efficiently and effectively if H.R. 15960 were enacted into law?" I believe the answer to both of these questions is an unequivocal "No." My reasons follow:

The two main programs with which we are concerned are comprehensive health planning and regional medical programs. I believe testimony at the hearings indicated how slow CHP has been in becoming operational. There are a variety of reasons for this, foremost of which is the necessity for local areawide health planning agencies to receive local financial support prior to Federal funding, sometimes as much as 50-percent. This local support has been hard to come

by in all too many instances. More importantly, however, because of CHP's requirement that its policy-making body be composed of 51 percent "consumers", the health professionals who actually deliver services, have not participated in CHP as they have in RMP. For this reason the deliverers of health services feel more a part of RMP. Thus, when one really looks in depth at the two programs as they have evolved, one can only conclude that as practical matter there really is no overlap at all, and that the two programs actually complement one another. As I testified, the CHP mechanism can be the voice through which the local community can inform the professionals of their needs, and RMP is the mechanism through which the professionals can respond to those needs. Further, I would like to reemphasize from my testimony, that at the local level there is already close coordination between CHP and RMP, and I am sure even closer cooperation will result as both programs become fully operational.

I sincerely believe that RMP is the best chance for the private health service deliverers to be involved at local, regional, and national levels in a Federal program; and equally as important, the best chance for a Federal program to receive such broad-based support and involvement of the private health professionals. This is why the separate identity and integrity of RMP is so important. We can't afford to lose these people, because if we do, the future effectiveness of Federal health programs whose objectives are improving the *quantity and quality of health* services to the people closer to their homes, will be seriously impaired in my judgment.

Allow me for a moment to comment about the matter of advisory councils, an issue that is also closely connected with some of the things I have mentioned above.

We have stated on several occasions that we have no objection to a national health council which would advise on broad health policy matters and report either to the Secretary or President, but we fail to see how such a council could carry out the present functions of the National Advisory Council of Regional Medical Programs. And we further suspect that coordination of the programs at the Federal level could much more easily be achieved by employment of management mechanisms other than that of an advisory council if "coordination" is actually the end result desired.

The National Advisory Council of RMP was never intended to function as primarily a coordinating body. As an advisory group, it has reviewed operational programs, advised on their adequacy, set general policy for RMP, and has begun to set levels of achievement. Because it is composed of national leaders and men of eminence in their field, they have been able to bring a high level of quality to the program. The RMP Council has been able to review the program in terms of the feasibility and the practicality of the proposals based upon the broad and eminent experience of the individual council members. A council concerned with many programs would find it difficult to achieve this result to the degree it has been achieved in RMP. In my opinion coordination of the several programs can best be achieved by the respective staffs of those programs at the Federal management level.

The substitution of an overall policy group could not possibly go into the detail of each proposal and at the same time perform the many other functions that they would be required to do in advising the Secretary on all of the programs. To compromise of the National Advisory Council would be to eliminate a great resource of quality input from regional medical programs.

I hope my comments might be of some help to you in clarifying why feel H.R. 15960 would not be an effective piece of legislation for better coordination of these health programs. Please feel free to contact me if I can be of my further service.

Very truly yours,

J. Gordon Barrow, M.D.,
Director, Georgia RMP and
Chairman, National RMP Coordinators Steering Committee.

Judge MAXWELL. May I mention our situation?

Mr. JARMAN. Yes.

Judge MAXWELL. As far as Minnesota, we have a unique way of handling this. As far as our director of the agency of comprehensive planning in our State and the associate director of the Northland regional area division, the university division, they are both physicians and they are husband and wife.

Mr. KYROS. That is very good there. Thank you very much, Mr. Chairman.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

I want to thank Dr. Dotter and Judge Maxwell, particularly, for their testimony about the more rural areas. It applies to several areas of my district. I am glad that Dr. Barrow cited an example from the Appalachian area of North Carolina, and commented on the great job they are doing there.

I notice you state that this region indicates a 67-percent reduction in mortality from acute myocardial infarction, and there are overall improvements in other areas.

Dr. BARROW. That is what we have been told.

Mr. PREYER. These are good, hard facts as to the results we are getting from these programs, and I thank you very much for your testimony.

Mr. JARMAN. Mr. Rogers.

Mr. ROGERS. May I ask one thing, Mr. Chairman. I realize you are trying to innovate deliveries into areas where there are practically no health personnel. What would be your feeling if we gave authorization to the Public Health Service in those areas where it is critical and it is not possible to get a doctor, to assign a public health doctor there, or perhaps a public health nurse, until you could get a doctor there?

Dr. BARROW. May I answer personally, and not speaking for RMP coordinators because we have not discussed this, but I have very strong feelings on this.

Mr. ROGERS. All right.

Dr. BARROW. I feel that the only way we are going to serve some of these areas both in the ghetto and rural area is to assign physicians. I feel that the 2-year PHS people are a tremendous potential source. I administered the heart disease control program in the State of Georgia for 11 years and had experience in using the 2-year PHS assignees serving out time in the PHS rather than military time. We only use less than half of our graduates presently in our military service, so that more than half of the doctors now escape without any obligation at all.

It is not fair for half of them to serve 2 years in Vietnam and the other half not to serve a day. I feel that all young physicians, if any

are expected to serve, should serve equal time; so I would propose that each physician be drafted for a 2-year period or volunteer for a 2-year period; that those needed in the Armed Forces be taken out of the pool, and then those remaining could be assigned to areas of need in ghettoes and rural areas throughout the country to serve this need.

I think allied health professionals as well, nurses and corpsmen and others, could be assigned and this would make, to me, a tremendously useful adjunct.

Mr. ROGERS. I think we are going to have to get into something like that to reach some areas, and if it is only for a 2-year period, then next they could bring someone in after 2 years, so it is not a real hardship, and he gets back into where he wants to go in life.

I would be interested in having any comment in writing for the record that you could give us on that.

Dr. BARROW. I would be pleased to.

(The following letter was received for the record:)

GEORGIA REGIONAL MEDICAL PROGRAM,
Atlanta, Ga., July 17, 1970.

Hon. PAUL G. ROGERS,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: As you requested during my recent testimony before the House Commerce Committee, I would like to insert this further statement concerning the possible service of physicians, serving their two years of Armed Forces obligation in the Public Health Service, in areas short of physician services. I have made an attempt to contact the American Medical Association, the Academy of General Practice, and the College of Physicians concerning their official positions on this matter, but because of summer vacations have been unable to get a definitive statement from any of them to date. However, I think it is public knowledge that each of these organizations have expressed concern about the inadequacy of physician coverage in both rural and ghetto areas where physicians are now desperately needed.

I might again express my personal opinion that all physicians and perhaps allied health professionals as well might be asked to serve in these areas during their two years of commitment to the draft. This might have several beneficial side effects. First, it would introduce many of these young physicians to rural and phetto conditions for the first time, and perhaps interest some of them in practicing in these areas permanently; second, it would provide a supply of medical services for these areas which might otherwise be unobtainable and finally, if these physicians and allied health professionals were working under proper supervision, it would give the areas superior health services. I personally would like to see such a use of these two-year Public Health Service draftees.

I appreciate the opportunity of expressing these opinions and if I can give any further assistance or information, I will be glad to do so.

Yours sincerely,

J. GORDON BARROW, M.D.,
Director.

Mr. ROGERS. Thank you.

Dr. DOTTER. Excuse me, but it might also be helpful to get testimony from existing senior class students or junior class students at various medical schools as to their reaction to that.

Mr. ROGERS. Yes.

Dr. DOTTER. We were talking this morning about the difference in medical students now as opposed to 10 years ago, and there does seem to be greater awareness about public need in various areas.

Mr. ROGERS. Yes, the younger students I talked to have a great feeling for wanting to get out and do something in a public service way.

Dr. DOTTER. This might be well received.

Mr. JARMAN. Thank you for contributing, gentlemen, to our hearing record.

The committee stands adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12:25 p.m., the subcommittee adjourned, to reconvene at 10 a.m., Thursday, June 4, 1970.)

COMPREHENSIVE HEALTH PLANNING AND REGIONAL MEDICAL PROGRAMS

THURSDAY, JUNE 4, 1970

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. John Jarman (chairman) presiding.

Mr. JARMAN. The subcommittee will please be in order.

We continue hearings on bills relating to the heart, cancer, and stroke program, also bills relating to the comprehensive health program.

Let me now introduce our colleague from our own Interstate and Foreign Commerce Committee, Congressman Kuykendall, to introduce our first witness today.

STATEMENT OF HON. DAN KUYKENDALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. KUYKENDALL. Chairman Jarman and Chairman Staggers and members of the committee, for the second time the first witness is testifying before this committee; in the 90th Congress I had the privilege of introducing him then on a different subject. I have a bill in on the subject that you have now under discussion. Dr. Bland Cannon from Memphis, Tenn., is widely known in the field of medical education and particularly known as a member of the National Advisory Council for Regional Medical Programs, Dr. Cannon's expertise in this area goes way back to his being one of the cofounders of the Mid-South Medical Center Council, which covers parts of the States of Tennessee, Arkansas, and Mississippi in a Regional Medical Center Council. I recommend the testimony of Dr. Cannon and I commend this very fine physician and citizen expert in the field of medical work, his education, in medical councils, as well as the medical profession itself; I commend you, Dr. Bland Cannon of Memphis, Tenn.

Mr. JARMAN. Thank you very much, Congressman.

STATEMENT OF DR. BLAND CANNON, MEMBER, COUNCIL ON MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY DR. C. H. WILLIAM RUHE, DIRECTOR, DIVISION OF MEDICAL EDUCATION; AND HARRY N. PETERSON, ATTORNEY, LEGISLATIVE DEPARTMENT

Dr. CANNON. I want to thank Congressman Kuykendall for his introduction. I am Dr. Bland W. Cannon of Memphis, Tenn., a practicing neurological surgeon and a member of the American Medical Association's Council on Medical Education. With me to present the views of the American Medical Association on legislation extending the regional medical program and comprehensive health planning and public health services are Dr. C. H. William Ruhe, to my right, who is director of the AMA Division of Medical Education; and Dr. Harry N. Peterson, an attorney in our legislative department.

Mr. Chairman, there are a number of bills before this committee for hearing. For ease in responding to them, I shall classify them broadly into two groups: one, those bills which would primarily extend, with some modifications, the regional medical programs and the program for comprehensive health planning and public health services; and second, those bills which would combine those programs along with a third program, health facilities and services research and development.

The AMA has been vitally interested in these programs since their inception, and has testified concerning them before this committee in the past. At the time of the adoption of the regional medical programs many amendments proposed by the association were incorporated in the legislation which resulted in the program being more effective and more acceptable to the profession and to the public. In 1968, the association testified in support of the extension of the program, citing the support the program had received from the medical profession, including direct participation by some State medical associations as program grantees and active participation in lesser roles by others. In December of 1969 the AMA House of Delegates affirmed "its support of the concept of regional medical programs as enacted in Public Law 89–239" and urged AMA members to "participate at all levels in giving guidance to implementing regional medical programs in line with the highest tradition of the private practice of medicine."

In addition to extending RMP, several of the bills before you would now provide for an expansion of the program to include diseases other than heart disease, cancer and stroke, and related diseases. One bill, H.R. 14486, would broaden the scope to include heart disease, cancer and stroke "and other major diseases." We support this modification of the program. The same bill would also require that before operational grants may be approved, an opportunity must be provided for consideration of the application by each public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan area, or other local area plan, covering any area in which the regional medical program for which the application is made will be located.

On its face this requirement may seem to be beneficial. However, we view with some concern the imposition of any requirement, par-

ticularly a requirement nationwide, which might have the effect of impeding the development of some operational programs.

Mr. Chairman, the American Medical Association has also endorsed the concept of comprehensive health planning—another subject of the legislation before you. For many years we have supported voluntary efforts in health planning—State, local and areawide. The association has encouraged physicians and their professional organizations to seek and to accept the responsibility of working in the planning group throughout all stages of planning, in order to provide guidance in choosing goals and programs which will realistically meet the community's health needs. Many groups have a legitimate interest in community health and should be involved in the planning process, but the medical profession has a particular expertise which it brings to a planning group. In extending the program we urge you to adopt a modification which will call for participation on the State health planning council of a greater number of practicing physicians.

At the time of the adoption of the comprehensive health planning and public health services amendments we voiced our objection to portions of the legislation providing for public health services and project grants for health services without defining the services intended to be provided. We believe that this legislation should be clarified to indicate a limitation of the services to those which would be appropriate as public health services.

The other category of bills which I will now discuss, represented by H.R. 15960 and H.R. 16147, would incorporate under a single legislative act three programs: regional medical programs, comprehensive health planning and public health services, and health facilities and services research and development. In our opinion an amalgamation of these programs would not be in the best interest of the public and would not best serve to accomplish the goals originally sought by the enactment of the individual programs.

In 1968, testifying for the AMA on the extension of RMP, I then stated, after voicing the profession's acceptance of the program because of changes which had been made in its original structure:

> RMP began auspiciously and, since that time, continues to promise a hopeful future. But there are still some who would like to see the Regional Medical Programs as an instrument by which the organization and delivery of health care to the American people could be changed in some revolutionary manner. * * * We view with favor the early progress of RMP, its ability to build on existing patterns of medical care (sometimes adding new features or changing old ones as local demands and resources make possible) and the local flexibility which allows the program to make a real contribution to the health care of our Nation.

While it has been stated that a primary purpose of combining the programs is to achieve coordination and avoid duplication of effort, it is apparent from the legislation that a change in the thrust of the programs is intended. We believe that coordination and integration can be developed best at the local or regional level.

There is convincing evidence that this has already developed in some regions under the existing legislation, and effective coordination should be fostered and developed in other regions through local initiative. Since the two programs are under the same general jurisdiction, greater coordination can, and should, occur at the Federal level with-

out the necessity of combining the programs legislatively. While some measure of coordination may result from a combination of the programs, the substantial result would be a change in the nature and direction of regional medical programs from what has been essentially a program of education and related demonstration of patient care.

We would view with grave concern any attempt to change this essentially educational program to a program for the provision of health services. The medical profession today generally views RMP as a means of aiding the physician to provide better care to his patients. It is this attitude which has brought about the outstanding cooperation between practicing physicians and RMP and which has been a major cause of success for the program thus far. If RMP returns to an earlier concept of providing services to the patient, rather than its present goal of assisting the individual physician to treat the patient more effectively, this cooperation will, in many cases, be lost. The program's beneficial accomplishments will then be diminished.

An examination of the change in present section 900 which would be made by the proposed combination indicates a potential redirection of RMP. In its present form, section 900 clearly denotes an educational program. After stating with some specificity the manner of accomplishing this end, it provides:

> (c) by these means, to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies.

This language, along with other language denoting the educational aspects of the program, would be deleted under the new proposal.

SUMMARY

In summary, Mr. Chairman, we support an extension of the regional medical programs and with the reservations stated, the program for comprehensive health planning and public health services. In so doing, we want to stress that RMP should continue as a program of continuing medical education, with patient care being limited to demonstrations as an adjunct of the education and research process. We oppose the legislation proposing to combine the individual programs. These programs are relatively new, and we believe should be evaluated as well as allowed to develop further evidence of their individual strengths and weaknesses.

An ongoing evaluation of regional medical programs by Arthur D. Little & Associates resulted from our testimony 2 years ago and has been in progress for 2 years. I imagine, Mr. Chairman, that there are some progress reports. We do not have them. Your committee may have them.

We thank you for the opportunity of presenting the views of the American Medical Association on this important health legislation, and we will now attempt to answer any questions which you might have.

Mr. JARMAN. Thank you very much, Dr. Cannon.

Now the Chair has one additional comment and question. You make reference to several of the bills before the subcommittee providing for expansion of the programs to include diseases other than heart,

cancer, and stroke. We have had very strong testimony as to the kidney disease program need and status of medical progress in this area, and an urging that it, for instance, be included as a category.

Do I understand from your testimony that you favor limiting the program to the specific reference to "heart, cancer, and stroke and other major diseases" rather than any other specific category being in there?

Dr. CANNON. That is correct. We feel the definition of what is "major," major as in mortality and major in morbidity, involves priorities that must be assessed, but major diseases would include kidney disease.

Mr. JARMAN. I understand. Mr. Hastings?

Mr. HASTINGS. No questions.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. Dr. Cannon, most of our witnesses, I believe, have opposed the legislation proposing to combine the individual programs, but I think you have given us one of the more specific and detailed impressive arguments against combining them, very effectively.

Just to follow up one moment on the question the chairman asked you about your suggestion for including diseases other than heart, cancer, and stroke, the objection has been that to include "other major diseases" would dilute the effort now going into heart, cancer, and stroke if the funding remained at the present level. I assume if we included the phrase "and other major diseases," that you would be in favor of increasing the funding also?

Dr. CANNON. I would be in favor of increasing the funding on the capacity side of the health service. I think this is one of the programs for which it took about 3 years to really get the organization structure firmed up. Only in the last 6 months have all regions become operational.

We now have full staffs in all regions. This has been a difficult task with the manpower shortage situation. The structure is there now for a more effective operation. We do need the funds to make the program more realistic in its value and to continue the values that it has already gained.

Mr. PREYER. Would you have any specific suggestion as to what the authorization should be increased to if we included the phrase "and other major diseases"?

Dr. CANNON. That would be extremely difficult, Mr. Preyer, but there must be priorities set and these priorities must be determined by people who are in a position, who have a certain expertise.

I think the National Advisory Council has wisely set priorities, because if you considered heart disease, cancer, and stroke, it is hard to divorce heart disease from kidney disease. For instance, in children throat infections with streptococcus are considered one of the major causes of heart disease later in life. So actually we could get into prevention of strep throat in children, but your advisory council has very wisely established priorities so that the thrust would not be in all directions at once.

We put the thrust on the major killers and this we considered an effective thrust. The evaluation of the programs, by Little & Associates, may show us that our efforts have have different effects than we think and that maybe they are adding significantly to improvements that we are not aware of.

Mr. PREYER. There is a story about doctors that goes something like, a fellow goes to his doctor and says, "What shall I do to get well?" He says, "Give up wine, women and song." The man says, "What is your second-best advice?

On this question of other major diseases, do you have any second-best advice if we can't, or if the committee decides we can't include "other major diseases"? Does the American Medical Association have any position as to which two should be included or which three, if it gets to that point?

Dr. CANNON. You have those people appearing before you who represent special interests. Their special interests may have been stimulated by Congressman "Fats" Everett's plight in kidney disease, it might be stimulated by one of their children having cerebral palsy.

You have so many people asking so much, I think it would be unwise to specify in law which diseases take priority. You hit the big three and leave it to your advisory councils and the experts to try to come up with where the funds should go, but don't tighten it up so tight that they can't go expand the effort in the direction where the program is shown to be doing the most good.

The only way we would know is by an ongoing evaluation.

Mr. PREYER. Thank you. I have one final question. You suggest two modifications: One, to call for participation on the State Health Planning Council of a greater number of practicing physicians and, two, legislation—or clarifying legislation which would indicate a limitation of the services of those whch would be approprate as public health services.

Neither of these provisions are in any of these bills at the present time, I take it? These are something you suggest for adding?

Mr. PETERSON. Yes; that is correct. They are not in any of the bills at this time.

Mr. JARMAN. Thank you, Dr. Cannon and gentlemen.

It is a pleasure to welcome Dr. Ruhe to the subcommittee again. Do you have any additional comments that you or Mr. Peterson would like to make?

Dr. RUHE. No, sir.

Mr. JARMAN. Thank you, gentlemen, for the excellent presentation.

Our next witnesses this morning are Dr. Lewis January, professor of medicine, University of Iowa, and Dr. Campbell Moses, medical director of the American Heart Association, appearing here for the American Heart Association.

It is good to have you here, gentlemen.

STATEMENT OF DR. LEWIS E. JANUARY, FORMER PRESIDENT, AMERICAN HEART ASSOCIATION; ACCOMPANIED BY DR. CAMPBELL MOSES, MEDICAL DIRECTOR, AMERICAN HEART ASSOCIATION

Dr. JANUARY. Thank you, Mr. Chairman and gentlemen. I am Dr. Lewis E. January, University of Iowa, and formerly president of the American Heart Association, and with me is Dr. Campbell Moss, our medical director.

I shall be very brief. The American Heart Association appreciates the opportunity to be heard because we have been involved in one

way or another in all of the legislation on the RMP since the report of the President's Commission on Heart Disease, Cancer, and Stroke.

I must say we have been very impressed with the effectiveness of the regional medical program activities in getting doctors, voluntary health agencies, hospitals, medical schools, medical societies, nurses, osteopaths—to name a few—to work together in improving the quality of medical care. We have reviewed the several bills introduced and have given especially careful consiedration to the administration health planning.

It is our considered judgment that Congressman Staggers' bill, H.R. 14284, most effectively provides opportunities for building on the excellent groundwork laid in the past 3 years by the developing of regional medical programs. This is so because it does this without disrupting the present organization, an organization that has obtained the confident cooperation, as you have just heard, of all levels of medical responsibility, and has done this in spite of some initial suspicion by physicians to become involved with anything smacking of what too often is referred to as "Government medicine."

Physicians generally do support the regional medical programs and so does the American Heart Association.

Most importantly, we think this bill retains the categorical emphasis on disease states—heart disease, cancer, and stroke—and yet provides separate authorizations for other chronic disease programs not specifically specified. The present administration seems strongly in favor of comprehensive health planning and, indeed, we, too, favor intelligent integrated planning for total medical care. However, the hard facts are that if we have appropriate preventive, diagnostic therapeutic and rehabilitation facilities for heart disease, cancer, and stroke patients, then the major burden will have been met and, at the same time, the facilities and experience will be equally useful in the management of many other diseases. The categorical emphasis merely provides a convenient handle for channeling support, not diluting it, and it does not sharply delimit the use of facilities which may be developed to help physicians render better care for their patients.

The Staggers bill provides the mechanism for improving health services for persons residing in areas with limited health services, and it requires that the regions take into consideration the plans of relevant areawide and State health and other planning agencies. Specific review and approval of such agencies is not required, however. This mechanism thus permits integration of regional medical programs with Comprehensive Health Planning, maintaining the virtues and independence of each approach.

In addition to providing authorization for 3 years at the level of $50 million for chronic disease programs, it authorizes $125 million, $150 million and $175 million in fiscal years 1971, 1972, and 1973 for regional medical program grants. While these amounts are substantially less than the amounts originally authorized for regional medical programs, they will go a long way toward doing the job.

The other bills introduced and particularly the administration's proposal, H.R. 15690, have the laudable objective which we have supported from the very beginning of coordinating regional medical programs and comprehensive health planning, but we disagree completely with the mechanism of a common advisory committee and giving the

authority for funding to Public Health Department officers. We believe that this loss of identification of the regional medical programs and loss of ultimate funding authority from the National Advisory Council would be disastrous to the continued success of regional medical programs.

After all, RMP has already proven that it is operating effectively and economically and harmoniously with the health planning community. Our major purpose for being here is to urge favorable consideration of H.R. 14284 by your committee, Mr. Chairman.

Thank you, we will be happy to answer any questions that we can, if you have any.

Mr. JARMAN. Thank you, Doctor, and the committee is well aware of the fact that the American Heart Association has appeared twice before in support of this program and we appreciate your taking time to comment on the legislation before us and to indicate your continued support of the regional medical program.

Mr. Nelsen?

Mr. NELSEN. No questions.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. No questions?

Mr. JARMAN. Mr. Carter?

Mr. CARTER. No questions?

Mr. JARMAN. Mr. Hastings?

Mr. HASTINGS. No questions.

Mr. JARMAN. Thank you.

Dr. JANUARY. Thank you, sir.

Mr. JARMAN. Our next witness is Mr. Joseph S. Murtaugh, director, Department of Planning and Policy Development, Association of American Medical Colleges, here in Washington.

STATEMENT OF JOSEPH S. MURTAUGH, DIRECTOR, DEPARTMENT OF PLANNING AND POLICY DEVELOPMENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY JOHN DANIELSON, DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS AND HEALTH SERVICES

Mr. MURTAUGH. Thank you, Mr. Chairman.

I am accompanied by Mr. John Danielson, director of the Department of Teaching Hospitals and Health Services of the Association of American Medical Colleges.

On behalf of the AAMC, I welcome this opportunity to present to the subcommittee the association's views on certain aspects of H.R. 15960 and associated bills amending and extending regional medical programs, comprehensive health planning, and related health programs.

The Association of American Medical Colleges is comprised of all of the 107 medical schools in the United States and 379 of the major teaching hospitals. This community of institutions encompasses most of the processes of medical education and a substantial portion of the medical and health related research carried on in this country as well as providing training for large numbers of related health professions and occupations and contributing in a considerable and critical

way to the improvement of the community health scene through innovation, demonstration and providing medical and health services. Thus the association and its membership have a direct and deep interest in the programs with which the legislation now before this subcommittee deals.

There are a total of 10 bills before the subcommittee dealing with regional medical programs, comprehensive health planning, and related activities. In the interest of brevity, simplicity and meaningful comment, the following remarks are addressed to what appear to be the two basic alternative approaches encompassed in these various proposals.

The first approach, recommended by the executive branch, is exemplified by H.R. 15960, introduced by Mr. Staggers and Mr. Springer. This bill, entitled "The Health Services Improvement Act of 1970," proposes encompassing regional medical programs, comprehensive health planning activities, authorities for the National Center for Health Services Research and Development and certain activities in the area of health statistics into a single statute under one general statement of purposes and objectives, to be guided by a single advisory council with an overall appropriation authorization and with various amendments of the individual program authorities, substantial in the case of regional medical programs.

The second approach, exemplified by H.R. 17570 of Mr. Jarman and H.R. 15895 of Mr. Rogers, would separately extend with some amendment the basic authorities for these principal programs as they now exist with their respective purposes and objectives intact and with new appropriation authorizations.

The basic question, therefore, is which of these two approaches will most advance our national health effort as well as best serve the overall public interest.

While the former approach, represented by H.R. 15960, would appear to offer certain advantages in terms of legislative and statutory economy and, perhaps, in simplicity of administration, the program modifications it proposes, particularly in regional medical programs, are of a major order and, if enacted, would considerably change the nature and conduct of these programs.

After careful consideration of these legislative alternatives and their program implications, the executive council of the Association of American Medical Colleges has concluded to recommend against the legislative approach reflected by H.R. 15960 at this time and urge separate extension of the existing program authorities with appropriate amendment. The reasons for this conclusion are as follows:

The major programs with which the proposed legislation deals—regional medical programs, comprehensive health planning, and the National Center for Health Services Research and Development—were initiated to serve clearcut and distinct purposes and roles as important complementary components of the Nation's overall health effort. A brief review of the nature of these programs is an essential context for a discussion of problems presented by the proposed legislation:

Regional medical program are aimed at improving the quality of care available for the victims of the major killer diseases in all the areas and communities of the Nation. This objective has been sought

by developing voluntary cooperative arrangements that would directly link centers of scientific and academic medicine with hospitals, community health facilities and practitioners on a regional basis.

Under these arrangements, programs of education, training, demonstration, and investigation could be developed to make broadly available new medical advances and technology to overcome existing limitations in the character and quality of care available to victims of these diseases in a particular region. This program is centered in the private and unofficial framework of medicine and health and has been heavily dependent upon, and responsive to, local initiative and determination.

Comprehensive health planning, on the other hand, is centered in the public and official framework of health action and is aimed at the development of comprehensive health planning at both State and local levels, improving the organization and delivery of health services, guiding the development of health resources to secure their most efficient utilization and supporting public health services. These are distinct health functions vital to the development of the overall health framework of the Nation and to making progress in the pressing health service problems confronting us.

The National Center for Health Services Research and Development is the national agency for the conduct and support of research and investigation into the problem surrounding the delivery of health services and the fostering of experiments and developments in new mechanisms, devices and systems for health and medical care. Its programs are intended to provide the flow of new technology and knowledge necessary to increase the availability, accessibility and effectiveness of health services, to reduce their cost and increase our capability to make health services meet health needs. The support provided research and development proposals by the National Center is based on an assessment of their importance, scientific merit and problem relevance in a national context. Thus, the National Center serves the same critical role in health services research and development as the National Institutes of Health does in biomedical research.

The consolidation and changes in these programs as proposed in H.R. 15960 would appear to modify and thereby confuse the role, objectives and functions of these three different programs in a manner which seems unnecessary and unwise at this stage of their development. The consequence of this course of action would be, we believe, to obscure the national objectives being sought, increase the possibility of duplication, and threaten current and future progress in these important areas of national health action.

Thus, H.R. 15960 would extend regional medical programs into improving the "distribution and efficiency" of health services and "developing systems for organizing and delivering medical care." Aside from the question of how appropriate such a role is for the institutions and agencies now involved in regional medical programs, the language utilized is hardly distinguishable from the objectives set forth for the other program components of the bill. The failure in the past to articulate such distinctions at the national level has contributed substantially to confusion, duplication of action and program conflicts at the local level. Now that increasing progress is being made at the local and regional levels in working out mutually agreeable

concepts of the respective roles of regional medical programs and comprehensive health planning and patterns of useful working relationships, it seems most unfortunate to cast another cloud of confusion over these programs again from the national level.

Another possible consequence of changes proposed in these programs under H.R. 15960 would be to diminish the emphasis within regional medical programs upon local and regional needs and problems and the impetus now given in the present programs to local initiative and determination in developing and organizing the attack upon them. The opportunity provided by regional medical programs for local hospitals, health agencies, and practicing physicians in conjunction with a medical center to design their own set of programs based on their local perception of needs, strength, and deficits has been one of the unique and innovative aspects of regional medical programs. The extent of participation by practicing physicians and medical societies in regional medical programs has been a most heartening aspect of the progress thus far. In large part this participation has been forthcoming because of the sense of protection given by the so-called noninterference clause in the present statute. Free from fear of the imposition of federally designed solutions to their local problems, but with assurance of support, the members of the local medical communities, in most instances, have turned with a will to seeking solutions to their local problems with the best and broadest uses of available resources. Changes in the thrust of the regional medical programs program and removal of the "noninterference" clause may militate against this vital participation just at the very threshold of yielding the fruits of the prolonged process of local development and accommodation.

In like manner, the proposed changes would appear to deemphasize another critical concept of regional medical programs; namely, the effort to link the medical schools and other centers of scientific and academic medicine to the framework of health institutions and services in a regional area to broaden the availability of the latest advances in diagonsis, therapy, and other medical capability. Providing a bridge between the world of the medical sciences and the community health scene has been the central theme of regional medical programs from the beginning. It has provided the means for medical schools and teaching hospitals to extend their capability to the solution of community health problems and to provide training and technical assistance and, at the same time, expose scientist and academician to the real problems of community health. This is a set of relationships which serve the overall national health need well and should not be threatened by poorly thought through program changes or hasty reorganization.

A major development proposed in H.R. 15960 is the establishment of a new National Advisory Council on Planning Organization and Delivery of Health Services. This council would provide advice and assistance to the Secretary in administering and coordinating all of the programs encompassed in the act. The existing National Advisory Council for regional medical programs would be abolished. Two questions in respect to this proposal are worthy of note.

How well will a single advisory council serve the needs and provide assistance to the four programs encompassed in the act? We believe

it is likely to generate contention among the administrators of the programs involved. The fact that it will have the function of approval of grants prior to award in one program (RMP) and not the others could possibly introduce a considerable bias in its program relationships.

What is the relationship of this new council to the National Advisory Health Council? The National Advisory Health Council has served as the overall health advisory group for the Nation since 1930. It seems unnecessary duplication to create another overall advisory council to provide for coordination of these programs when the existing National Advisory Health Council could probably well serve this need.

A final consideration which has important implications for the further development of national health policy would appear to be inherent in the process of program integration, which H.R. 15960 would clearly foster. This relates to how the public and private interests in the further evolution of our national health and medical care system will eventually be reconciled.

The development of regional medical programs along one line and comprehensive health planning along another represents clear recognition that there is both a private and public role in advancing the health of the Nation. National action is thus being taken through both these sets of institutions, arrangements and activities and there is clear need for wise coordination in administration of the programs. However, to preserve the great advantages that this duality of effort provides, it seems desirable to retain a high degree of distinction in the formulation of policy for and in guiding the content and emphasis of these complementary programs. It also seems both desirable and inevitable that the ultimate resolution of the relationship between the private role and the public interest in health must take place at the community level in the context of the manifold variations of needs, wants, capability, resources and ingenuity that characterize the American community scene.

Furthermore, the elimination of the separate statutory base, appropriation authorizations and expression of objectives for regional medical programs (now concerned with the private and unofficial health framework) and comprehensive health planning programs (now concerned with the public and official framework of health) and the placing of the policy advisory functions for the further development of these programs in a single overall national advisory committee could have a most critical consequence. It would appear to move downward the process of decisionmaking in respect to the resolution of the private versus the public role in the national health framework, from the levels of executive and legislative exchange to an intradepartmental function. This would come at a time when the most difficult and complex issues of this relationship are beginning to emerge. These issues would seem to be of such importance and potentially so controversial that the final formulation of public policy in respect to them should take place in a setting which permits the full workings of our democratic processes to come to play.

It is for these reasons that the executive council of the Association of American Medical Colleges would urge continuation of the separate existing statutory authorizations for comprehensive health planning

and regional medical programs following the approach taken in H.R. 17570 and H.R. 15895.

H.R. 17570 would appear to provide amendments to the existing regional medical programs statute which program experience and development thus far would indicate to be desirable and appropriate. H.R. 15895 could be amended to include the language contained in part C and section 3 of part D of H.R. 15960 to provide requisite authorities for the National Center for Health Services Research and Development and the proposed extension of the programs of the National Center for Health Statistics. The necessary and desirable coordination of these programs could be achieved through the existing administrative and advisory structure.

In conclusion, Mr. Chairman, I think it important to emphasize that the Association of American Medical Colleges is fully supportive of comprehensive health planning at the local, State and national levels. We have urged all of our member institutions to participate in and contribute fully to these programs and activities, as we have their involvement in regional medical programs. The only matter of concern relates to how the processes of review and approval of activities under these programs bear on our member institutions. The medical schools and teaching hospitals serve both specific local purposes and broad national objectives. While it seems appropriate for the activities of these institutions that are directed towards community and regional needs to be encompassed in the local planning and review processes, the functions that serve national objectives in the education of the health professions, medical research and other national needs should not be subject to such local determinations.

Thus, we believe that the Nation's medical schools and teaching hospitals should be clearly responsive to the needs of the immediate community in which they are located as well as meeting fully their broad national responsibilities.

Thank you, Mr. Chairman.

Mr. JARMAN. Your statement is very comprehensive and will certainly be helpful to the committee. As you know, Dr. Egeberg, appearing as the first witness in these hearings, presented the administration's proposed legislation, which would provide, as you indicate, for a combined statement of purposes and combined National Advisory Council for both regional medical programs and the comprehensive health planning program. But your organization, as well as all other witnesses that appeared before us have spoken out strongly and definitely in favor of continuation of the separate existing statutory authorizations for comprehensive health planning and regional medical programs. We had no other testimony in the hearings in favor of the combined approach, which issue is being debated in both Houses of the Congress. We have not received any other testimony in the hearings in support of that legislative proposal except from the leadoff witness, Dr. Egeberg.

Mr. Nelsen?

Mr. NELSEN. Thank you, Mr. Chairman.

On page 9 I noted that you referred to H.R. 15895. Is that right? My copy says H.R. 15885.

Mr. MURTAUGH. That was an error. The bill I am referring to is Mr. Rogers' bill, H.R. 15895.

Mr. NELSEN. Thank you, no other questions.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. I just want to thank Dr. Murtaugh for his testimony. I think your point about the present system being the best one for ultimately resolving the relationship between the private role and the public role is an extremely good point. I gather what you are saying is we have a system that is beginning to work and let's not tamper with it at this time.

Mr. MURTAUGH. Yes, sir.

Mr. PREYER. Don't pull up your potatoes to look at the roots everyday to see if they are growing properly.

Mr. MURTAUGH. Very well put, sir.

Mr. PREYER. Thank you, Mr. Murtaugh.

Mr. JARMAN. Mr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. Certainly I think you have made a good presentation. I agree with you that the regional medical programs have been quite effective and in some places they have not been implemented properly, I regret to say, but I hope in the near future they will.

I check on them quite regularly and also on the CHP, which I have not found always satisfactory. I am afraid in many cases the little people will want to determine the locations of the hospitals, which they probably should, but at least they wind up in arguments over these things quite often.

Another thing at the State level there will be some controversy between them and the Hill-Burton people. Do you think that CHP groups should determine the location of the hospital or the Hill-Burton group, what is your idea on that?

Mr. MURTAUGH. I wish I had adequate basis to respond fully to your question, Mr. Carter.

It is a complex matter and the scope of my experience would not lead me to any clear conclusion in respect to it. I do believe that the task of attempting to guide public investment in major health facilities is an extremely critical one and one that has to take into account all of the considerations involved.

Surely, to make certain that there is the best utilization of those public resources and that the process reduces the gap between available services and clear needs. Now I am just not informed enough of the Hill-Burton and comprehensive planning relationships at the State level to really aid you in answering.

Mr. CARTER. I believe the present law says that the Hill-Burton groups will give consideration to what the CHP people say, but they are the final, or they make the final decisions.

Mr. MURTAUGH. Perhaps Mr. Danielson would have a comment on that point.

Mr. DANIELSON. I am John Danielson, Association of American Medical Colleges, and I think what you indicated is true, that there is a consideration depending on what the State relationship is between the comprehensive health planning group and the work working with Hill-Burton. How effective that relationship is will determine how effective placement of hospitals and consideration of hospitals is made.

I do think there ought to be a reinforcement of the comments made by Dr. Bland Cannon of AMA in reference to greater involvement of

the CHP group of those people who are catually responsible for delivering the health care to a community. And the reason why we, I think, have taken the position we have, is that we believe the RMP programs are moving more and more toward looking at the issue of planning, planning done by voluntary planning agencies as well as comprehensive planning agencies, and I think the linking of planning of RMP is effective, but we believe effective as related to the specific program.

But I would think there should be greater emphasis, to answer specifically your question, of an improved relationship between Hill-Burton and comprehensive health planning people rather than taking the authority from one or totally away from the other.

Mr. CARTER. There is another controversy, I mean one must have final authority, it seems to me. At the present time it does reside, I understand, in the Hill-Burton people.

Mr. DANIELSON. I believe that is probably where it ought to reside.

Mr. CARTER. I hope that CHP planning will be more successful than I have observed in the past. Certainly I think that the regional health programs, RMP, should be separate from this group and I feel it has a great future if properly implemented. It will offer a great help to communities, small communities throughout our country.

That is all, thank you, Mr. Chairman.

Mr. JARMAN. Mr. Skubitz?

Mr. SKUBITZ. Thank you, Mr. Chairman.

I regret that I was not here from the beginning, Mr. Murtaugh, to hear all of your testimony. I am not in a position to ask questions at this moment. However, I was impressed by Congressman Preyer's statement "Don't pull up the potatoes to see the roots," but I want to remind you that sometimes in raising potatoes you can have beautiful tops but no potatoes.

Thank you.

Mr. JARMAN. Mr. Hastings?

Mr. HASTINGS. One question. Do you take a position on the specific inclusion of other diseases such as kidney disease?

Mr. MURTAUGH. I think the response that Dr. Cannon gave to the addition of "further diseases" to the regional medical program was a very wise response.

The concept, as I understood, behind regional medical programs is to deal first with those diseases which impose the greatest burden in terms of premature death and suffering and also where there exists a major differential between capability to deal with those diseases in centers of academic medicine and generality of capability within the community and place the first effort on overcoming that differential and proceeding in a similar manner, utilizing that concept as a priority.

In the case of kidney disease, I believe there is a set of problems of that nature and it would be appropriate to be high in the further diseases to be centered upon in the conduct of these programs.

Mr. HASTINGS. But you don't stay with the inclusion specifically?

Mr. MURTAUGH. I personally would say, I see no harm in it at all. I believe that the statement of heart disease, cancer, and stroke and other major diseases, in allowing a determination to be made within the advisory council process is a wise one.

Mr. HASTINGS. Thank you; no further questions.

Mr. JARMAN. Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

I am sorry I was not here to hear the testimony. I will read it. I had to be at another committee, but as I understand, you feel that the two should not be joined?

Mr. MURTAUGH. Yes; that is our recommendation.

Mr. ROGERS. I agree with that. I think that is proper. Thank you very much, Mr. Chairman.

Mr. JARMAN. Mr. Murtaugh, the committee is very conscious of your background in your work at the National Institutes of Health and we appreciate your and Mr. Danielson's presence here.

Mr. MURTAUGH. Thank you very much.

Mr. JARMAN. Our next witness is Dr. James C. Metts, Savannah, Ga., and we are asking our colleague, Congressman Elliott Hagan of Georgia, to introduce Dr. Metts at this time.

STATEMENT OF HON. G. ELLIOTT HAGAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. HAGAN. Thank you very much, Mr. Chairman and gentlemen of the committee. I appreciate this opportunity very much to present an outstanding man from my district and I am sure that his testimony, with which I am thoroughly in accord, having spent much time with him, should be of some benefit in your deliberations. It is my privilege today to introduce my constituent, Dr. James C. Metts, Jr., a physician in the private practice of internal medicine in Savannah, Ga. Dr. Metts is chairman of Savannah's Community Cardiovascular Council and director of the comprehensive stroke unit. He is one of our outstanding men of medicine from Georgia in my district or elsewhere in the country, Mr. Chairman, and it is a great pleasure for me to present him to the committee.

Thank you very much.

Mr. JARMAN. Thank you very much. It is good to have you with us, Dr. Metts.

STATEMENT OF DR. JAMES C. METTS, JR., SAVANNAH, GA.

Dr. METTS. Thank you, sir.

Mr. JARMAN. Off the record.

(Discussion off the record.)

Mr. JARMAN. In the interest of time, if you would like to submit your entire statement for the record and comment on the highlights of the statement, I would suggest that approach to you.

Dr. METTS. All right, I will do that. I would like to enter my prepared statement in its entirety.

Mr. JARMAN. It will be placed in the record in full.

Dr. METTS. Basically, here I am a private physician practicing in Savannah and represent the city through its community cardiovascular council and am here to present certain recommendations regarding Congressman Staggers' bill, 14284.

This is a very good bill, but there are some modifications or specific recommendations I would have. I have not included this in my testimony, but I will mention in passing we are opposed to H.R. 15960, and we agree with the previous testimony by the witnesses here.

My comments will be restricted to the problem of heart disease and stroke. This was previously considered under chronic disease programs. It is well documented that cardiovascular diseases account for over one-half of the deaths in Georgia, and my county of Chatham, in general, has an inordinately high amount of heart attacks and strokes, and this is my particular interest.

The heart disease and stroke control program, which is a division of the Chronic Disease Section, is being phased out by the Department of Health, Education, and Welfare on June 30, 1970. This is the only organization, to my knowledge, in this country that was attempting to do something at the community level to modify the rate of attacks of heart disease and strokes.

Now, we had been involved in a legislative hassle and I had been here to testify before Senator Magnuson's committee and he ruled in our favor and specifically earmarked some funds to continue the heart disease and stroke program. I have his recommendation appended as a table in back of my testimony. This legislation was also ignored by the Department of Health, Education, and Welfare.

I have also been up here to testify before Senator Yarborough's committee and I think his bill is a companion bill to Mr. Staggers' bill, and we were in favor of Senator Yarborough's bill and I do not know what the upshot of that has been yet.

In view of the magnitude of heart disease and stroke, and the fact is that half of the people dying in the country die annually from heart disease and strokes, so we are at a loss to know how the Department of Health, Education, and Welfare can justify their limitation of it.

As a specific case in point, I asked one highly placed HEW official whether he had had even one physician recommend that the Framingham study be abolished. To my amazement he stated no physician had ever recommended that course of action, but he did not consider it pertinent because the decision to abolish this monumental epidemiologic study was political and not medical or scientific. It had never occurred to him in the course of making a decision of this magnitude he should consult someone who knew what they were talking about.

Just out of hand, they abolished the study for a paltry amount of money. The heart disease, stroke, and cancer program on a nationwide basis was only costing about $4 million a year and it is a trifle investment when you consider that heart disease and strokes are costing us $20 to $30 billion, not million, a year.

These are catastrophic diseases, particularly stroke. I get my information from the papers, but the recent episode of Mr. Finch certainly sounds like a transient stroke and this should bring matters home to you. This came out of the blue and he was lucky. Usually it prevents you from bringing a wage earner and profitable member of society, but rather a chronic welfare recipient even if they are trial cases.

In Savannah, Ga., we are trying, in conjunction with the Public Health Service—we are trying to conduct a communitywide attempt to modify the rate of heart disease and stroke attacks. This has never been done, it has never been demonstrated you can do this, that you can launch a public health preventative campaign on heart disease and strokes. It has never been documented and that is what we are trying to do.

This thing has been pretty well wiped out. We had a signed contract with HEW and they arbitrarily and unilaterally violated their contract, and their actions are so arbitrary we are thinking of returning to Washington to take Mr. Finch to court to seek an injunction. Their actions were indefensible as my testimony here states.

Now my recommendation is this: With the abolition of the heart disease and stroke control program, which is under the chronic disease section, the only agency left that deals with the problem is the regional medical program service and the regional medical program is concerning itself more and more with health planning and systems of health care delivery. While comprehensive health planning and analysis of health care delivery systems is vital, the regional medical programs is not actively concerning itself with community intervention in the field of heart and stroke.

RMP is an excellent program, but this leaves a tremendous gap in the actual application of what is now known about heart disease and stroke, its actual applications to community health. The heart disease and stroke control program is a professional corps of epidemiologists, statisticians, health workers and what have you, who were aavilable to help a community such as ours launch this project.

This corps is being pretty well disbanded and it is my recommendation that some specific legislation be included under the RMP service to provide for a heart disease and stroke program. Beforehand, chronic diseases included heart, stroke, cigarette smoking, nutrition, cancer, and artificial kidney dialysis. Most of these programs have been dropped, but have remaining nutrition and cigarette smoking and these have been elevated to divisional status. It would be my recommendation that some similar course of action be followed in the case of heart disease and stroke. Because the heart disease and stroke control program concerns itself with the clinical and community application of current knowledge, and the regional medical programs concerns itself more with administrative systems, I would recommend that you consider that part B be clarified and expanded to include the heart disease and stroke control program in Mr. Staggers' bill. This would permit continuation of a desperately needed professional corps of experienced epidemiologists and investigators who could assist our various communities in our local efforts to improve our health.

As an interim measure, what we have done is transfer a basic nucleus of personnel from Arlington, Va., down to the field station in Atlanta, Ga., and they will, to some extent, continue to function.

But this is only a pending measure and Mr. Staggers' legislations should be clarified or extended in this particular direction.

That, basically, is the sum of my statement.

(Dr. Metts' prepared statement follows:)

STATEMENT OF DR. JAMES C. METTS, JR., CHAIRMAN, COMMUNITY CARDIOVASCULAR COUNCIL; DIRECTOR, COMPREHENSIVE STROKE UNIT; CHAIRMAN, CANDLER GENERAL HOSPITAL'S LOCAL ADVISORY GROUP TO THE GEORGIA REGIONAL MEDICAL PROGRAM

My name is Dr. James C. Metts, Jr. I am a physician in the private practice of internal medicine in Savannah, Georgia, and I represent the Community of Savannah, Georgia, through its Community Cardiovascular Council.

I am here to present certain recommendations and suggestions regarding Congressman Staggers' bill, H.R. 14284, which is now pending before the House. It is our opinion that this is a very good bill, but we feel that certain sections should be clarified. My testimony relates to the Chronic Disease Section of the Regional Medical Program Services. In all sincerity, I am not competent to speak on the whole problem of Chronic Diseases, but must restrict my comments to the problem of Heart Disease and Stroke.

It is well documented that Cardiovascular Disease (Heart Attack and Stroke) account for more than one-half of the deaths in Georgia (See Table I), and my County of Chatham has one of the highest attack rates of Heart Attack and Stroke in the United States. These diseases are estimated to cost this country between twenty to thirty billion dollars annually. We have been able to determine that Heart Disease and Stroke have certain risk factors which can be manipulated and controlled, and in view of the rising number of deaths from Cardiovascular Disease each year, it is imperative that we attempt to do something about these risk factors at the earliest possible moment which is *now*. Secretary Robert Finch recently suffered what appears to have been a mild stroke and more and more of our productive citizens are being attacked by these dreaded diseases each day.

The Heart Disease and Stroke Control Program, which is a division of the Chronic Disease Section, has already been disbanded and will be completely abolished by June 30, 1970. This was the one program of the Chronic Disease Section which was attempting to operate on a community level at the present time to modify the actual attack rate of Heart Disease and Stroke. This was the only program of this sort in the entire world and HEW, after being warned repeatedly and after ignoring specific legislation in Senator Magnuson's Appropriations Bill chose to abolish it.

In times past the Heart Disease and Stroke Control Program was simply one facet of the Chronic Disease Section under the United States Public Health Service. This really seems inappropriate when one considers that Heart Disease and Stroke account for more than one-half of the deaths in this country annually. (See Tables II, III, & IV). In its recent economy move, the Department of HEW considered the seven programs under the auspices of the Chronic Disease Control Programs, and decided that it would continue the sections on renal dialysis, nutrition and cigarette smoking. Without minimizing the importance of these programs, they are relatively inconsequental when compared with the impact of Cardiovascular Diseases in this country.

I have inquired at the Department of HEW as to how a decision to abolish the Heart Disease and Stroke Control Programs could be justified. As a specific case in point, I asked a highly placed HEW official as to whether he had ever had even one physician recommend that the Framingham Study be abolished. To my complete amazement he stated that no physician had ever recommended this court of action, but that he did not consider this pertinent because the decision to abolish this monumental epidemiological study had been political, not medical or scientific. Apparently it had never occurred to him that in the course of making a decision of this magnitude he should consult someone who knew what they were talking about.

At the present time we are attempting to salvage what we can from projects which had been conducted under the Heart Disease and Stroke Control Program. This is a make shift effort at best and we are simply trying to hold on until we can get some specific legislative support which may make HEW more responsible to the needs of our country.

There is a desperate need to estabilsh a specific legislative structure for the control of Heart Disease and Stroke on a community level within this country.

With the abolition of the Heart Disease and Stroke Control Program under the Chronic Disease Section, the only public health agency in this country charged with wide scale intervention in the field of Heart Disease and Stroke is the Regional Medical Program. This organization shows great promise but concerns itself primarily with the systems of health care delivery and comprehensive health planning. These are certainly worthwhile areas, but do not fill the vacancy left by the abolition of the Heart Disease and Stroke Control Program. For this reason some specific step must be taken to preserve the hard core professional epidemiologists and health care workers previously serving the Heart Disease and Stroke Control Program.

In the case of our specific projects here in Savannah, Georgia, we are moving the remainder of our professional staff from Arlington to our Field Station in Atlanta, Georgia, where it will function under the auspices of the Center for Disease Control (previously Communicable Disease Center). I mention this as only one example of an administrative alternative. In the case of retal dialysis, nutrition and cigarette smoking which had previously been under the auspices of the Chronic Disease Programs, these were elevated to divisional status. In view of the overwhelming and urgent nature of Cardiovascular Disease in this country, it would appear obvious that at the very least Cardiovascular Disease should also be elevated to divisional status.

Savannah, Georgia, was selected as a location for a pilot study and intervention project because it has the highest rate of Cardiovascular Disease in the United States. Should we in Savannah be able to modify our morbility and mortality from Cardiovascular Disease (and I feel that we will be able to if given the chance), our program could then be aplied to other areas in this country whose citizens suffer from these diseases.

This past December I testified before Senator Magnuson's Committee and this past February before Senator Yarborough's Committee, pointing out that funding projects such as ours was of no real value unless some provision could be made to give us access to manpower and experience in conducting projects to determine the cause of Heart Disease and Stroke. Senator Magnuson agreed with us whole-heartedly and was kind enough to express himself in his Senate Report Number 91–610, Calendar Number 607, p. 23, which I now quote "The Committee is strongly opposed to the proposal of the Department to make a $4 million reduction in Chronic Disease Control Programs and shift this amount to operational and planning grants to Regional Medical Programs." "Considering the awesome toll in death and disability which these conditions annually extract from the American people, the Committee cannot accede to the elimination of programs of demonstrated value".

Despite Senator Magnuson's Committee's recommendation, HEW has remained determined to abolish the Heart Disease and Stroke Control Program. As I stated earlier, the Heart Disease and Stroke Control Program has been disbanded as of June 30, 1970, and I can only attribute this action to a very inferior grade of information and advice which Secretary Finch and Surgeon General Jesse Steinfeld, with whom I have met, are receiving from their subordinates in HEW. Since the Congress has expressed itself clearly and specifically on this matter, I cannot understand HEW's refusal to consider the Senate's opinion. This is another reason why you must earmark separate and specific legislation for Heart Disease and Stroke, perhaps under the auspices of the Center for Disease Control, as in the case of cigarette smoking and nutrition.

Gentlemen, we in Savannah, Georgia, signed a contract with the United States Government through the United States Public Health Service. In this contract a group of private physicians and individuals agreed to provide certain services to our community providing that we received some assistance from the Federal Government. This included not only funds but also the assignment of full-time personnel, who were essential to our projects. Most of these personnel have already been removed. Despite this contract which we though was binding upon both parties, the Federal Government has seen fit to withdraw these personnel from our project. This was such a flagrant violation of our contract that we instituted a suit in Federal Court against Secretary Robert Finch and the Department of HEW seeking an injunction.

Through their recent actions, it is obvious that HEW is not responsive to the will of the Congress of the United States. This being the case, it is essential that this committee, in finalizing Congressman Staggers' excellent legislation, spell out in detail, the separate and specific legislative and administrative guidelines as to what they may or may not do. If you fail to do this, many ongoing and basic projects in the research of Heart Disease and Stroke will be dead the minute this bill is passed. This is not speculation. I speak from the hard experience from the last year and I can document what I say. If you do not have this separate and specific legislation, you will automatically condemn a number of projects which have been several years in formation and which are just now reaching the point of being really productive. The harm which has already been done by the recent activities of HEW will require years to repair, if in fact, they are even repairable.

This is my third trip to Washington, D.C., to testify before the Congress of the United States about the same situation. We simply do not have the time nor energy to fight a political battle with HEW. We are sick and tired of having our efforts diluted in this most urgent area. HEW is making us politic and campaign to preserve programs which the Congress of the United States has already established. The whole purpose of Regional Medical Programs and the Partnership for Health, was to provide real health care to real people on a community level. Our Savannah Program was conceived at a local level by a group of physicians interested in making available to the people in Savannah the practical application of University research. To our way of thinking, we were doing what President Nixon and Congress has said should be done. We have now exhausted our efforts, so here we are once again, appealing to our Congress for judgment and assistance. If our requested legislation is not specifically made into law, we have failed our citizens who look to us for fairness and for help. It is left up to you. We have shown you that HEW has chosen the political route instead of the right and proper way. You are the people's only hope. It now rests in your hands after this long and exhausting political battle.

We thank you for your kind attention.

PERTINENT POINTS

Private physicians in Savannah, Georgia, have launched an attack on heart and stroke with the assistance of the United States Public Health Service's Heart Disease and Stroke Control Program.

This Program is unique in that it originated with the private citizen of the community and was not something thrust upon them by the Federal Government.

Heart Disease and Stroke cause the deaths of over one-half of the people in our country annually. Our area has the highest incidence of these diseases in the country.

Heart Disease and Strokes cost from twenty to thirty billion dollars annually.

The Heart Disease and Stroke Control Program is the only agency currently attempting to do something about excessive rate of Heart Disease and Stroke.

If our Savannah Cardiovascular Project is successful, this will serve as a model for the rest of the country.

The Heart Disease and Stroke Control Program provides trained personnel for our effort and these personnel cannot be supplied to us by any other governmental or private agency.

Despite Senator Magnuson's specific recommendation, HEW has abolished the Heart Disease and Stroke Control Program.

TABLE I

Health Statistics Released for 1967-68

Heart disease was responsible for almost one-third of the total deaths in Georgia last year. Over 14,000 died of heart disease while almost 6,000 more died of stroke.

As a cause of death, cancer dropped to third place in 1968. It had been the second most frequent cause in 1967.

The Biostatistics Service of the Georgia Department of Public Health prepared the chart below giving graphic outline of the state's mortality rate.

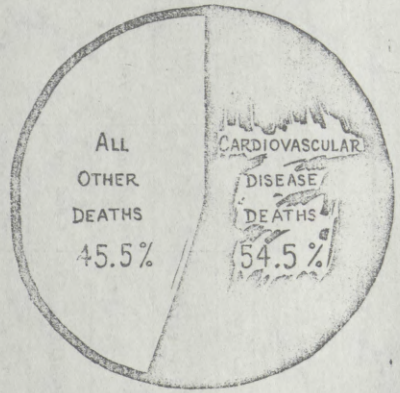
The serious outbreak of influenza in the late part of 1968 was responsible for pushing the death rate in this category to a new high, almost 500 more than the previous year, or an increase of more than 30%.

Homicides and suicides increased at a far greater rate than did the net population.

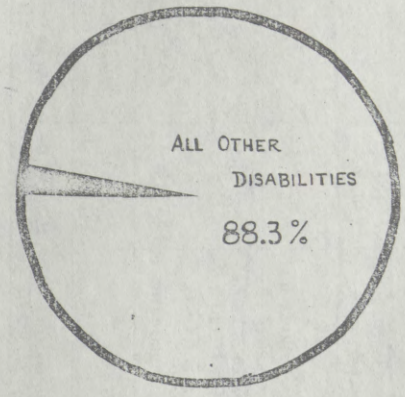
Cause of Death	1968		1967	
	Rank	Number	Rank	Number
Heart Disease	1	14,155	1	12,946
Stroke	2	5,828	3	5,494
Cancer	3	5,534	2	5,519
Influenza & Pneumonia	4	2,022	5	1,546
Motor Vehicle Accidents	5	1,730	4	1,553
Accidents (other than Motor Vehicle)	6	1,464	6	1,377
Total all deaths		41,331		38,448
Live Births		87,322		86,469
Population (Estimated as of July 1)		4,568,000		4,509,000
Homicides		700		617
Suicides		497		455

TABLE II

MORBIDITY VS. FEDERAL FUNDING



MORTALITY
(US BUREAU OF THE CENSUS)



FUNDING
("CHANGING TIMES" OCT. '69)

TABLE III

DISCRIMINATION AMONG HEALTH DOLLARS

DISORDER	ESTIMATED CASES	ANNUAL DEATHS	FEDERAL FUNDS EXPENDED / CASE
CANCER	940,000 (10TH)	320,000 2ND	$193.00 1ST
MENTAL RETARDATION	6,000,000 8TH	NONE 12TH	84.67 2ND
MUSCULAR DISTROPHY & NEUROMUSCULAR	200,000 15TH	600 12TH	24.00 3RD
MENTAL DISORDERS	19,000,000 4TH	25,000 4TH	19.04 4TH
CEREBRAL PALSY	800,000 13TH	NONE 12TH	13.90 5TH
BLINDNESS	1,217,000 11TH	NONE 12TH	13.48 6TH
MULTIPLE SCLEROSIS & RELATED	500,000 14TH	1,570 11TH	8.00 7TH
VENERAL DISEASES	1,600,000 10TH	2,400 9TH	7.19 8TH
HEART & CIRCULATORY DISORDERS	25,000,000 1ST	1,002,000 1ST	6.44 9TH
KIDNEY DISEASES	3,000,000 9TH	19,950 5TH	6.53 10TH
CHRONIC RESPIRATORY	9,775,000 7TH	33,000 3RD	2.60 11TH
BIRTH DEFECTS	15,000,000 6TH	18,000 6TH	2.28 12TH
ALCOHOLISM	6,000,000 8TH	2,980 8TH	1.04 13TH
ARTHRITIS & RHEUMATITS	16,000,000 5TH	2,130 10TH	0.78 14TH
ALLERGIC DISORDERS	21,183,000 2ND	4,230 7TH	0.52 15TH
HEARING IMPAIRMENTS	20,000,000 3RD	NONE 12TH	0.33 16TH

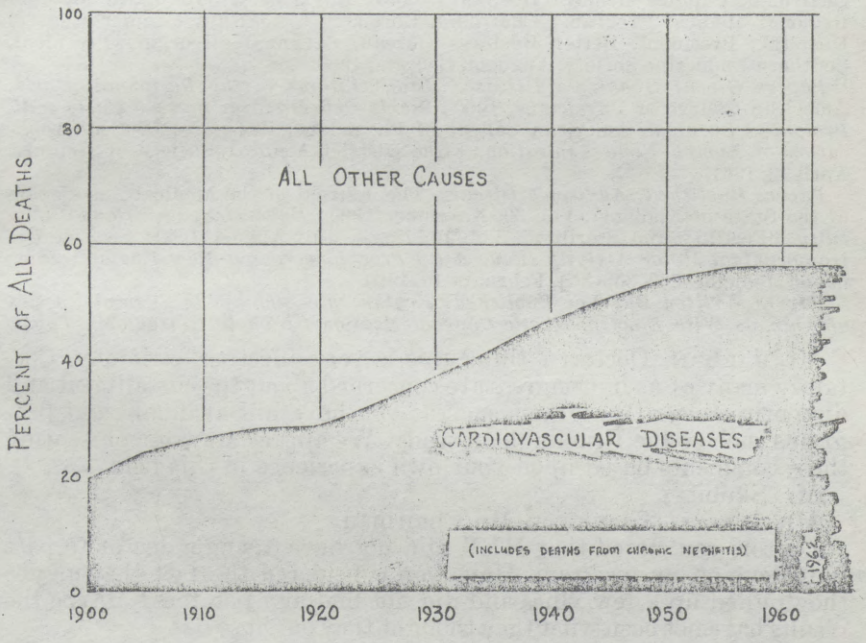
REMARKS: HEART & CIRCULATORY DISORDERS —

- KILL 3-TIMES AS MANY PEOPLE AS ANY OTHER ONE DISORDER.
- EFFECT 3,817,000 MORE PEOPLE AS ANY OTHER ONE DISORDER.
- RECEIVE ONLY 1/30TH THE FUNDING PROVIDED 2ND LARGEST KILLER.
- RECEIVE ONLY 1/17TH THE FUNDING PROVIDED THE NON-KILLERS.

SOURCE OF STATISTICS: OCT 1969 "CHANGING TIMES"

TABLE IV

HEART MORTALITY RATE



CURRICULUM VITAE

James Clayton Metts, Jr., Board Certified Internist. Private practice of Internal Medicine in Savannah, Georgia, since 1961.

Graduated University of North Carolina, Chapel Hill, North Carolina, 1951, with a B. S. in Chemistry.

Graduated from the Medical College of Georgia, Augusta, Georgia, in 1955, an M. D. Degree. Rotating internship and six months of residency training in the Presbyterian-St. Lukes Hospital, Chicago, Illinois. Served 24 months in the United States Air Force as a physician specializing in internal medicine.

Returned to Eugene Talmadge Memorial Hospital, Augusta, Georgia, for thirty additional months of residency training in internal medicine.

Certified by the Internal Medicine Board in 1964.

Positions Held: Chief of Medicine, Memorial Hospital, 1965, Savannah, Georgia; President of the First District Medical Association of Georgia in 1968; Chairman, Community Cardiovascular Council of Savannah, Georgia; Director, Comprehensive Stroke Unit, Candler General Hospital, Savannah, Georgia; Chairman, Candler General Hospital's Local Advisory Group to the Georgia Regional Medical Program; Chairman, Coronary Care Unit, Candler General Hospital; President, Better Business Bureau, Savannah, Georgia; President, Southern Endocrine Society, Augusta, Georgia, 1960.

Papers Given: Hodgkin's Disease: Manifestations in the Peripheral Blood, American College of Physicians, 1960; *Sickle Cell Disease: Sixteen Cases with Prolonged Survival,* American College of Physicians, 1960; *The Clinical Application of Lymph Node Aspiration,* First District Medical Society of Georgia, April 12, 1961.

Papers Published: Addison's Disease, The Journal of the Medical Association of the State of Alabama, Vol. 30, November 1960; *Endocrinopathies and Infertility,* "Fertility and Sterility", Vol. 10, No. 4, July-August 1959; *Several Extrapyramidal Motor Activity Induced By Prochlorperazine.* New England Journal of Medicine, 262–353–354, February 18, 1960.

Papers Written But Not Published: Erythrocyte Sickling in Several Species of Animals With Electrophoretic Characterization Of Their Hemoglobin Types.

Mr. JARMAN. Doctor, I think this is very effective testimony. Certainly many of us in Congress are concerned about the curtailment and discontinuance of programs such as you have in Savannah, and programs such as the Framingham study. We appreciate your presenting these comments based upon your own experience in this field.

Mr. Skubitz?

Mr. SKUBITZ. Thank you, Mr. Chairman.

Doctor, you stated that HEW did not have a single doctor to pass judgment on its program. Have you considered the fact that maybe they pulled up a few vines and did not find any potatoes? Maybe the results have not been what they thought they ought to be?

It does not take a doctor to make that sort of determination.

Dr. METTS. You are right, it would not take a doctor to make that determination. Apparently their investigation did not go that far. The Framingham study is recommended by everyone who knows about it and it is one of the most beautiful monumental studies.

Mr. SKUBITZ. By "everybody who knows about it," who are you talking about?

Dr. METTS. Every individual that is concerned with health that I ever discussed the Framingham study with had nothing but praise.

Mr. SKUBITZ. You do not answer my question. I am in favor of this program, but I have not had the opportunity to question the Department to determine its objectives and reasons. One thing that sort of sticks in my "craw" is the tremendous amount of money we are paying out to try to train doctors and in getting researchers in place. We heard doctor after doctor talk about the need for continuing grant programs for medical schools and loans for medical students. The

only reason we passed the program was to get doctors and we are not getting them.

These are the things that bother me a bit. We ought to look into these programs and see if we are getting value received for the dollars we spent.

Dr. METTS. I would love to see it, because this is my sentiment entirely. I could not agree more heartily. I am a private physician, I am not salaried by any organization, and I have to fund my own way and I certainly agree with this. This is one of my pet complaints, the private physicians are overloaded and people sitting in universities are telling us how to do and what to do, but are not doing it.

I want more people digging good potatoes. Your skepticism is justified, but Framingham I selected because it is sort of like "motherhood" or "country." You can't say anything really bad about it.

Mr. SKUBITZ. I note that you say on page 10, "I don't have time or energy to fight the political battle, we are sick and tired of our efforts being diluted in this most urgent area."

I got news for you. Don't give up because if you do the programs will be diluted.

Dr. METTS. The thing that has impressed me is that Senators and Congressmen have shown a greater comprehension of the problem than the people in HEW. The people at HEW are the people that are supposed to know what they are doing, but they don't.

Mr. SKUBITZ. Thank you.

Mr. JARMAN. Mr. Rogers?

Mr. ROGERS. Thank you very much, Doctor, for your testimony. I think here again we have pointed up what is happening in the whole health field. I am very much concerned about it.

I don't think we are, by any means, giving emphasis to health as we should in the present programing. That is when we compare it to education and welfare in the Department.

I hope this committee can do something to begin to establish a more proper priority for health with the administration. Thank you.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Hastings?

Mr. HASTINGS. No questions.

Mr. JARMAN. Mr. Kyros?

Mr. KYROS. I would like to ask you, how do you feel about the suggestion that we incorporate, under a single legislative act, the three programs, regional medical program, CHP and Public Health Services Act?

Dr. METTS. I am much opposed to it. There were previous witnesses who were uniformly opposed to it and it is an extremely bad idea.

Mr. KYROS. Give me an example of where their would be harmful in your area.

Dr. METTS. It is our feeling you would destroy identity and effectiveness of the regional medical program, and I speak in a nonpartisan sense because I am not a part of the RMP. It took a long time getting started and has become effective, and I feel you will destroy the mechanism you set up.

Mr. KYROS. Why do you say "destroy the mechanism?" Those are just words.

Dr. METTS. Not mechanism, but perhaps the administrative framework. I have met with these people in my capacity working with them and I see the decisionmaking process, the reviewmaking process, and I have lived with it this past year and they are just getting to where I think they can function effectively.

I think if you change their administrative or legislative setup, this will contribute to other things and as far as the people in Public Health I talked to, and I have talked to many, they feel this combination would be a good opportunity for individuals who are primarily interested in a career building or empire building, this sort of thing, to get into the health care field.

Mr. KYROS. Why would it be more so under consolidation of H.R. 15960 than to have three separate programs being administered, three separate programs which nevertheless have some facets in common? Why would it be less empire building?

Dr. METTS. This is to answer, to give you specific examples. This is the way things work. We have seen the beginnings of this for some time in the CHP care planning and, as I say, I also rely on other people's opinions and I taked to career people in health and they reviewed this legislation in depth, and this is their concensus of opinion, with which I do agree.

I base my experience just on the experience of the past year, having worked with these people.

Mr. KYROS. Sure. I am still waiting for a specific example.

Give me an example of a case or doctor, money, or program and tell me how if you had three programs to consolidate, it would not work and would be harmful and cost more money. You just told me generally you don't like the concept, but I don't understand what your specific concrete objection is to that.

Dr. METTS. The first specific concrete objection is the program is set up and functioning effectively. I have always considered it a bad idea to take a functioning organization and tamper with it. This is my most specific objection.

The second is I have become peripherally involved with CHP planning through model cities and our CHP agency in Savannah, and in reviewing plans and applications for funds, as I recall, they applied for $78,000 for 1 year's planning in Savannah and you could sit down and plan for a lot less money than that and the sort of things that were in there were just inflated salaries and no evidence that anyone was going to do anything.

I object to expanding a project of this type and particularly mixing it with a program or organization that is functioning effectively.

Mr. KYROS. Thank you very much, Doctor. I appreciate your testimony.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. No questions, thank you.

Mr. SKUBITZ. May I ask the witness one more question, Mr. Chairman?

Do you know Dr. Egeberg?

Dr. METTS. I have seen him on one occasion.

Mr. SKUBITZ. I think you ought to meet him. I think you will find that he is not a bureaucrat and that he is in fact a pretty sound down-to-earth sort of fellow.

Dr. METTS. From my experience I would say he is a character.

Mr. SKUBITZ. Maybe that is a good thing. Maybe we need some characters.

Dr. METTS. I am not criticizing.

Mr. SKUBITZ. Can you define what you mean by character?

Dr. METTS. He makes an impression on you, I can't quote him because it is unquoteable.

Mr. SKUBITZ. Maybe he makes an impression. I kind of think he knows what he is talking about.

Dr. METTS. He made a good impression. My criticism of the bill is not criticism of him. I just don't like the bill.

Mr. SKUBITZ. What I am getting at is you talk about HEW and Dr. Egeberg as one and the same thing—and then paint him as a bureaucrat—which he isn't.

Dr. METTS. I will make clear, my communication problem was with Dr. Joe English. You can talk to him at some length and you can't be communicating your ideas to him very well. I do not feel, I talked briefly to Dr. Stanfield, but I do not feel that the ideas were communicated to Egeberg or Finch.

I don't think it went that far up the ladder. I think the only time it came to Mr. Finch's attention was when I wrote him and notified him I was filing a court injunction against him personally and I think the subordinates then brought the matter to his attention.

Mr. SKUBITZ. What was your action about?

Dr. METTS. The HEW had unilaterally and arbitrarily violated a written contract with us, signed with the medical society and hospital.

Mr. SKUBITZ. What was the charge?

Dr. METTS. Their basis was they wanted to reduce their budget, purely budgetary consideration. They withdrew personnel written into our contract and did not notify me of this. The first I knew was when the personnel were gone.

Mr. SKUBITZ. That is all, Mr. Chairman.

Mr. JARMAN. Dr. Metts, thank you very much.

Our final witness is Mr. Symond R. Gottlieb, president-elect. Association of Areawide Health Planning Agencies.

Will you introduce your associates.

STATEMENT OF SYMOND R. GOTTLIEB, PRESIDENT-ELECT, ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES; ACCOMPANIED BY EDWARD A. LENTZ, PRESIDENT; WILLIAM Mc. HISCOCK, DIRECTOR; AND STEVEN SIEVERTS, DIRECTOR

Mr. GOTTLIEB. I will, Mr. Chairman. I am Symond R. Gottlieb, president-elect of the Association of Areawide Health Planning Agencies and area director of the Health Planning Agency of southeastern Wisconsin and Milwaukee. Mr. Edward Lentz is president of the association and has a similar post in Cincinnati; and to my right is Mr. Willam Mc. Hiscock, director, and he has a similar post in Baltimore, Md.; and to my far right is Steven Sieverts, another director of the association, who has a similar post in Pittsburgh.

This is our first opportunity really to meet with the committee, and don't lean over yet, Mr. Rogers, because I think we all ought to join in in wishing you a happy birthday.

Mr. ROGERS. Thank you. This old man needs your good wishes. You are very kind, thank you.

Mr. GOTTLIEB. Mr. Chairman, because this is our first opportunity to appear before this committee our association has prepared a rather lengthy statement concerning comprehensive health planning. In the interests of your time, we would be happy to present a summary of our complete statement; but we would like permission to file our complete statement for the record.

Mr. JARMAN. Thank you for your consideration. Permission is granted.

Mr. GOTTLIEB. Mr. Chairman, we are here today on behalf of the Association of Areawide Health Planning Agencies. The 85 member agencies of our association and their thousands of participating members and advisers are dedicated to the attainment of the goals set forth in Public Law 89–749. But they see those goals in grave jeopardy unless prompt and positive action is taken by the Congress and the Federal administration with respect to comprehensive health planning.

In the past few years an increasing number of organizations and individuals have advocated the expansion of the health planning concept, especially in terms of the use of the advice of areawide health planning agencies by fiscal authorities when making decisions on the expenditure of funds. Within the past few weeks, this House passed and sent to the Senate a bill under which reimbursement for the capital expenditures of health care providers would be related to the advice of planning agencies under medicare and other Federal programs. Similar actions have been taken or advocated by others. These mandates depend absolutely upon the existence of effective areawide health planning agencies throughout the Nation; but the existence and effective operation of such agencies now requires a special effort by all who are concerned with the Nation's health problems.

Although planning is no panacea, properly applied and effectively supported, health planning at the local level has proved a useful tool to assure that resources allocated to health care are effectively utilized so that the goal of adequate health care for all of our people can be attained. The areawide health planning agency provides a community focus and leadership in health affairs at the local level. Among other things, it provides a technical framework within which action can occur. It maintains a set of relationships with a broad cross section of local people and organizations to increase the likelihood that health care decisions are relevant to community needs and to enhance the probability that implementation will be effective.

And, the areawide health planning agency is action-oriented—providing planning assistance to individual providers, to consumer groups, and to public officials; bringing about coordination and joint action in planning and programing among a variety of providers; and, advising public and private fiscal authorities and other decision-makers concerning the most appropriate use of funds and other resources for health.

During the 3-year period since the enactment of Public Law 89–749, a great deal of local effort, energy, and imagination have been devoted throughout the country to the task of building effective areawide comprehensive health planning agencies, frequently building upon the successes and failures of existing health planning agencies—as pro-

visions of several reports of this distinguished committee have pointed out. The development, acceptance, and operation of such organizations require marked changes in behavior patterns by large and varied groups of people. Such changes do not come about easily. Thousands of people and organizations have been drawn hesitantly and uncertainly into the orbit of areawide health planning agencies—each with its own goals and expectations. It is a foundation upon which effective health planning can be built, if Federal actions and decisions do not undermine them before they get started.

The continued development and operation of effective areawide health planning agencies (as envisioned under Public Law 89–749) are currently threatened by several factors that are somewhat beyond their control. It is these factors that form the basis for our suggestions today.

First, these agencies require an unambiguous expression of Federal support for comprehensive health planning. In addition to adequate financing, such Federal support should consist of a reaffirmation of national policy with respect to comprehensive health planning, an expression of encouragement for the participants and reasonable patience in looking for results. There is need for clear recognition of the role of areawide health planning in relation to a broad range of Federal health programs.

We urge that no changes should be made in current Federal legislation unless they unequivocally clarify national policy in support of comprehensive health planning, strengthen the administration of the program at the Federal level, and demonstrate additional Federal supports for the efforts of areawide health planning agencies.

Therefore, the association of areawide health planning agencies strongly supports the extension of section 314(b), of Public Law 89–749, as amended, as proposed in H.R. 15895, with only a few important modifications. The association specifically applauds section 3(c)(2)(B) of H.R. 15895 insofar as it explicitly assigns responsibility to areawide health planning agencies to assist health care facilities with their capital programing.

The first modification that we would suggest stems from an apparent lack of consistency and clarity to date in the Federal administration of the program, stemming to some extent from inadequate responsiveness to the interests and concerns of those who are directly affected by comprehensive health planning programs.

The Federal administration of Public Law 89–749 has also been marked by insufficient staff support. The association therefore recommends that H.R. 15895 include provision for a permanent advisory committee to assist the Secretary with the development and revision of policies, guidelines, procedures, and information for comprehensive health planning and to advise concerning relationships between comprehensive health planning and other Federal health programs.

Such an advisory committee should consist of a majority of persons representing the consumers of health care; and the balance of its membership should include representatives of the providers of health care, of third party financing agencies, of State health planning agencies, of areawide health planning agencies, of State government, and of local government. Advisory committees to regional offices of the Department of Health, Education, and Welfare should be similarly

constituted and assigned similar responsibilities, and should be given consistent guidelines through linkages with the national advisory committee. We suggest further that the national advisory committee concern itself immediately with the adequacy of the Federal administration of the comprehensive health planning program.

The second modification we propose stems from the relatively imperfect expression of the concept of a partnership between the public and private sectors in current legislation and administrative interpretation. The involvement of the interests of local government in areawide health planning agencies is indeed important; but the provisions of Public Law 90–174 singled out such interests for representation without corresponding attention to the interests of the private sector and providers of care.

Whether intended or not, this provision seems to suggest a partnership in which one partner is more equal than the other and has created many local problems. We practitioners have learned the hard way that there can be no dominant partner if the health planning agency is to achieve its purpose of bringing local people togther in a sound working relationship.

The provisions of section 3(c)(2)(A) of H.R. 15895 are certainly a step in the direction of clarifying the partnership concept, but its wording is still somewhat ambiguous. A broad cross-section of people should be on the governing board, membership, and/or advisory committees of the agency, and the method of involvement should not be too strictly prescribed. Introduction of the term "areawide health planning council" in addition to the "agency" will lead to confusion. Experience also leads us to the conclusion that insisting on "representatives" of named organizations is not a useful method to achieve a balanced and effective local governing structure that will, in fact, operate in the total community's interest.

The association, therefore, recommends that H.R. 15895 be amended to provide that grants may be given to areawide health planning agencies ". . . provided that such public or nonprofit agency is generally acceptable to the area it serves and has made a bona fide effort to include persons associated with the interests of local government, major health professional groups and health care institutions or agencies, and members of the general public broadly reflecting the population to be served, provided that the consumers of health care constitute at least a majority of the governing board or advisory council of such agency . . ."

The third modification that we would suggest stems from the unavailability of sufficient qualified persons to staff such agencies. It has been estimated that about 250 areawide health planning agencies in the Nation would require about 5,000 full-time staff members of all kinds. Additional people are required for State health planning agencies, Federal health planning programs, and related programs. Continued and expanded support for graduate programs in health planning is necessary; but, more important, support is needed for a broad range of education and training programs—for example, in-service training, consultation, short courses and seminars, and others—to speed the process of bringing qualified persons from related disciplines into health planning and upgrading staff members currently employed.

The association, therefore, recommends that the authorization of funds to support the education of health planners under section 314

(c) be increased to $10 million for fiscal year 1971, to $12 million for fiscal year 1972, and to $15 million for fiscal year 1973—and this is in H.R. 15895—and that the Secretary be authorized to use up to 25 percent of such funds to support a broad range of education and training programs—for example, in-service training, consultation, short courses and seminars, and others—for health planners.

The fourth and final modification we propose deals with the planning agency's inability to obtain adequate funding with adequate assurance of the stability and continuity of such funding. It has been estimated that adequate financing to enable 250 areawide health planning agencies to carry out all of their functions effectively would require about $100 million per year from all sources. Current administration of the Federal grant program is based on a 50–50 matching program. Currently available Federal funds are quite inadequate even for the current 125 agencies. Local funds are extremely hard to generate for a new organization without a "track record" in the local community. To compound the problem, doubts about the seriousness of the Federal purpose with respect to comprehensive health planning, uncertainties about the future of the program, and the lack of consistency and clarity in Federal administration of the program have caused concern about the stability of a local investment in planning. As a result, agencies either do not get started, or they are inadequately staffed and forced to try to carry out ineffective work programs.

The association therefore recommends that H.R. 15895 provide money authorizations for grants to areawide health planning agencies in the amount of at least $30 million for fiscal 1971; $30 million for fiscal 1972; and $50 million for fiscal 1973. The association further recommends that the Secretary be authorized to make grants to such agencies of up to 100 percent of their operating expenses during their first operating year, up to 90 percent in their second year, up to 80 percent in their third year, and up to 75 percent of their annual operating expenses thereafter.

With current fund shortages and the multiplicity of worthy demands for more funds, we recognize that a request for additional planning funds is difficult to fulfill. Nevertheless, the expenditure of one-tenth of 1 percent of this Nation's investment in health to carry out an essential part of the Nation's health care system is strongly urged as a wise investment, as sound economics, and as good for the Nation's health.

Mr. Chairman, I will be glad to answer any questions.

(Mr. Gottlieb's prepared statement follows:)

STATEMENT OF SYMOND R. GOTTLIEB, PRESIDENT-ELECT, ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES

Speaking for the Association, Edward A. Lentz, president, Cincinnati, Ohio, Symond R. Gottlieb, president-elect, Milwaukee, Wis., William Mc. Hiscock, director, Baltimore, Md., Steven Sieverts, director, Pittsburgh, Pa.

Mr. Chairman: We are here today on behalf of the Association of Areawide Health Planning Agencies. Our interest in and awareness of the legislation being considered is too obvious to require explanation. The 85 member agencies of our Association and their thousands of participating members and advisors are dedicated to the attainment of the goals set forth in P.L. 89–749. Because the attainment of those highly laudable goals is in grave jeopardy, they feel that the actions of this Committee and this Congress with respect to comprehensive

health planning are crucial to the successful implementation of a concept that could make so important a contribution to resolution of the nation's health crisis.

Since the passage of the original Hill-Burton Act in 1946 the federal government, state governments, many local communities, and a wide variety of organizations have demonstrated an irregular but growing interest in planning as a method of achieving optimum use of resources for health. The development of health facilities planning agencies, partly under the now repealed Section 318 of the Public Health Service Act; the introduction of planning into mental health under the Community Mental Centers Act; the introduction of planning into rehabilitation services under P.L. 89–333; and other federal legislation seemed to infuse the planning mechanism with gradually growing support. As more kinds of people in the public and private sectors spoke up in favor of the planning concept, locally organized planning agencies began to achieve sporadic and scattered success. The concepts implied in P.L. 89–749 seemed to suggest that the long progression toward effective health planning might now begin to demonstrate the desired results.

A great many people throughout the nation seemed to know or sense that a milestone had been reached, with the passage of P.L. 89–749. Position papers of large and small organizations were developed that tended to encourage the development of a system by which decisions concerning the use of resources were related directly to the advice of areawide health planning agencies. Such organizations as the American Hospital Association, the Blue Cross Association, the Health Insurance Council and many others in the private sector openly advocated the expansion of the health planning concept. Within the past few weeks this very House passed and sent to the Senate a bill under which reimbursement for certain capital expenditures would be related to the advice of planning agencies. Several states have passed, and others are currently considering, franchising or certificate of need legislation that would be partly dependent upon the advice of areawide health planning agencies.

But even as more programs are developed that place reliance on the work of health planning agencies; and even as more people and organizations are beginning to understand the values that effective health planning can bring to help resolve the nation's health problems; the development and very existence of the areawide health planning agencies required to carry out such mandates are in very grave jeopardy. Areawide comprehensive health planning is now at the crossroads; and the expectations of those who see it as a necessary mechanism in the development of the nation's health system are doomed unless prompt and positive action is taken by the Congress and the federal administration.

Before indicating the kinds of action that our Association believes to be necessary, a few words describing the nature of areawide health planning are in order to ensure that we all have the same frame of reference. We do not feel that health planning is the panacea for all of the ills of the health system; and we would hope that none of its advocates have such expectations. Properly applied and effectively supported, health planning at the local level provides a useful tool in the battle to provide assurance that resources allocated to health are effectively and efficiently utilized so that the goal of adequate health care for all of our people can be attained.

The well-staffed areawide comprehensive health planning agency provides a community focus and necessary leadership in local health affairs. It develops planning tools that provide a technical framework within which action can occur—such planning tools as the accumulation of facts concerning health needs and resources, the identification and evaluation of alternative courses of action, guidelines for the orderly development of health services and facilities, and the identification of community health goals and priorities.

The second primary function of the health planning agency is to maintain effective continuing liaison with professional and non-professional groups, with local government, and with the general public in connection with all of its activities. These functions are maintained to increase the likelihood that health planning is relevant, to achieve maximum acceptability of the planning tools, and to enhance the probability that implementation will be effective.

Because planning without action is meaningless, the third primary function of the local health planning agency is implementation. This function takes the form of planning assistance to individual institutions, agencies, and community groups and public officials; of coordination of the planning and programming activities of all providers of care; and of advice to fiscal authorities and others

who make major decisions concerning the use of resources for health on the most effective and efficient use of such financial and other resources.

The authority of the areawide health planning agency to carry out these functions derives primarily from the composition of the agency itself by virtue of its membership and governing board having been drawn from appropriate parts of the local economic, social, political, and professional power structures. The membership must be such that its authority is recognized by all who deal with it; so that, in fact, its authority is conferred upon the agency by the community it serves—this fact alone suggests the need to tailor each health planning agency the way in which each community operates. The primary authority of the health planning agency is buttressed by its ability to influence the dispensing of funds for health care, as recognized by this House in the Social Security Amendments you recently passed (H.R. 17550). In turn, this ability to influence the dispensing of funds is confered on the planning agency by the fiscal authorities, as will be true under Medicare, Medicaid, and other federal purchasing programs if the Senate concurs. Thus, effective health planning requires a variety of kinds of support from the public and private sectors at the local, state, and national levels.

During the three-year period since the enactment of P.L. 89–749 a great deal of local effort, energy, and imagination have been devoted throughout the country to the task of building effective areawide comprehensive health planning agencies, frequently building upon the successes and failures of existing health planning agencies. The development, acceptance, and operation of such organizations required marked changes in behavior patterns by large and varied groups of people. Such changes do not come about easily. The attempt to make such changes raises hopes and expectations in some people and poses serious threats to others. Thousands of people have been involved in this effort throughout the nation. Untold numbers of provider organizations and individual providers, huge numbers of local governmental units, and thousands of consumers of all kinds have been drawn hesitantly and uncertainly into the orbit of areawide comprehensive health planning agencies. They have come into it with some goals in mind, and with some expectations, and many of those goals and expectations were dictated by congressional and federal administrative actions.

In most of the 125 areas of the country where such agencies have moved past the preliminary organizational stages, the participants are only beginning to develop a common set of goals and an identity with the organization. This feeling of commonality and organizational identity is essential if areawide health planning agencies are to deal effectively with the complex problems involved in the reorganization of the delivery system. Although much progress has been made and is being made in the development and operation of effective health planning agencies at the local level, they are currently threatened by several important developments that are somewhat beyond their control.

The most important single factor threatening the survival and effective operation of areawide health planning agencies is the apparent ambivalence of the federal government with respect to comprehensive health planning and the lack of assurance of stable and continuing federal support for our efforts at the local level. Federal support in this sense is not only a matter of assisting with the financing of areawide health planning agencies—important though such financing may be. Federal support must include a clear-cut statement of national policy with respect to health planning that is buttressed by effective administration at the federal level. It must also include an understanding of the complexities of the health planning process that provides encouragement for the participants and that demonstrates the patience required to enable planning agencies to develop effectively at the local level. Federal support should also include adequate recognition of the way in which areawide health planning agencies can be of assistance to the administration of a wide variety of federal health programs.

It must be recognized that every time that the goals or expectations of the people involved in or with areawide health planning agencies are changed by external forces, it becomes more difficult to retain the interest and support of the very people who must be involved if programs concerned with the organization and management of human resources to achieve a social purpose are to succeed. Their worst fears are realized by the inconsistent and impatient actions of legislative and administrative bodies that cannot wait for results, or that fail to support their efforts. Their frustration is expressed in anger and resentment against the forces they cannot control; and such frustration is often expressed by their sudden departure from the scene of active involvement. Before major and sudden changes are made in such a program, and before the threatening

forces for change become too ominous, those with legislative and administrative responsibility should be quite sure that the path is incorrect and that the "right" people are not involved. The imposition of such changes in direction, or the threat of such changes, will most assuredly drive the best of the current participants in areawide health planning agencies out of active involvement.

The Association of Areawide Health Planning Agencies, therefore, strongly supports those sections of H.R. 15895 that provide for an extension of the provisions of Sections 314(b) of P.L. 89–749, as amended, for a three-year period beginning July 1, 1970. Furthermore, the Association recommends that no changes be made in the current legislation unless they unequivocally clarify national policy in support of comprehensive health planning, strengthen the administration of the program at the federal level, and demonstrate additional federal support for the efforts of areawide health planning agencies. Therefore, this Association supports the basic intent of H.R. 15895 and specifically applauds Section 3(a)(2)(B) of such bill insofar as it explicitly assigns responsibility to areawide health planning agencies to assist health care facilities with their capital programming.

The second major factor threatening the survival and effective functioning of areawide health planning agencies is the apparent lack of consistency and clarity in the administration of the comprehensive health planning program at the federal level. There seems to be more uncertainty about the purposes, goals, and functions of health planning agencies in the federal administration than there is in many local communities where health planning agencies have been developed. There seems to be a lack of understanding of the way in which planning agencies can and must operate in their diverse and heterogeneous communities throughout the country; and there often seems to be a lack of responsiveness to the interests and concerns of those who are most directly affected by the operation of the program. Those responsible for national administration of the program often seem to be unable to cope with the complex series of relationships that must be maintained between comprehensive health planning and other federal programs. And, there often seems to be a tendency in the administration of this program to try to use the mechanism of the areawide health planning agency to achieve too diverse a set of objectives that may conflict with each other and subvert the primary purposes of the agency. Furthermore, the federal administration of P.L. 89–749 has been marked by insufficient staff support.

The Association of Areawide Health Planning Agencies, therefore, recommends that H.R. 15895 include provision for a permanent advisory committee to assist the Secretary and the organizational unit to which administrative responsibility is delegated with the development and revision of policies, guidelines, procedures, and information for comprehensive health planning and to advise concerning relationships between the comprehensive health planning program and other federal programs. The Association further recommends that such an advisory committee should consist of a majority of persons representing the consumers of health care, and that the balance of its membership should include representatives of the providers of health care, of third party financing agencies, of state health planning agencies, of areawide health planning agencies, of state government, and of local government.

The provisions for such an advisory committee, meeting at regular intervals and establishing such subcommittees as might be needed, would offer a useful method of beginning the movement toward consistent and clear-cut national policies and administration with respect to comprehensive health planning. Its purely advisory role must be carefully preserved, however, and it should not be used as a substitute for the authority of the Secretary to carry out the intent of Congress with respect to comprehensive health planning. *Regional advisory committees to DHEW regional offices should be similarily constituted and have similar responsibilities in each region of the country, and should be given consistent guidelines through linkages with the National Advisory Committee.* We suggest further that the National Advisory Committee concern itself immediately with the adequacy of the federal administration of the comprehensive health planning program.

The third major factor threatening the survival and effective functioning of areawide health planning agencies is the imperfect understanding of the concept of a "partnership" as expressed in P.L. 89–749. The legislation promoted the concept that in our pluralistic society the nation's health goals can best be met through an effective partnership between the nongovernmental and governmental sectors at all levels. Our Association clearly and unequivocally supports

the partnership concept, recognizing that such a partnership connotes equal rights, privileges, duties and responsibilities. But the concept of a partnership between the public and private sectors necessarily requires mutual trust and confidence—as does every partnership. Implementation of the concept requires sensitivity, fairness, and avoidance of the appearance of favoritism in developing the rules of the game or in the administration of the program.

The provision of section 2(a)(3)(b)(2), P.L. 90–174, (amending P.L. 89–749) requires that the interests of local government must be represented in areawide health planning agencies. Our Association certainly agrees that local governments throughout the nation play or should play an important role in providing health service and/or in financing health services. Local governmental units are also responsible for a variety of activities that affect and are affected by the organization and operation of the community's health system. It is most appropriate and desirable that local governments be deeply involved in the operation of areawide health planning agencies in any appropriate manner.

But, within the partnership concept, it is equally appropriate and desirable that consumers in the private sector, private health care institutions and agencies, health professionals and other providers of care, private health care financing agencies, and others in the private sector be deeply involved in the operation of areawide health planning agencies. Any implication in federal legislation or administration, whether intended or not, that the governmental sector at the local level should be given preference in the operation of areawide health planning agencies dangerously impedes the implementation of the partnership concept. The provisions of P.L. 90–174, singling out local governmental units for representation in the areawide health planning agencies without equal recognition of private interests carries a great risk; and, in some parts of the nation this provision, as interpreted, has seriously decreased the rate at which effective areawide health planning agencies could be developed. We practitioners have learned the hard way that there can be no dominant partner if the health planning agency is to achieve its purpose of bringing local people together in a sound working relationship.

The provisions of Section 3(c)(2)(A) of H.R. 15895 indicate an intent to improve the understanding of the partnership concept, but its wording is still somewhat ambiguous. This section introduces for the first time the idea of an "areawide health planning council" as something to be distinguished from an "areawide health planning agency." This provision would be quite confusing and may prove to be too restrictive. Furthermore, it is the individual expertise of a broad cross-section of the community that is needed for effective planning; and such expertise will not be found if agencies are restricted to "representatives" of organized groups. Although the intent of this provision is sound, it would be far more effective to build its concepts into the governing board, membership, and/or advisory structure of the agency itself.

The Association of Areawide Health Planning Agencies therefore, recommends that H.R. 15895 include a provision specifically amending Section 2(a)(3)(b)(2), P.L. 90–174, to provide that grants will be made (for areawide health planning agencies) "provided that such public or nonprofit agency is generally acceptable to the area it serves and has made a bona fide effort to include persons associated with the interests of local government, major health professional groups and health care institutions or agencies, and members of the general public broadly reflecting the population to be served, provided that the consumers of health care constitute at least a majority of the governing board or advisory council of such agency." If supported by administrative policies and procedures that do not give unfair advantage to either the public or private sectors, the Association believes that such a provision will help immeasurably to create effective areawide health planning agencies throughout the country.

The fourth major factor threatening the survival and effective functioning of areawide health planning agencies is the unavailability of sufficient qualified persons to staff such agencies. The shortage of qualified persons is not unique to this aspect of the health field; but it is exacerbated by the fact that health planning is a relatively new field of concentrated activity. Very few people have had specific training for health planning; and only a slightly greater number have any specific experience in community health planning.

It has been estimated that total coverage of the nation would require approximately 250 areawide health planning agencies. It has also been estimated that adequate professional staffing of those 250 agencies to carry out all of their functions effectively would require about 5,000 full-time professional staff

members of all kinds. To this number must be added requirements for State health planning agencies, for federal health planning programs, and for collateral health planning activities.

Some of these people have been and will continue to be drawn out of such established fields as public health, hospital administration, medical care administration, social work, and a variety of specialized academic disciplines. Such personnel require a substantially higher level of in-service training and other continuing education at a much more rapidly accelerated rate that has heretofore been possible. Others of these professional staff numbers will be drawn from the emerging graduate programs in health planning that have been financed under Section 314(c), P.L. 89–749, as amended. But to date their number has been very small and production is increasing at a very limited rate.

The Association therefore strongly supports the increased money authorization provision of Section 4 of H.R. 13895 (amending Section 314c) including authorization of $10,000,000 for fiscal 1971, $12,000,000 for fiscal 1972 and $15,000,000 for fiscal 1973. The Association further recommends that the Secretary be authorized to use up to 25 percent of such funds for the development of a broad range of education and training programs (e.g., in-services training, consultation, short courses and seminars, and others) for health planners; and, that the Secretary be authorized to use up to one percent of such funds to assist in recruiting qualified persons into graduate education and in-service education programs.

The fifth major factor threatening the survival and effective functioning of areawide health planning agencies is their inability to obtain adequate funding with adequate assurance of the stability and continuity of such funding. It has been estimated that adequate financing to enable 250 areawide health planning agencies to carry out all of their functions effectively could require about $100 million from all sources—and if added responsibilities are given such agencies by other legislation, their financial requirements would be higher.

Although P.L. 89–749, as amended, provides that areawide health planning agencies may be granted up to 75 percent of their operating expenses, federal funds for this purpose have been so limited that administrative policies have been required to limit such grants to no more than 50 percent of the operating expenses of such agencies. In almost every part of the country, it has proved to be extremely difficult to obtain adequate amounts of local funds to match the federal grant and to operate a total areawide health planning program effectively. The principle reason for the difficulty in local fund-raising is that it is extremely difficult to demonstrate to potential contributors the benefits that will accrue to them from the successful operations of an areawide health planning agency until the agency has a "track record". In many instances, adequate local funding cannot be obtained until successful operation has demonstrated concrete results that can be reasonably understood and accepted by local private and public sources.

The difficulty in obtaining local funding has delayed in many instances the development of any areawide health planning agencies. In many other instances, the inability to raise adequate local funds has forced the development of agencies that will be seriously understaffed and that will be carrying out work programs that are far too limited to be effective. And, in most of the other agencies that have been developed, if local funding were obtained in reasonable amounts, the limited availability of federal funds forced a reduction in the agency's total budget that seriously impaired its ability to operate effectively.

To compound the matter still further, doubts about the seriousness of the federal purpose with respect to comprehensive health planning, uncertainties about the future of the program, and the lack of consistency and clarity that have already been cited have caused concern about the stability of a local investment in planning. Qualified staff members see work in an areawide health planning agency as "high-risk" employment and require higher salaries than they might in other positions. Turnover among staff members is extremely high because of uncertainties about the federal posture and local acceptance and the cost of orientation and training is inordinately high. It is extremely clear to those who have participated in areawide health planning that adequate, stable, and continuous financing is a goal that must be achieved quickly if areawide health planning agencies are to survive and to operate effectively.

The Association of Areawide Health Planning Agencies therefore, recommends that H.R. 15895 provide money authorization for grants to areawide health planning agencies in the amount of at least $30,000,000 for fiscal 1971, $40,000,000 for fiscal 1972, and $50,000,000 for fiscal 1973.

The Association of Areawide Health Planning Agencies further recommends that H.R. 15895 include a provision authorizing the Secretary to make grants to areawide health planning agencies of up to 100 percent of their operating expenses during the first operating year, up to 90 percent of their operating expenses during their second operating year, up to 80 percent of their operating expenses during their third operating year, and up to 75 percent of their operating expenses thereafter. Sufficient funds should be authorized and appropriated to bring such levels of federal matching to reality.

We well recognize the practical difficulties of increasing authorizations and appropriations in these times of funding shortages for all kinds of important programs. The expenditure of more than $100 million for a program that has yet to prove its real value is especially difficult. But we are talking about planning as an essential aspect of the management of the nation's health system, a system that will soon be using $100 billion of public and private funds. The expenditure of one-tenth of one percent of this nation's investment in health to carry out an essential part of the management of the nation's health care system is strongly urged as a wise investment, as sound economics, and as good for the nation's health.

APPENDIX I

TABLE 1.—ESTIMATED AVERAGE PERSONNEL REQUIREMENTS FOR A SINGLE AREAWIDE HEALTH PLANNING AGENCY, BY TYPE OF AREA

Type of staff	Major SMSA		Minor SMSA		Rural area	
	Low	High	Low	High	Low	High
Professional staff	23.5	33.5	16.3	23.3	12.7	18.2
Secretarial and other	7.8	11.2	5.4	7.8	4.2	6.0
Total personnel	31.3	44.7	21.7	31.1	16.9	24.2

TABLE 2.—ESTIMATED PERSONNEL REQUIREMENTS FOR 250 AREAWIDE HEALTH PLANNING AGENCIES, BY TYPE OF AREA

Type of staff	Major SMSA's (50)		Minor SMSA's (150)		Rural areas (50)		Total agencies (250)	
	Low	High	Low	High	Low	High	Low	High
Professional staff	1,175	1,675	2,445	3,495	635	910	4,255	6,080
Secretarial and other	390	560	810	1,170	210	300	1,410	2,030
Total personnel	1,565	2,235	3,255	4,665	845	1,210	5,665	8,110

TABLE 3.—ESTIMATED AVERAGE EXPENSE BUDGET REQUIREMENTS FOR A SINGLE AREAWIDE HEALTH PLANNING AGENCY, BY TYPE OF AREA

Expense category	Major SMSA		Minor SMSA		Rural area	
	Low	High	Low	High	Low	High
Personnel expense:						
Professional staff	$399,500	$569,500	$244,500	$349,500	$165,100	$236,600
Secretarial and other	39,000	56,000	24,300	35,100	16,800	24,000
Total personnel	438,500	625,500	268,800	384,600	181,900	260,600
Other expense	109,625	156,375	67,200	96,150	35,475	65,150
Total estimated expense	548,125	781,875	336,000	480,750	227,375	325,750

TABLE 4.—ESTIMATED EXPENSE BUDGET REQUIREMENTS FOR 250 AREAWIDE HEALTH PLANNING AGENCIES BY TYPE OF AREA

[In thousands]

Expense category	Major SMSA's (50)		Minor SMSA's (150)		Rural areas (50)		Total agencies (250)	
	Low	High	Low	High	Low	High	Low	High
Personnel expense:								
Professional staff	$19,975	$28,475	$36,675	$52,425	$8,255	$11,830	$64,905	$92,730
Secretarial and other	1,950	2,800	3,645	5,265	840	1,200	6,435	9,265
Total personnel	21,925	31,275	40,320	52,690	9,095	13,030	71,340	101,995
Other expense	5,481	7,819	10,080	14,423	2,274	3,258	17,835	25,499
Total estimated expenses	27,406	39,093	50,400	72,113	11,369	16,288	89,175	127,494

APPENDIX II

ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES: POSITION PAPER FOR LEGISLATIVE AND ADMINISTRATIVE STRENGTHENING OF COMPREHENSIVE HEALTH PLANNING—ADOPTED: FEBRUARY 4, 1969

A. INTRODUCTION

Two years have passed since Congress enacted P.L. 89–749, "The Comprehensive Health Planning and Public Health Services Amendments of 1966", and a year of experience has been gained since that Act was amended by P.L. 90–174, "Partnership for Health Amendments of 1967." The concepts expressed in this important legislation were in a sense natural extensions of earlier federal programs that encouraged planning in health affairs by state government and of voluntary efforts that have been carried on for many years in many communities through the nation. But the concepts also expressed a bold new approach to health planning that holds great promise for the orderly development of a rational health care system that will in fact ensure every citizen the right to good health.

Any new program that is so vast in scope and complexity and that involves so many different interests and people will, of necessity, require a great deal of time to implement adequately. A great deal of discussion and education will be necessary to effect its purposes; and its implementation will necessarily involve substantial conflict and substantial use of "trial and error" methods.

As an organization representing a large number of agencies that have substantial experience in health planning and in the functioning of local communities throughout the nation, the Association of Areawide Health Planning Agencies expresses its confidence in the concepts embodied in P.L. 89–749, as amended. The Association believes that legislation provides a basic structure that encourages health planning within the framework of our pluralistics society, recognizing as it does the essential relationships among a large variety of private and governmental interests at the federal, state, and local levels as well as the tremendous diversity in the functioning of thousands of communities and 50 states and territories. An evaluation of experience to date with the legislation and its implementation by members of this Association suggests many directions that might be taken to strengthen the concepts embodied in the law and to assist those responsible for administering the law to make rapid progress toward the realization of those concepts.

Specific recommendations designed to strengthen the legislation and its administration are made at the conclusion of this report. As a basis for those recommendations, it is useful to discuss P.L. 89–749, as amended, and its current administration within the framework of the concepts embodied in that legislation. As viewed by the Association of Areawide Health Planning Agencies, there seem to be five basic concepts that make it worthwhile to try to strengthen P.L. 89–749 and to take all reasonable steps to make its implementation as effective as possible.

B. CONCEPTS UNDERLYING P.L. 89–749, AS AMENDED

1. *The legislation promotes the concept that comprehensive health planning on a national, state, areawide, and local basis will contribute materially to the health of the American people by assisting in the rational allocation of resources to that purpose.*

This Association firmly agrees with this concept. With substantially less than two years of experience under P.L. 89–749, as amended, it is premature to measure the impact of comprehensive health planning on the health levels of people or on the rational allocation of resources. Its real value can probably not be measured for at least a decade. The program should be given an adequate amount of time to prove itself, making only such legislative and procedural changes as will increase the likelihood that it will be effective.

The best evidence that such a planning mechanism might serve its purpose is drawn from the many examples of health planning that have been carried on productively at the national, state, areawide, and local levels for some or all of the past two decades. The Hill-Burton program, programs affecting environmental health planning by regional planning commissions, mental health and mental retardation planning in many states and metropolitan areas, planning by dozens of voluntary health and welfare agencies, and the work of more than 70 voluntary areawide health facilities planning agencies (partially funded under the now-repealed Section 318 of the Public Health Services Act) all tend to provide substantial evidence that health planning can be effective.

The proliferation of health planning agencies in itself provides an excellent reason for continuing toward further development of the comprehensive health planning concept. It is equally clear, however, that every effort be made to build upon the strengths that have been created in each of these organizations in the several states, metropolitan areas, and local communities, rather than to establish a new or a parallel system that sacrifices their accumulated experience and expertise. The wisdom of making appropriate use of existing organizations would be strongly reinforced in those health planning activities where large amounts of federal funds have already been allocated to build them to their current level of experience and knowledge. Recognition of the important contributions of the past is always important, but it is crucial during the period of transition leading to the effective implementation of the comprehensive health planning concept—especially when it is axiomatic that the transition will take longer in some communities and areas than in others.

2. *The legislation promotes the concept that there is a relationship between planning and implementation; but that these are distinct functions, especially in health affairs where there are multiple points of decision-making.*

The Association agrees that areawide health planning further represents a series of activities designed to reflect community values, directed toward those who are responsible for providing services, establishing policy, or managing funds. Decisions for implementing programs should be related to the areawide planning process, but distinct and separate from it. The Association recognizes that it is especially difficult to define each function and to describe the relationship when decision-making is based in a variety of governmental programs at all levels and in a variety of decision-makers in the nongovernmental sector. As suggested by P.L. 89–749, the health planning process is intended to provide advice concerning health needs, priorities, and resources including identification of alternatives and recommendations, to all kinds of decision-makers in the public and private sectors to assist them in making reasonably rational decisions. The legislation and its interpretation is somewhat less clear concerning the responsibility of these decision-makers to take into account the results of the planning process. In this task of articulating the nature of the planning process and the decision-making process and of the relationship between them, it is important that the legislation and its administration be as consistent and as unequivocal as possible.

To strengthen this aspect of the concept, it must be asked whether Sections 314(a) (statewide planning) and 314(b) (areawide planning) are not so different from Section 314(d) (block grants for public health services) and Section 314(e) (project grants for described demonstration projects in the delivery of health services) that their inclusion in a single title and in a single adminis-

trative unit confuses the two functions? It may not be surprising that a good many people and agencies seem to operate as though the entire purpose of the planning process at the state and (occasionally) areawide levels is to allocate funds under Sections 314(d) and (e), in spite of the clear intent that the planning process is to have a much broader purpose. The law clearly and properly intends that the planning process should influence the way in which funds and other resources are allocated for health regardless of their source in the public or private sector. It may also account for some of the dismay expressed in some quarters when it was learned that the allocation of Section 314(e) funds was to be based upon national priorities, determined outside of the planning process proposed in P.L. 89–749.

It seems possible that the confusion that seems to exist between the planning function, the decision-making function, and the relationship between the two functions is further augmented by the current administrative locus of the Office of Comprehensive Health Planning. As will be noted below, the nature of this administrative structure may also endanger other concepts envisioned in P.L. 89–749. But the placement of OCHP as a section of the Division of Community Health Services seems to leave some doubt about whether OCHP is a planning device or a mechanism for assisting in the operation of direct service programs. Unfortunately, the same confusion is found in many states, when the designated state agency is a sub-unit of a state health department that also has broad operating responsibilities for direct service programs.

A final example of an apparent inconsistency in the distinction between the planning function and the decision-making function is found in P.L. 90–174. The amendment to Section 314(a) has implications with respect to other concepts embodied in P.L. 89–749, as will be noted, but the direction to the state agency to assist individual facilities with their capital programing at least reflects the decision-making function. Tied as it is to the concept of a master plan for capital needs, this provision seems to reflect the decision-making function to a larger degree than it reflects the planning function. Unless it is very carefully administered, it seems likely that it will contribute further to the confusion concerning the nature of the planning process. As a planning function, considerations of facilities must be related to considerations of programs, manpower and financing (capital and operating) and all three must be developed out of a planning process that leaves little room for the master plan concept. Certainly, as originally proposed, this amendment was intended to be supportive of a part of the decision-making process. Since other aspects of the decision-making process with respect to capital needs are currently being reconsidered, it would be most helpful to reconsider also their relationship to the planning process.

3. *The legislation promotes the concept that in our pluralistic society the nations health goals can best be met through a partnership among responsible organizations and individuals at the national, state, areawide, and local levels, with adequate recognition of the diversity among states, among regions of each state, and among local communities.*

The Association clearly supports this underlying concept of P.L. 89–749, as amended, and will support all effective legislation and administrative efforts to translate the concept into action. There is a great need, however, to define at as early a date as possible, the role of each organizational level in a health planning system together with the desirable patterns of relationship to be sought among the several levels. Since such a definition of roles and relationships must also take into account the diverse capabilities, levels of interest, and forces that operate in each state, within each region, and within each community, it is obviously of flexibility. Nevertheless, this concept is so crucial to the successful implementation of P.L. 89–749, as amended, that the task should have a high administrative priority and deserves the assistance of all national organizations with an interest in the subject matter.

The intent of the legislation with respect to this concept is reasonably clear, although it would be desirable to take steps to ensure that any aspects of the law that promote inconsistency in its interpretation are corrected. For example, the amendment to Section 314(a) in P.L. 90–174 that directs the designated state agency to assist facilities with their capital programing seems to overlook the fact that such assistance, if necessary as a legislative direction at all, might more appropriately be assigned to the areawide health planning agency under Section 314(b). It is quite possible that no specific decisions on assignment of any responsibilities for any aspects of the health planning process can be assigned without at least administrative definition of relative roles and relationships. It might be far more useful for the legislation to give more specific recognition to the

need to define these roles and relationships, leaving specific definitions and necessary assignments of specific responsibilities to the administrative mechanisms. It would be especially helpful, if the legislation could provide some insight into the extent to which health planning is intended to be a "grass roots upward" process as opposed to a "top-down" process.

Part of the problem of clarity in defining roles and relationships is also found in the current organizational locus of the Office of Comprehensive Health Planning, as described above. It is reasonably clear that P.L. 89–749 did not contemplate national health planning, at least within the federal establishment. There is no indication that any other federal health planning programs or any federal operating programs are to be brought within the planning and/or decision-making orbit of P.L. 89–749. Thus, a definition of roles and relationships in the planning process could not, within this particular legislation, include a definition of the role of the federal government. Unfortunately, the lack of a federal role and the reduction of OCHP to a grants management program, reduces the level of support that the federal establishment would give to the planning process at the state, area-wide, and local levels. Each federal department, administration, division, and section has its counterparts in every state and many local communities, has its own channels of communications, and helps to support its own operational or planning programs. Even without adopting a concept of national health planning, it should be possible to give OCHP sufficient status in the Department of Health, Education, and Welfare, so that it can provide reasonable support to state, areawide, and local comprehensive planning efforts.

To implement this concept of P.L. 89–749 effectively it is also important to maintain maximum flexibility in the statutes, regulations, information and policy statements, guidelines, procedures, and administrative interpretations relating to the organization of planning agencies at each level to their method of operation. It is extremely important to avoid the temptation to build into these pronouncements and interpretations purposes that are not spelled out in this law, that run contrary to this law, or that are presumed to represent federal policy through interpretation of other legislation. The concept of a partnership among national, state, areawide, and local interest groups is quite sound. But as a partnership, it must be based to a large extent upon an aura of mutual confidence among the partners. To attain this degree of mutual confidence and respect, it must be accepted that within the concept, spirit, and letter of the legislation, each partner has or will develop the capacity to carry out its part of the task. It must also be generally recognized that each partner is most knowledgeable about its own sphere of activity, and that each of the other partners must rely to a very great extent upon that knowledge and mutual assistance. For example, the most effective method of carrying out environmental health planning and personal health services planning in an appropriate relationship may very well depend more upon a deep knowledge of the way in which a particular community functions than upon a desirable but theoretical pattern.

Clearly it is necessary that each partner must have a basis for judging and evaluating the performanec of each of the other partners and for facilitating relationships. Such criteria for judgment and such policies and guidelines should be kept at a necessary minimum. The most effective partnership is achieved when all of the partners have an equal opportunity to participate in the development of those guidelines and criteria and when all such guidelines and criteria that are used by any partner are open and available in advance to all of the partners. In both the development of the guidelines and criteria and in their application, it is also extremely important that each partner be represented by the most knowledgeable and experienced people in its sphere of activity. And, finally, in this regard, it is essentially important that, beyond the definitions of the roles of each partner, nothing in the legislation nor its administration should be construed in such a way as to suggest that any of the partners is dominant.

4. *The legislation promotes the concept that in our pluralistic society the nation's health goals can best be met through an effective partnership between the nongovernmental and governmental sectors at all levels.*

The Association clearly and unequivocally supports this concept of a partnership between the private and public sectors in health planning, recognizing that such a partnership connotes equal rights, privileges, duties, and obligations. Most of the comments concerning the national-state-areawide-local partnership apply with equal force to the private-public partnership. The relative importance of this concept may vary considerably in various sections of the nation and in different communities, but its essential nature is significant in the entire arena of health affairs.

Certainly it is important to encourage people and organizations in both the private and public sectors at all levels to participate actively in the planning process and to relate planning to the decision-making process. The amendment to Section 314(b) in P.L. 90–174 that requires appropriate representation of the interests of local government may have the laudable purpose of seeking to stimulate local government to participate in areawide health planning. Since no other groups are, on an equal basis, urged to participate in areawide health planning with the same specificity, it is not surprising to find that this amendment might be construed as making the public partner at the local level "more equal" than the private partner. The fact that this provision has been interpreted as giving local government a veto power in the development of an areawide health planning agency that is not similarly given to other partners could be most damaging to the partnership concept.

If planning is a process, as P.L. 89–749 contemplates, the vigorous advocacy of the public-private partnership concept (along with the other concepts) is essential. Such advocacy should include equal consideration of the roles of the public and private partners at all levels. It is interesting to find, for example, strong insistence on the involvement of all major public and private interests at the areawide level (with an over-emphasis on local government) without similar provision for similar involvement at the state or federal (both regional and central offices) levels. While the techniques of involvement may differ at each level—the most meaningful involvement probably can only occur at the local or areawide level—the principle of involvement should not vary if the partnership is to succeed.

Further, geographic diversity, with all that such diversity connotes, suggests that rigid definitions concerning the kinds and amounts of involvement of all interest groups at any level will be self-defeating. Local communities and areas and states should be permitted to work out the appropriate kind of organizational arrangements without the added weight of the federal government being thrown to one or another of the contending forces. Clearly, the results achieved in each community or area or state should not do violence to the purpose of the federal legislation and clearcut federal policies. But in pursuing those purposes and policies, it is equally important that the federal administrative units do not do violence to the concepts underlying this legislation. The same kind of restraint upon rigid thinking should be exhibited whether the issue concerns the nature of representation in the planning organization, the relationship of personnel health services planning to environmental health planning, or the approach to the planning process. No one approach is right or wrong for all communities, and a planning agency that does not reflect its own community will be totally ineffective. Adequate opportunity for innovation, experimentation and flexibility in the organization and operation of the planning process as well as in the delivery of health services is undoubtedly in the best interest of the nation.

5. *The legislation promotes the concept that effective comprehensive health planning requires adequate funding for the planning task and adequate numbers of qualified planning personnel employed in health planning at the national, state, areawide, local, and institutional and operating agency levels.*

Based upon the accumulated experience of its members, the Association clearly accepts the truism that effective health planning depends to a very large extent upon adequate financing of the planning organization and upon the activities of highly qualified planning personnel. Experience to date under P.L. 89–749 suggests that the development of both areawide and state planning agencies that can strive to meet the goals of this legislation will soon be hampered by shortages of both funds and qualified people—if, in fact, evidence of such shortages has not already been clearly noted. The several state agencies are already pushed beyond their financial and personnel capacities, and most of them have not even moved past the initial organization phases. With development grants alone, on a 50–50 matching basis, funding of areawide health planning agencies will undoubtedly reach the authorized limits by the end of fiscal 1969. Since there is a potential of at least 250 areawide health planning agencies under Section 314(b) if the states are to be effectively covered, the operational cost of areawide planning will undoubtedly exceed current authorizations within two years at least by a substantial amount.

All of the funds authorized for training planning personnel are already committed, and it has already become clear that inadequate numbers of qualified personnel will be made available within the scope of the program intended by P.L. 89–749. It seems quite likely that additional training funds will be needed under Section 314(c) beyond current authorizations, with some additional allow-

ance for on-the-job training of planning personnel. Concurrently, it must be anticipated that in the face of severe personnel shortages, salary levels of planning personnel will undoubtedly increase. Not only will this increase the need for total fund authorization under Sections 314 (a) and (b), but it will especially hamper designated state agencies in their search for personnel. Because of the restrictions of many civil service systems and a lack of understanding of the role of planning personnel, many state agencies already find it difficult to secure sufficient numbers of qualified personnel. As salary levels increase, this will even more seriously hamper the designated state agencies unless new methods of classifying such personnel can be developed.

As noted in an earlier section of this analysis, the time required for the transition from earlier health planning efforts to the full concept of areawide comprehensive health planning will vary considerably among local communities. It would be most unfortunate if organizations developed partly with federal funds that have filled a planning need in their own communities were allowed to founder because adequate financing could not be obtained. The loss of experience, expertise, personnel, established relationships, and community confidence in health planning would be inestimable. In the information and policies supporting Section 314(b) of P.L. 89–749 it was provided that funding of agencies formerly funded under Section 318 might be continued for one additional year. It is already apparent that it will take at least three or four years in many communities to build strong areawide health planning agencies under P.L. 89–749. This kind of transitional funding should be made available for an indefinite period to any community that has an on-going health planning organization that has been partially financed with federal funds in the past and that demonstrates a sincere willingness to take steps leading to the development of a 314(b) agency. It has become quite clear during the past two years that, especially with the current administrative constraints, the task of developing sound, viable areawide health planning agencies is a difficult one at best. The organizational task is most worthwhile, but it should not be carried on at the expense of all of the productive health planning efforts that have engaged the attention of our local communities for the past decade.

C. RECOMMENDATIONS

1. A permanent national health planning advisory committee, with appropriate programatic subcommittees, should be established to consult regularly with the Secretary and with the Office of Comprehensive Health Planning. The national advisory committee should consist of representatives of major national professional organizations, state health planning agencies, areawide health planning agencies, third party financing agencies, and public representatives. The general charges of the national health planning advisory committee would include at least:

a. Review of all current regulations, policies, guidelines and administrative interpretations (formal or informal) to examine their implications, their flexibility and degree to which they have been circulated to all interested organizations.

b. Recommend appropriate revisions of the regulations, policies, guidelines and administrative interpretation to ensure that the concepts underlying P.L. 89–749, as amended, are implemented as effectively as possible with adequate circulation for review and comment prior to their final adoption.

c. Prepare specific recommendations concerning the definitions of roles and relationships among local, areawide and state health planning agencies and between them and the regional offices and the central office of the Department of Health, Education and Welfare and after appropriate circulation, secure their final adoption.

d. Prepare specific recommendations concerning regulations, policies, guidelines and administrative interpretations concerning inventories of health services and concerning the implementation of the capital programing provisions of Section 2, paragraph 2, Subsection (a)2 of P.L. 90–174 (if such provisions are not repealed) and after appropriate circulation, secure their final adoption.

e. Carry on deliberations, using all appropriate consultation and conference techniques, concerning the possible role of the private sector at the national level and the federal establishment in health planning, including consideration of the possibility of providing a method of establishing national health policies and priorities as advisory to the President and the Congress and all major interest groups and the development of methods

of coordinating the planning and programs of the several federal departments and the departmental units in a manner that is supportive of national health policies and comprehensive health planning in the several states and local areas.

2. If the permanent national health planning advisory committee is not established immediately, special task forces composed of representatives of similar groups should be convened at the earliest feasible date to consider each of the subject areas described in 1, above.

3. Regional health advisory committees in each HEW region should be expanded to include a broader cross-section of representatives of professional groups, state health planning agencies, areawide health planning agencies, third party financing agencies, and the general public. Alternatively professional advisory committees composed of planning personnel from state and areawide health planning agencies should be established as advisory to each regional office. At least one staff member in each regional office should be given a person experienced in areawide health planning. Procedures for the review of applications for grants under Section 314(b) should be reassessed and streamlined wherever possible. Site visit teams should be reconstituted to include experienced and knowledgeable professional staff currently engaged in major aspects of areawide health planning, interested university faculty members, and qualified staff members of the regional office. The report of the site visit team should, along with material filed in the application, be the basis for review by the regional advisory committee. To enhance the consultation value to the site visit, copies of the site visit report should be transmitted to the applicant.

4. All regulations, significant policies, guidelines, criteria, and administrative interpretations, on which grant applications are to be judged should be reduced to writing and circulated to all interested groups at the national, state, areawide, and local level for consideration and comment prior to their effective date. Such written bases for judgment should be based upon a basic concern with the way in which diverse communities actually function rather than upon some superimposed concept of the way all communities should function.

5. The Department of Health, Education, and Welfare should cause to be convened an annual conference among representatives of the OCHP, the regional offices of HEW, all state health planning agencies, and all areawide health planning agencies for the purpose of discussing and making recommendations to the Secretary concerning national health priorities that might arise outside of the planning process or be especially supportive of the planning process.

6. The Secretary of Health, Education, and Welfare should take the responsibility of coordinating more vigorously those federal planning and program functions that affect or are affected by comprehensive health planning activities at the state and areawide levels.

7. The Comprehensive Health Planning and Public Health Services Amendments of 1966 (P.L. 89–749), as amended by P.L. 90–174, should be extended for a five-year period after the expiration of fiscal 1970; provided that specific provision is included to provide for evaluation of the results of comprehensive health planning at the federal, state and areawide levels.

8. Authorization and appropriation of funds to be awarded under Section 314(a), Section 314(b), and Section 314(c) of P.L. 89–749 should be consistent with the amount requested by the administration and the total scope of the program. If specific legislative provision is not made to provide matching funds during the transitional period to areawide health facilities planning agencies or other regional health planning agencies formerly financed partially by federal funds, then such provision should be made administratively by interpretation of Section 314(b). Such transitional federal funding should be made available as long as the grantee agency and its community demonstrate a sincere willingness to take the steps necessary to develop an areawide comprehensive health planning agency. With or without such funding, administrative policy should clearly reflect the congressional intent to construct a comprehensive health planning system that is based in those agencies with demonstrated experience and competence that were partially financed by federal funds prior to the enactment of P.L. 89–749.

9. In any legislative revision of P.L. 89–749, Sections 314(a), (b), and (c) should be identified in a single title with an appropriate administrative mechanism described; and Sections 314(d) and (e) should be identified in a separate title with a different appropriate administrative mechanism described. If separate titles are found to be undesirable, separate administrative mechanisms should nevertheless be established. If it is the Congressional intent that

Section 314(e) should be used to implement national health priorities that arise outside of the planning process, then such intent should be clearly stated. If it is not so stated, then decision-making concerning Section 314(e) funds should be related to the planning process at the areawide and state levels by administrative procedures.

10. The amendment in P.L. 90–174 to Section 314(a) directing the designated state agency to assist individual facilities with their capital programing should be repealed, with directions to those now considering revision of the Hill-Burton program to include its concept in their deliberations. If repeal of this amendment is found to be undesirable or if the function is transferred to Hill-Burton, legislative changes should be made clearly indicating the Congressional intent to delegate this responsibility to areawide health planning agencies under Section 314(b). If not repealed, administrative interpretation should foster the concept that capital needs of institutions are only a part of comprehensive health planning, that they arise out of the planning process, and that advice to facilities should include concern with programs and manpower and financing (capital and operating).

11. The amendment to Section 314(b) in P.L. 90–174 providing that the areawide health planning agency have appropriate representation of the interests of local government should be repealed and Section 314(b) should be amended to read as follows:

"... (a) project grants to any public or nonprofit agency to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan, area or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services, provided that such public or nonprofit agency is generally acceptable in the area it serves and has made a bona fide effort to include representation of the interests of local government, major professional groups and health care institutions or agencies, and members of the general public broadly reflecting the population to be served;..."

Whether such an amendment is adopted or not, it is clearly not the Congressional intent of P.L. 90–174 to give local government unique veto power over the areawide planning agency, and such administrative interpretations should be avoided.

Whether such an amendment is adopted or not, administrative policies and guidelines should clearly reflect the flexibility required to develop a viable organization in diverse communities by providing that the several interests, whether public or private, professional or non-professional, might be expressed through the use of a variety of organizational techniques, e.g., governing board, membership corporations, advisory boards, advisory councils, general and/or special advisory committees, liaison committees, ad hoc committees, task forces, joint project committees and interlocking memberships.

12. Every reasonable effort should be made to augment and improve the supply of qualified personnel engaged in health planning at the institutional or operating agency, local, areawide, state, regional office and federal central office levels. In addition to broadening support for graduate education programs (full course and short course) on-the-job programs in established and qualified agencies at all levels should be supported and encouraged. Designated state planning agencies should be given some assistance by the federal authority in developing realistic job descriptions and specifications so that realistic salaries can be assigned and qualified personnel recruited.

APPENDIX III

ASSOCIATION OF AREAWIDE HEALTH PLANNING AGENCIES POSITION STATEMENT ON HEALTH PLANNING MANPOWER—ADOPTED: DECEMBER 3, 1969

The recruitment of community health planners has been and continues to be a major problem throughout the nation. The field of areawide health planning has entered a period of a rapid expansion, stimulated largely by federal support, earlier under the Hill-Burton program and now under P.L. 89–749. In contrast, the supply of qualified, trained manpower to staff emerging health planning agencies has not kept pace with the demand. At this critical time, as new areawide health planning agencies emerge from the organizational period into operational responsibilities, planning programs will suffer unless there are qualified

individuals to staff and guide those efforts. This position statement focuses on the manpower needs of areawide health planning agencies; the need for qualified health planning personnel in other settings is acknowledged, with the suggestion that this matter be the subject of a separate statement.

Recruitment has been hampered first because comprehensive health planning has not been considered an important function in most communities (and consequently the career image of the community health planner has not been clearly defined nor widely disseminated), and second because educational institutions have not had incentives to develop appropriate programs to teach the broad concepts of health planning.

The manpower problems concerning health planning personnel—recruiting, training, utilizing to best advantage, retraining and retaining—have assumed major proportions, and potentially present serious obstacles to effective implementation of the federal legislation at the areawide level. If progress is to be made in this emerging professional field, the AAHP and its member organizations must assume responsibility and provide immediate leadership in resolving these problems.

The planning process must be defined and the needs of areawide health planning agencies must be generally described in order to provide guidance and stimulation for development of methodology for the recruitement, education, and training of professional health planners. Therefore, for purposes of this statement, the health planning process is broadly defined as those activities which are aimed at identification of health problems or needs, and determination of alternative courses of action to meet those needs, followed by decision-making steps to promote implementation of resulting proposals. Throughout all the activities, stimulating evaluation by the community is included. By its very nature, the health planning process should lend itself to the development of proposals and plans which will be innovative, go beyond established health policy norms, and have long range implications, and which may well require extensive re-ordering of institutional and community priorities, and consequent reallocation of community resources. Further, it should be recognized that health planning is but one component of the community planning process aimed at better services for all citizens. Therefore, it is assumed that the health planner should work in harmony with other community planners, both generalist and specialist, in developing proposals for resolving community problems. These characteristics have certain implications for staff requirements of areawide health planning agencies.

In describing the needs of areawide health planning agencies, it is assumed that agency personnel needs will vary from community to community, and differ from time to time in one community. However, an areawide health planning agency has a responsibility to assure itself and its community that the variety of viewpoints which exists in that area can have a forum for accurate interpretation, so that each perspective can have its opportunity to influence the planning process. Such a concept implies the need for a balanced staff. At the start, it is assumed that every areawide agency should have a core of "generalist health planners" whose expertise encompasses a generic knowledge of "community," as well as a working knowledge of his own specific locale, its health needs and resources. While the generalist planner will have knowledge about specific aspects of the health field that is less detailed than that of others, he should have a greater knowledge about the total community, including a broad community perspective with regard to health services. At the same time, the requirement for specialist planners is equally acknowledged, with the assumption that in its early stages of operation, an areawide health planning agency may contract for the services of such experts, and with the additional assumption that such specialist planners may be added to the staff of the areawide health planning agency as the agency matures and as the size and scope of its operations warrant.

In preparing "community health generalists", programs should be academically based and provide a balance of conceptual and technical skills. To provide the conceptual skills, a strong academic background should include an understanding and appreciation of social values and goals, as well as health administration, organization and planning principles. To achieve technical proficiency, health planners should be equipped with modern management skills to include applied research methodology, qualitative and quantitative analytical techiques. The existence of P. L. 89–749, 314(c) funds should encourage the innovative development of varied training programs, both full-time and short term, so that the process of developing the soundest possible curricula will evolve.

To aid the AAHPA and its member agencies to assume appropriate responsibilities in this complex problem area, the following recommendations are offered as possible steps which can be taken in the immediate future.

Recommendations

I. to the AAHPA.—The AAHPA should:

A. Take the initiative in developing—together with its member agencies, other interested groups, and educational institutions—a broad program of public education and information to: (1) Create awareness of the need for health planners; (2) Aid in recruiting qualified people in the field.

B. Promote active exchange of personnel between the areawide agencies on the one hand, and state and federal agencies, university programs, and health and environmental services on the other, for appropriate varying lengths of time for purposes of orientation, continuing education, and development of technical expertise in specialty areas. It would seem particularly desirable that young professionals entering the planning field be afforded the opportunity to gain experience in related health planning activities at federal, state, and local levels.

C. Continue expansion and broadening of the scope of Association-sponsored special institutes dealing with planning issues.

D. Develop a placement service for health planning positions to serve both agencies seeking staff personnel and individuals seeking employment opportunities.

E. Establish a Standing Committee to: (1) recommend to the Association policies regarding basic education, formal training, and continuing education for health planning personnel; (2) advise educational resources on matters pertaining to health planning curricula.

II. To the areawide health planning agencies.—The areawide health planning agencies should:

A. Recruit planning staffs from a variety of backgrounds and professional disciplines in order to achieve a balance which reflects the nature of the community being served, and to aim at augmenting appropriately the skills available in the agency.

B. Provide a climate conducive to continuing professional growth and development, by encouraging staff members to exercise their own initiative and creativity.

C. Assist in arranging: (1) continuing education of staff through inservice programs, as well as outside formal training; (2) orientation and training of other community planners who have health interests, concerns, and/or responsibilities; (3) education of consumers and providers at the community level to enhance their participation in areawide health planning activities.

D. Encourage institutions of higher learning in their own geographc areas to include content related to health planning in curricula in appropriate schools: (1) to foster this development, the areawide agencies should provide materials which reflect their activities, for use in such educational programs; (2) where appropriate, to gain field experience selected health planning classes should be invited to participate in actual planning activities that coincide with educational objectives.

E. Establish policies to foster placement of students, from a variety of disciplines, in areawide health planning agencies for supervised undergraduate and post-graduate field experiences.

Mr. JARMAN. I think it is helpful to the subcommittee to have specific and definite recommendations as to legislation before us. Many times we get testimony that is general and is an indication of sentiment in thinking, but it is the specfic that I thnk is most helpful to the subcommittee.

Mr. Skubitz?

Mr. SKUBITZ. Thank you, Mr. Chairman.

Does your association issue an annual report of any nature showing what you accomplished for the past year?

Mr. GOTTLIEB. The association itself, no.

Mr. SKUBITZ. It doesn't?

Mr. GOTTLIEB. We have an annual meeting and we have a report at that meeting, but we don't have money for things like that.

Mr. SKUBITZ. You have no record of your accomplishments?

Mr. GOTTLIEB. Yes; I think we have a gentleman that can answer it a little.

Mr. SKUBITZ. Could you place it in the record to show you have done a job?

Mr. GOTTLIEB. It is not in a formal record now, but, with your permission, Mr. Lentz can answer some of that.

Mr. SKUBITZ. I think if you are here claiming you have a great program, you ought to have some sort of an achievement record available.

Mr. LENTZ. I think you should know about the association. We are all volunteers in the sense we have no full-time staff. We don't really have a part-time staff except what we do collectively and individually.

So to speak to your point about the association, we have issued periodically some position reports.

Mr. SKUBITZ. I am not interested in that, but accomplishments.

Mr. LENTZ. Accomplishments of planning specifically?

Mr. SKUBITZ. Yes. You mentioned on page 8 the money for the program is on a matching basis?

Mr. LENTZ. That is correct. Up to 75 percent.

Mr. SKUBITZ. You state that local funds are extremely hard to generate for a new organization without a "track record" in the local community. Maybe I interpret this wrong, but what you are saying to me is, "We don't have anything to sell and therefore no one contributes"; is this the wrong interpretation?

Mr. LENTZ. Not necessarily so, but you have people concerned not only about the need for planning but also results and it takes time to point to specific accomplishments.

Mr. SKUBITZ. This is where I get back to the potatoes point. Are we talking about leaves or potatoes? Potatoes is what I am interested in at the moment.

Mr. LENTZ. Yes, and you also have to have good soil and workers to work.

Mr. SKUBITZ. We will provide the soil in the form of money if you can show us you are growing anything.

Mr. LENTZ. Let me give a couple of examples and turn it over to the others. I happen to be director of a new agency in Cincinnati which historically had a planning organization since 1917. It is one of the early developments in health planning in this country, but as far as CHP area health planning, we put together 14 counties in three States; four counties in Ohio; eight counties in Kentucky; and two counties in Indiana. Solutions to health problems may be found in a single neighborhood, in a local area, or in the entire region. Let me give you just a couple of examples.

We have been in operation for 8 months, the time it takes from point zero to get a staff to get people organized as well as at the same time trying to raise money. This is sort of where we are.

The projects and activities now range from, or are starting to get stabilized organizations that go to three States, meaning I have to work in two regional offices, three State offices of planning also, as well as many local communities. Our work ranges widely. At the local

level, we are concerned with such projects as Model Cities planning, Neighborhood Health Center development, and Prepaid Group Practice development. We have also been involved in working with universities, especially in relationship to their affiliation with the county hospital system. We have advised the county commissioners concerning three tax levies for health facility development. And, we have tried to answer the question of: "How do we obtain a physician for a small village?"

But the solution to a problem may be intercounty in nature. Thus, we have helped with development of a satellite hospital in a neighboring county, when the joint facility is in Campbell County, Ky. All local funds were involved; but the planning agency was asked to assist with planning the system from the beginning.

The areawide concept may be in implementation of the Federal program in air pollution control where we already now have had a series of Federal standards developing in three States that have to designate the local planning authority. So I say it varies in a community like Cincinnati that has a history of planning since 1970 to taking on new dimensions of what the Federal requirements will expect along with local and State requirements.

So I think we have raised our money from a variety of sources from people who still want answers now just like you do.

Mr. SKUBITZ. I hope you understand I am not opposed to the program. I am trying to be a devil's advocate here and find out what you have been doing. Another thing, you speak of need for $10 million.

Now the association recommends authorization to support education of health planners in section 314 to be increased to $10 million for fiscal 1971.

What is the estimate based on? Did you pick $10 million out of the sky or do you have some specific program that you are ready to give us to show that it is worth $10 million?

Mr. GOTTLIEB. That particular figure comes directly out of H.R. 15895, and they are the money authorization figures in Mr. Rogers' bill.

Mr. SKUBITZ. Mr. Rogers, can you explain? Well, strike that question. That is all, Mr. Chairman.

Mr. JARMAN. Mr. Gottlieb.

Mr. GOTTLIEB. If you were to expand the question and ask where we got the figures in terms of the amount of money required to operate 250 areawide health planning agencies, I would be happy to discuss that question.

Mr. SKUBITZ. That is where you give us the $100 million and I see that where you say you need around 5,000 full-time people and I can understand that. I am sure Mr. Rogers has the figures.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Rogers?

Mr. ROGERS. The gentleman is very kind. Actually what we have done is projected from you and the rest of us approved on the original law, so we are really building on that.

How many are operational of your areawide planning councils?

Mr. GOTTLIEB. There are 10 currently operational and there are 31 currently ready to go, awaiting word next week, as a matter of fact.

Mr. ROGERS. And the rest are in the planning stage?

Mr. GOTTLIEB. Yes; the rest are in developmental stage.

Mr. ROGERS. How long will it be, would you estimate, until the items are operational, say, on the 125?

Mr. GOTTLIEB. I think that is a difficult thing to estimate. If we go on the basis of the usual rate of development, starting from scratch, I would say that it would take about 2 years before that 125 would be operational.

Mr. ROGERS. Now you make a good suggestion perhaps on the makeup of the areawide councils and you feel we have stressed the local government too much; is that correct?

Mr. GOTTLIEB. Yes; I think so, but only in the sense that by singling them out—and I realize the intent was to emphasize the importance of local government involvement—without specifying that other kinds of groups in the private sector should also be involved, the wrong impression was created. People administering the program at the State and Federal levels interpreted the section to mean that local governments have a veto power over the development of a planning organization that was not extended to any other party in interest. We believe that the interests of the public and private sector at the local level must be balanced; and we should like to see this mistaken impression corrected, while continuing to recognize the importance of the involvement of local government.

Mr. ROGERS. What has been the most difficult problem, would you say, in the areawide planning groups? That is, other than money.

Mr. GOTTLIEB. I think the most difficult problem stems from a lack of consistency and a lack of a clear definition of the role of the areawide health planning agency in the Federal administration of the program. With many different kinds of groups, organizations, and interests competing at the local level, there is no pattern around which they can all focus in the development of the agency that they can all accept so that rivalries and antagonisms cannot be easily settled.

Mr. ROGERS. That is what I understand, in trying to get the various groups together, the medical profession wanted to control it and hospital associations want to control it and pretty much now it is being worked out, I understand, through some headknocking.

Mr. GOTTLIEB. Most of us have the scars to prove it.

Mr. ROGERS. We are beginning to make progress now though?

Mr. GOTTLIEB. I think so.

Mr. ROGERS. I visited one in Miami which I think is doing an excellent job and it took about a year to get everybody together, they said, but now they are really working and I was amazed. Their attendance has been 85 to 90 percent at every meeting, which is exceptional, so I think we are on our way and I commend you for your interest and devoting your time, often when you are not paid, and I think that is excellent.

Thank you and thank you, Mr. Chairman.

Mr. JARMAN. Mr. Kyros?

Mr. KYROS. No questions.

Mr. JARMAN. Mr. Preyer?

Mr. PREYER. No questions.

Mr. JARMAN. Thank you for being with us, gentlemen.

This concludes the committee's hearings and the committee will stand adjourned.

(The following statements and letters we received for the record.)

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association is a federation of State optometric associations and societies representing just over 15,000 of the 17,000 optometrists engaged in practice in fifty States and the District of Columbia.

OPTOMETRY'S POSITION

As one of the five fully accredited disciplines comprising the Nation's primary health care team, optometry supports the laudable goal of renewing legislative authority for the Regional Medical Programs, which hold great potential for making major contributions to research, provision of highly specialized equipment and programming in the areas of the major "killer" diseases.

However, the American Optometric Association strongly opposes domination of the existing Comprehensive Health Planning program by the Regional Medical Programs, as would be the case with the Administration's proposal.

DESIRABILITY OF RESTRICTING SCOPE TO "KILLER DISEASES"

With reference to H.R. 17570, the American Optometric Association believes that adoption of the phrase "and other major diseases and conditions, and for other purposes" broadens the scope of Regional Medical Programs far beyond the desirable parameters set forth by the Congress when the legislation was originally enacted.

The reasons for our objection to this language are several. Generally, the phrase "and other major diseases and conditions" could lead to unnecessary overlapping of Regional Medical Programs with programs and projects already initiated by State and Area-wide planning and service agencies under the Comprehensive Health Planning and Services Act (Partnerships for Health), thus causing needless duplication and unwarranted expense to the Federal government.

The Comprehensive Health program, enacted in 1966, is only now beginning to function effectively, and is utilizing the combined knowledge and skills of professionals from all recognized health care fields. The Regional Medical Program does not utilize all available manpower and resources, such as those offered by the independent health profession of optometry.

A strong possibility also exists that inclusion of the phrase "other major diseases and conditions" could divert substantial sums of financial support from the vitally important areas of research and services provided for in relation to the specific killer diseases enumerated in the legislation.

Retention of such a broad definition could change the emphasis of Regional Medical Programs to the extent that RMP parallels the scope of activities encompassed by the Comprehensive Health Planning mechanism. Comprehensive Health is a system which concentrates on local, State and area needs, and which by its nature pinpoints those health problems peculiar to a specific geographic area. Based on the planning achieved under the Comprehensive Health program, local, State and area units then proceed to obtain the Federal financial assistance and services required in accordance with the priorities established. There is no justification for promoting and encouraging the overlapping of these two programs, when such overlapping would impair the integrity and definitive areas of responsibility of both the Comprehensive Health and Regional Medical programs. Such an approach does not, however, preclude the possibility of cooperative efforts between the two systems in those situations where cooperation will obviously result in more productive returns for the tax dollars invested.

RECOMMENDATIONS

The American Optometric Association urges deletion of the phrase "and other major diseases and conditions" in the short title of H.R. 17570 where it appears again at the end of line 6 and on line 7, page 2 of the bill under Sec. 2(a) section 900(a)(3) and wherever else it may appear in the proposed legislation.

The American Optometric Association urges that the Committee retain the language spelling out specific areas of research and services authorized by the Regional Medical Programs legislation. This will ensure that appropriations for Regional Medical Programs will in fact be concentrated on finding solutions to

the problems presented by the "killer diseases" rather than having the effort diffused by authorization to move into areas of activity more effectively and economically handled by ongoing Comprehensive Health Planning and Services programs.

Only in this way, we believe, can both programs develop their operational structures to a level of maximum efficiency.

CONCLUSION

The American Optometric Association appreciates this opportunity to place its views on record with the Committee, and will be pleased to cooperate in supplying any additional information the Committee may find helpful.

STATEMENT OF SAM A. WEEMS ON BEHALF OF FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman and Members of the Subcommittee, I am Sam Weems, Legislative Chairman of the Federation of American Hospitals. The Federation of American Hospitals is the national association of proprietary (investor-owned) hospitals and speaks for approximately 500 hospital facilities through its members and affiliated State organizations.

THE INVESTOR-OWNED HOSPITALS

Our records reflect that there are approximately 1,000 acute short-term proprietary hospitals in the United States. These facilities represent about 20 percent of the nation's non-governmental hospitals. However, in some areas of the country investor-owned facilities represent up to 100 percent of the hospitals. These hospitals have to a great extent served to prevent a health crisis by filling a gap in both those communities which were too poor to finance tax-exempt hospitals or in those communities which grew so rapidly that the area could not keep up with exploding populations.

Investor-owned proprietary hospitals throughout the United States provide emergency, maternity, pediatrics, and other specialized services, often without recouping the full cost of such services. They provide these services in recognition of the fact that they have an obligation to the community in which they are located.

The investor-owned hospitals of America as an integral part of the nation's health industry are ready with government and others to meet the challenges of the future.

The investor-owned hospitals of America are committed to providing quality health care at reasonable cost and we believe that the free-enterprise sector of the hospital field can make a significant contribution to the development of a more efficient and more effective delivery system. This can be done by stimulating competition and providing alternatives to the consumers of health care—all within the framework of a single system.

In this regard, the investor-owned hospitals support a coordinated system rooted in planning in order to avoid the unwarranted expenditures of health dollars and the duplication of facilities or costly equipment. The Federation of American Hospitals' long standing position on this subject is restated in the following resolution adopted in September, 1969.

"It is the obligation of all hospitals, irrespective of their ownership or sponsorship, to provide quality health to their communities. In fulfilling this obligation, all hospitals in a community should provide a full range of services consistent with the principles of comprehensive health planning, including the avoiding of unnecessary duplcation of services. Included in such a full range of services should be: obstetrics, pediatrics, intensive care, coronary care, emergency and outpatient services."

HEART DISEASE, CANCER, STROKE, AND KIDNEY AMENDMENTS FOR 1970

Mr. Chairman, the Federation of American Hospitals supports the extension of the Regional Medical Programs as proposed in H.R. 17570. Since the enactment of Public Law 89-239 in 1965, 55 Regional Medical Programs have been developed covering the entire United States.

The timing of this proposed extension is particularly critical because many of these programs are just now becoming operational. H.R. 17570 would provide for gradual increases in the authorizations for these programs to a high of $250 million in 1973. This long range commitment by the Congress would strengthen and reinforce the involvement of those segments of the health industry which have participated and are willing and able to participate in the program.

The present legislation places emphasis on supporting research, demonstrations, education and training programs concerned with Heart Disease, Cancer, Stroke and Related Diseases. These are the major killer diseases in America today, accounting for substantially more than one million deaths last year.

The Federation of American Hospitals supports the extension of the program to include Kidney Disease and "other major diseases and conditions." Leading physicians have discussed their frustrations at the knowledge that proven treatment exists which could save thousands of lives, if made available to the many kidney patients, the majority of whom are in their young or middle years. Nine out of ten patients with chronic kidney disease in the United States today face death because of their lack of access—financial or otherwise—to an artificial kidney machine and kidney transplantations.

While kidney disease is presently included under the Regional Medical Programs as a "related disease", we believe it should be specifically mentioned in order to receive earmarked funds.

Mr. Chairman, the investor-owned hospitals have not been included in Regional Medical Programs, however H.R. 17570 authorizes the Secretary of H.E.W. "to contract for . . . programs, services and atcivities of substantial use to two or more regional medical programs" . . . "development, trial, or demonstration of methods for the control of Heart Disease, Cancer, Stroke, Kidney Disease, or other major disease and conditions;" . . . and for "the conduct of cooperative clinical field trials," among other objectives.

This contractual authority, supplementing the Secretary's grant authority, would apply to investor-owned hospitals and the Federation of American Hospitals endorses and welcomes this amendment. We must use all existing resources to achieve national goals in improving our health care delivery system and H.R. 17570 recognizes this principle in expanding the contractual authority of the Secretary.

Mr. Chairman, the Federation of American Hospitals recognizes that the Subcommittee will also be considering H.R. 15960 which provides for a broader legislative package extending at the same time comprehensive health planning and health services research and development. In addition, H.R. 15960 creates a single advisory council for these programs. The Federation of American Hospitals does not take a policy position on these proposals at this time except to state our concern that the specific objectives of the Regional Medical Programs retain their independence. We would certainly be opposed to a merging of priorities which tended to subordinate the Regional Medical Programs to a position of lesser importance. In the same vein, we note that the creation of a single advisory council for three programs may weaken the ability of council members to deal constructively and effectively with programs just reaching the operational level.

Mr. Chairman, the Federation of American Hospitals expresses its gratitude to the Committee for this opportunity to present the investor-owned hospitals' views on this most important subject.

STATEMENT OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Comprehensive health planning is an effort to coordinate on a national scale a pluralistic health care system in our society. The potential of health planning is most promising; its purpose rational; and its implementation essential to the strengthening of our health care system.

Comprehensive health planning is a massive effort to link all of our health resources, both public and private, to achieve health goals within a setting that encourages flexibility, diversity of approach and innovation. Particularly encouraging in this respect is the emphasis by the Federal Government on drawing upon the skills, resources and productivity of the existing health system to meet public needs, rather than enlarging the Federal establishment for this purpose.

The Health Insurance Association of America, which represents over 300 insurance companies issuing approximately 80 percent of the health insurance provided by insurance companies, endorses the concept of comprehensive health planning as embodied in Public Law 89–749. 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 this 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; where its problems must be resolved; and where our resources can best be utilized.

Three years ago, in response to the challenges confronting community health systems and the charge of the "Partnership for Health" legislation, our member insurance companies established the Health Insurance Council Program for Community Health Action Planning (HiCHAP). The Health Insurance Council is a division of the Health Insurance Association of America.

The HiCHAP program represents a commitment to what health insurers view as a sound and constructive approach to promoting efficient delivery of quality health services to the public at reasonable cost. This commitment is being effected through active participation of insurance company people in state and area-wide planning programs, through developing information systems for the provision of technical data and research and through financial assistance to assist comprehensive health planning through the initial years of organization.

HiCHAP is currently cooperating with the Federal Government in an experimental program in three areas across the country which are structured to better interrelate financing to the organization and delivery of health services. Moreover, these efforts should strengthen comprehensive health planning by using the area-wide planning agency to help formulate, present and evaluate the many aspects of these programs.

The health insurance business appreciates that we not only have an opportunity to participate in this program, but that we also have a sense of responsibility to share our experience in management and administration gained over many years of serving those Americans who have entrusted to us the custody of their health care protection resources. We believe there is an interrelationship of comprehensive health planning and comprehensive health insurance and that each is contingent on the other for progress and effective performance.

It is on this basis of industry-wide exposure and involvement through the HiCHAP program in the health planning process at all levels that the following observations and recommendations relevant to H.R. 15895, the "Comprehensive Health Planning and Services Act of 1970," and H.R. 15960, the "Health Services Improvement Act of 1970," are submitted for consideration.

H.R. 15895 would amend and extend for three years the present partnership for health program and would authorize a total of $787.5 million over the period ending June 30, 1973. We are particularly pleased that this measure contains a significant increase in authorization of appropriations for areawide health planning agencies. It would amend the program to provide a better mechanism for coordination between the state planning agencies and the regional medical programs. It also provides for the establishment of an areawide health planning council which would include representatives to assure broad based community participation. We feel this bill has very positive features for building the capabilities of comprehensive planning to fulfill its mission as outlined in the preamble to Public Law 89–749.

We also believe that H.R. 15960 contains a number of provisions designed to strengthen the role of comprehensive health planning. One of the major efforts of this measure is to combine the Comprehensive Health Planning program, the Regional Medical Program, the National Center for Health Services Research and Development, and the National Center for Health Statistics under one title of the Public Health Service Act. However, there has been considerable concern expressed that a consolidation of the Regional Medical Program and Comprehensive Health Planning could potentially jeopardize their vitality and effectiveness.

We feel there may be a degree of credibility for this concern regarding a merger at this point in the history of these programs. Comprehensive health planning, in particular, is still in the embryo stage of development and needs clarity of direction and the complete concentration of its efforts. A consolidation at this time could dissipate the program by altering its focus. Therefore, we support the extension of the Comprehensive Health Planning program as contained in H.R. 15895.

It is recognized, however, that one of the primary responsibilities of comprehensive health planning is an effective and cooperative relationship with the Regional Medical Program and we are confident that coordination can be continued and achieved voluntarily by the separate programs. In addition, the resources of the National Center for Health Services Research and Development and the National Center for Health Statistics can still assist in any effort to further mutually held objectives by these programs in their present form.

Although we feel H.R. 15895 is the appropriate vehicle for advancing the present concept of comprehensive health planning, there are certain positive aspects of H.R. 15960 which we respectfully suggest should be incorporated in any legislation on the subject approved by your Subcommittee.

Specifically, assistance in programing capital needs for community health facilities should be related to the overall process of planning at the local level. Section 922(a)(9) provides that states shall consult with the areawide agency regarding a program for capital expenditures for health facilities construction.

There is also a need for funds to be allocated for health services development projects which are directly related to the planning process at the community level. We feel this can be enhanced by section 925 which ties health services development grants to review and comment by the areawide agency. Furthermore, we believe a close relationship should exist in the allocation of Public Health Service grants to the overall health planning program as set forth by the states.

Section 901 authorizes a 24-member National Advisory Council with representation from the fundamental sciences, the medical sciences, the organization, delivery and financing of health care and consumer categories. The Council would advise and assist the Secretary of Health, Education, and Welfare regarding regulation, policy and the coordinating of Federal health programs. We concur in the creation of, and need for, this National Advisory Council in order to insure maximum feasible participation of all interests in the health planning process. In addition, we would hope that the views of the planning agencies would be represented on this Council.

The Comprehensive Health Planning program should be granted the necessary authority and role of coordinating the pluralistic funding resources of the Federal agencies for health services, facilities, manpower, and environmental health. Section 943 would seem to facilitate this process by permitting joint funding and single administrative responsibilities where more than one Federal agency or more than one unit within the Department of Health, Education, and Welfare may be involved in a single project.

We also support a cooperative system of health information and statistics for undertaking research, development, demonstration and evaluation, relating to the design and implementation of a cooperative system for producing comparable and uniform health information and statistics at the Federal, state and local levels. The importance of this effort has been well demonstrated by any organization that has attempted to collect and aggregate meaningful data for planning or program development.

It should be emphasized that adequate funding for supporting comprehensive health planning is extremely vital in order for the program to advance the goal of quality health care throughout the nation. In support of this concern is the fact that a significant number of applications have been submitted to the Public Health Service in the latter part of this fiscal year for the conducting of areawide health planning, but have been held in abeyance due to the lack of support funds. In order to make the hopes of the program a reality it is necessary that there be adequate Federal financial assistance to meet the needs of all the agencies undertaking community health planning activities.

Public Law 89–749 incorporated the concept that environmental health planning is an essential component of a comprehensive approach to improving the health of the American people. We feel that this concept should be continued and emphasized that our environment is a fundamental part of the process of health planning. We believe that the health planning approach for our environmental problems at all levels will encourage continuous and positive response. The creation of a positive environment is a necessary link in the planning process for improving and fortifying the standard of life for all.

As in the case with most complex and vital social adventures, there is a natural impatience to witness significant accomplishments as quickly as possible. Comprehensive health planning is an effort to pull together and coordinate, in a cooperative effort, all of the mosaic pieces of our health care system. It is premature to expect significant achievements before the program has had an opportunity to mature and receive the respect of health care providers and consumers.

There have been successes; there will be disappointments. We firmly believe, however, that the Comprehensive Health Planning program provides the forum and mechanism for improving the health of the American people.

We appreciate this opportunity to submit our views to your Committee and we assure you of our availability for further discussion and elaboration on any aspect of this statement should you, the members of your Subcommittee or staff wish additional clarification.

STATEMENT OF JOHN J. SHEEHAN, LEGISLATIVE DIRECTER, UNITED STEEL WORKERS OF AMERICA

Mr. Chairman and members of this Subcommittee, my name is John J. Sheehan. I am the Legislative Director of the United Steelworkers of America, whose membership totals 1,200,000. We have approximately 3,500 local unions representing almost every industrial area of our nation.

The United Steelworkers of America has, over the years, supported several legislative approaches to the solution of national health problems. We continue this trend by joining with other organizations to amend the Regional Health Services program to include kidney and other related diseases as proposed in HR–17570.

I must, at the outset of my statement, admit that we cannot, and will not, address ourselves to the technical aspects of medicine, research, delivery system, etc. Instead, we address ourselves to the tragedies reported by our members, and their families, who have suffered the consequences of kidney disease, which can be treated satisfactorily, and who have also suffered because of the outrageously high cost of treatment currently experienced in the use of the dialysis machine and the operational transplant cost of candaver kidneys.

While our members have the help of their union (we request that you review the two examples attached as Exhibits A & B, and include them as part of the record) others effected, which number in the thousands, are virtually without help. This should not be the case. A national problem should be resolved by a national program.

The effect of our piecemeal approach, though important to the individual, leaves much to be desired by the victims of kidney disease as a whole, with and without organizational help, who live, from day to day, in constant fear and apprehension—unnecessarily.

Kidney disease can be treated. Dialysis treatment is known and accepted and transplants are increasingly and dramatically successful. Kidney computer banks for cross-matching of kidney tissues contribute to safer operations. Unfortunately, computer programing is limited to six regions of our nation. Thus, legislation to expand the availability of proven kidney disease treatment, through the dialysis machine; trained personnel, kidney transplants; and record keeping for tissue typing, through computerization, must include ways and means to deliver the required, but currently limited, service to those 50,000 plus annual victims who should have an opportunity to live.

Our organization supports amending the Regional Health Service program to include kidney and kidney related diseases as a first step in the eradication of kidney disease. We recommend that the funds earmarked for kidney disease in HR–17570 be increased by $5,000,000; that the major goals of the amendment be to develop a delivery system of service and equipment for home use and the necessary attendant training for use in the home; that the base of research in combating the disease and in manufacturing and designing a less costly dialysis machine be broadened; that educational material appropriate to the Regional Health Services program be widely distributed; that there be a remodeling of and the building of new kidney disease facilities, equipped for dialysis treatment, transplant operation facilities and intensive care units; that funds be provided to train professionals and subprofessionals interested in the field of kidney and kidney related diseases; and to work toward a program of preventive medicine.

Before closing my statement, I should like to make two additional points.

1. We are deeply concerned about those whose station in life, income, and location are such that home dialysis treatment is practically impossible. These victims cannot afford hospital care. Transportation costs are also a major factor, and the basic condition of their living quarters, some in slums, on farms, and reservations, are without the required utilities necessary for the operation of a dialysis machine. We suggest, therefore, that Congress earmark funds for experimental self-contained mobile units as a solution to this problem.

2. We expect that with the passage of HR–17570 future demands for cadaver kidneys will increase. Our Union has encouraged recent conference delegates from four of our districts to engage in a volunteer organ-donation program. We intend to encourage this activity throughout our Union and express ourselves fully on this matter during our national convention which will take place in September.

I thank the Committee for this opportunity to express the Steelworker's position and to encourage the Committee's full support of HR–17570.

EXHIBIT A

[From Steel Labor, February 1970]

Youngstown Mother Has Transplant as Result of USWA Fund Drive

Youngstown, Ohio.—The family of Mrs. Miranda Hentzl, who came home from Mount Sinai Hospital in Cleveland only two days before, greeted the new decade on Jan. 1 with renewed hope brought about by the kidney transplant operation the 34-year-old mother underwent on Dec. 21.

Born with one malformed kidney, whose other one had functioned more and more poorly over the past five years, Mrs. Hentzl already is now up and helping around the house at 2932 Roy St. here. "I feel like a new woman," she says, noting that her appetite has returned and that she feels like doing chores at home for the first time in several years.

Now on medication and being seen at the hospital twice a week, Mrs. Hentzl still faces a period of six months or more in which it remains to be seen whether or not her body will accept the new organ. Yet, she clearly has a chance now for a new and normal life, for which she and her family are extremely thankful. For without such an operation, she faced continued suffering, possible loss of sight, and eventual death.

Mrs. Hentzl and another young mother who also had been at Mt. Sinai awaiting transplantation each received a kidney—and a new lease on life—from the body of a 19-year-old Wooster, Ohio, boy, who was killed in a traffic accident only four days before Christmas. The recipients and their families are deeply grateful to the parents of the Wooster youth, who donated his kidneys to this cause.

In addition, Mrs. Hentzl; her husband Frank, a member of Local 1514 of the Carpenters Union in Niles, Ohio; two daughters, Terry 15, and Cynthia, nine; and her father, Anthony Leone, a member of USWA Local 1330 here, express their sincere thanks to the many contributors to the Miranda Henztl Kidney Fund, which several months ago was established by the officers of Local 1330.

The tragic fact is in America today that treatment for victims of chronic kidney disease is based primarily on their ability to pay . . . and to pay costs that are staggering. Part of the problem is that, although medical techniques have been developed for coping successfully with the disease, such as transplantation and the use of artificial kidney machines, neither adequate facilities nor medical personnel are available to handle the case load. Additionally, federal research grants have been expiring, as at Mt. Sinai on Dec. 31, 1968, as the research has proved successful and the need has shifted to treatment.

In investigating the situation, Michael Kunovic, president of Local 1330, found that the over-all cost of a kidney transplant operation at the Cleveland hospital was $40,000, and this was the sum that a fund-raising committee set out to raise. Mrs. Argie Collevecchio, a jaintress at the local union hall, in first mentioning the serious condition of her friend Miranda Hentzl to Mr. Kunovic last summer, noted that already doctor and hospital bills were eating up the family's entire earnings.

The fund-raising committee, co-chaired by Michael Rigley and Mr. Kunovic, had some success in raising money locally through benefit dances and sports contests. Because of the size of the sum and the immediacy of the need, the committee also called on fellow unionists for help—appealing to all locals in the Greater Youngstown AFL–CIO Council and sending letters to every USWA local in the United States and Canada.

More than 800 Steelworkers locals responded, producing the bulk of the nearly $30,000 that thus far has been raised. A plant collection by members of Local 309 in Alcoa, Tenn., netted $1,200, with a promise of some more to come.

But other smaller donations were just as heart-warming to members of the fund-raising committee. Local 1166 in Pittsburgh, for example, contributed $25 out of the $29.84 in its treasury. Members of Local 4028 in Santa Clara, Calif., who

had been on strike for nearly two months, donated $26 out of their own pockets. The 12-member Local 4579 in McKeesport, Pa., sent $10. Local 7073 in Corbin, Ky., in the tenth week of a strike at the National Standard Co., contributed $25 from its treasury and sent another $50 in individual donations. An administrator of a local in Alabama, feeling that he should not contribute from the local union's funds, sent his personal donation of $15. Local 3508 in Chattanooga, Tenn., contributed, although it had just finished a long strike.

Contributions came from USWA locals from coast to coast and in Canada. "We can't thank everyone personally," said Mr. Kunovic, "but we want to tell everyone that participated in any way that we could not have done without you." The Local 1330 president hopes, too, that the original $40,000 goal will be met. Further donations, made out to the Miranda Hentzl Kidney Fund, should be sent to the Dollar Savings and Trust Co., Youngstown, Ohio 44503.

Mrs. Hentzl became a patient in Mt. Sinai's renal program in September. She returned to the hospital in early December for treatment with the artificial kidney machine, undergoing a process called hemodialysis—the artificial removal of impurities from the blood, which is normally carried out by healthy kidneys. She was in the hospital early on Dec. 21, when the boy from Wooster was killed.

The physician at Wooster Community Hospital, upon learning that the kidneys were to be donated by the youth's parents, called the Organ Recovery Center in Cleveland, which set the wheels in motion for the transplant.

The organ recovery team at Cleveland's Veterans Administration Hospital flew to Wooster via Air Central's Helicopter Service, and brought the kidneys back to the regional tissue-typing center at the Cleveland Clinic, where both were determined to be useable and to match patients awaiting transplantation at Mt. Sinai. Miranda Hentzl and another young mother were the lucky ones, as the hospital's Public Information and Publications Department noted in a Dec. 30 news release.

For an estimated 8,000 other Americans this year, however, the story won't have so happy an ending. That's the number of people who are expected to die from kidney disease in 1970 from the lack of adequate treatment, for which facilities aren't available or for which the cost is too high.

U.S. Bills Would Aid Kidney Disease Fight

Several bills have been introduced in Congress which call for government action to control kidney disease in the United States. While the approaches are somewhat varied, the proposals note the federal responsibility to help finance treatment facilities, such as artificial kidney machines, and train the specialized personnel needed to make kidney centers operational.

The United Steelworkers of America, states Legislative Director Jack Sheehan, will support legislation implementing this federal responsibility. Hearings are expected to be held on three bills introduced by Sen. Jacob Javits (R–N.Y.) and Edward G. Biester, Jr. (R–Pa.) ; by Sen. Ralph Yarborough (D–Texas) ; and by Sens. Henry Jackson (D–Wash.) and Warren Magnuson (D–Wash.). Similar bills made little headway in the past two years.

Members of the USWA who have had experiences with kidney disease or have feelings on the subject are urged to communicate with STEEL LABOR. The union will be able to build a more solid case regarding these legislative proposals if USWA members take the time to express themselves on this matter.

EXHIBIT B

Local Union No. 1170, United Steelworkers of America, District No. 28

Dear Sir and Brother: Our local 1170 which represents 250 employees of Ferro Corporation, Cleveland, Ohio, has a member that finds himself and his family in a very grave financial crisis, and very much in need of the help of your local, the Steelworkers and anyone else that can help with a contribution.

We did not know how to go about helping our member John Kutolowski and his family until I read the story of Miranda Hentzl in the February issue of Steel Labor and how President Michael Kunovic of Local 1330 started a fund for one of his member's daughter. Local 1330 is a Steelworkers local of District

26, which is headed by Director Frank Leseganich and is located in Youngstown, Ohio. After reading this story of what was done in this local for one of it's members daughter, this gave us the idea of starting the Local 1170 USWA Jane Kutolowski Kidney Fund.

The financial problems have been brought about by the illness of John's daughter. Jane is twenty-two years old. She was attending Cleveland State University until about a year ago. At that time she became very ill and it was discovered that she had a kidney disease which had resulted in the total failure of her kidneys to perform their function of removing poisonous wastes from the blood stream. When waste materials are not removed from the blood, a person will die unless an artificial means of removing these wastes is employed.

Jane is currently being treated by hemodialysis on the artificial kidney machine here at Mt. Sinai Hospital. These treatments are performed twice each week and require her to spend a day in the hospital each time.

These twice weekly trips to the hospital have had several bad effects on the patient and her family. First of all, it has completely changed their lives for the worse. Jane is unable to attend classes now because she must come to the hospital two days each week, and she is unable to work at a regular job which would help pay for her college expenses and her medical care. She has to be driven to the hospital from their home by one or the other parent and of course that causes inconvenience and wear and tear on the nerves.

Secondly, the constant trips into the hospital have resulted in the Blue Cross hospitalization insurance running out. It covered 120 days of hospital care and cannot be reinstated unless Jane can stay out of the hospital for 90 days. That is impossible. The dialysis treatments she receives are necessary to keep her alive. Thus they are now faced with hospital and doctor bills which are piling up quickly and are not paid by insurance.

Only the wealthy family is able to carry this financial burden without help. The Kutolowski's are not able to meet these obligations and it causes them great worry and distress. They have asked Mr. Dixon, Administrative Assistant at Mt. Sinai, and myself, for advice and for whatever help we can give them. The family's intentions are honorable. They want to be able to pay the hospital and the doctors and they want the best care for their daughter.

There is available a program of care which will provide solutions to some of the problems of this patient and her family. Mt. Sinai Hospital has a Home Dialysis Program, wherein their staff will train Jane and her mother to perform the dialysis procedures on the kidney machine at home. The hospital currently has seventeen patients on this program who are doing very well. It allows them to return to the community in as productive a role as possible. For Jane it may mean that she could return to school and prepare herself for the future, to be trained for a job, to support herself and be financially self-sufficient with respect to the continuing dialysis treatments she requires.

The obstacles at this point in her progress to the Home Dialysis Program are financial ones. Even if her hospitalization insurance is reinstated, it will not cover the in-home expense for the rental of a machine or the expendable supplies necessary to carry out the dialysis treatments. The family does not have the income to cover these expenses.

Therefore, we are strongly appealing for your contributions to this cause, it can save a young girl's life.

We are urging all locals to donate what they can. Any amount you wish to give would be greatly appreciated.

This kind of help would demonstrate to the people of America that the working man and the great Unions that we have in this country show great concern for the welfare of all the people.

Fraternally yours,

NICK FUNARI,
Jane Kutolowski Kidney Fund.

AGREEMENT AND DECLARATION OF TRUST, LOCAL 1170, UNITED STEELWORKERS OF AMERICA, JANE KUTOLOWSKI KIDNEY FUND

I. *Creation of Fund.*—The undersigned hereby establish this fund for the charitable purposes set forth herein. All contributions, donations, and gifts given to the fund, as well as income obtained for the fund, shall be used exclusively in furtherance of the charitable purposes of the fund.

II. *Name of Fund.*—This fund shall be known as Local 1170 U.S.W.A. Jane Kutolowski Kidney Fund.

III. *Purposes of Fund.*—

(*a*) The Jane Kutolowski Fund is primarily established to finance treatment and care of chronic kidney disease at Mount Sinai Hospital of Cleveland, Ohio, or any other qualified comparable institution, and to provide for the payment of medical, surgical, hospital, and other expenses incurred in and incidental to such care for Jane Kutolowski.

(*b*) An alternative and continuing purpose of the Jane Kutolowski Kidney Fund is the financing of similar medical care for residents of the Cleveland and surrounding suburb area.

(*c*) In the event that neither the primary nor the alternative purposes of the Fund can be achieved, the Trustees are authorized to use the funds for some charitable purpose consistent with the spirit and humane considerations which motivated the establishment of this fund.

IV. *Administration of the Fund.*—The Jane Kutolowski Kidney Fund shall be administered by a Board of Four (4) Trustees to be appointed by Nick Funari. Should a Trustee resign or become incapacitated, a successor trustee shall be named by the incumbent trustees.

The Board of Trustees shall service without compensation and shall administer the fund in a manner consistent with the express and implied charitable purposes of the fund. No action shall be permitted or authorized by the Board of Trustees except upon the consent of the majority.

V. *Officers.*—The Board of Trustees shall elect from the board members, a chairman, a vice chairman, and a secretary-treasurer, all of whom shall service at the pleasure of the board. At any regular meeting the board may provide for the election of such to be held at any subsequent regular meeting.

VI. *Acceptance of the Trust by Trustees.*—A Trustee, upon signing this Agreement and Declaration of Trust, or upon written acceptance filed with the other trustees in the case of any successor Trustee, shall be deemed to accept the Trust created and established by this Agreement and Declaration of Trust and consent to act as Trustee and agree to administer the Trust Fund as provided herein.

VII. *Removal of Trustees.*—Any Trustee may be removed at any time by chairman of this Fund, upon giving written notice to the remaining Trustees. Such removed Trustee shall be fully discharged from all future duty or responsibility herein.

VIII. *Duties and Authority of Trustees.*—The Trustees, pursuant to the authority granted under the terms of the Trust Agreement, shall exercise said authority by taking such action as is necessary for the proper administration of the Trust Fund, including, but not limited to the following:

(*a*) Establish uniform and non-discriminatory procedures, rules, and regulations for the purpose of carrying out the provisions of the Trust;

(*b*) Take such actions and steps as may be necessary to establish a depository agreement, if deemed advisable, and to establish such agreements and regulations as may be necessary to effectuate such depository agreement;

(*c*) To hold cash in such amounts as may be in the opinion of the Trustees reasonable for the proper operation of this Trust;

(*d*) To pay from the Trust all reasonable expenses in administering the Trust, including but not limited to all expenses which the Trustees are hereby empowered to incur in connection with the setting up and operation of the Trust;

(*e*) To delegate any administerial powers or duties to any agent of the Trustees subject to mutual agreement by all parties concerned on the compensation payable for such administerial powers or duties to be performed;

(*f*) To engage such professional services as may, in the judgment of the Trustees, be required for the proper discharge of their responsibilities;

(*g*) To take all actions and do all things, whether or not expressly authorized herein, which the Trustees may deem necessary to accomplish the primary or alternative of the Trust Fund in the most efficient and economical manner.

IX. *Assets.*—Title to all assets of the Fund shall remain exclusively with the Trustees.

X. *Receipts and Disbursements.*—The Trustees shall receive all monies, and increments thereon, and make all disbursements therefrom upon check or orders signed by any two of the Trustees, or such other person as the Trustees may from time to time designate.

XI. *Interpretation.*—Subject to the stated purposes of the Fund and the provisions of this Agreement, the Trustees shall have full and exclusive authortiy to determine all questions relating to the methods of achieving the purposes of this Fund. They shall have full power to construe the provisions of this Agreement and the terms used herein, and shall be free to use their own judgment and discretion in all things pertaining to the affairs of the Trust. Any such determination, or any such construction, adopted by the Trustees in good faith shall be binding upon all of the parties hereto and the beneficiaries hereof.

XII. *Amendments.*—This Agreement may be amended by the Trustees provided, however, that no amendment may be made which will divert the Fund from the purposes set forth herein.

In Witness Whereof, the parties have affixed their signatures this —— day of ————, 19—— at ————————, Ohio.

————— —————.

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WASHINGTON/ALASKA REGIONAL MEDICAL PROGRAM,
Seattle, Wash., April 10, 1970.

Hon. PAUL G. ROGERS,
Member, Subcommittee on Public Health and Welfare, House of Representatives, Washington, D.C.

DEAR REPRESENTATIVE ROGERS: I write to support HR 14486, your bill to extend and amend Title IX of the PHS Act, which would extend the Regional Medical Program through 1973 and broaden the scope to include all major diseases, and to commend you for the time and effort you and your staff have committed to prepare this legislation. If possible, I would like my letter to appear in the hearings on HR 14486.

I have been Director of the Washington/Alaska RMP since the first meeting of its RAC in May, 1966, and since the approval of its planning grant in September of the same year. During the last nine months, as a member of the Coordinators Steering Committee to the Division of RMP and in other activities, I have had opportunity both in our region and nationally, to discuss extenson of PL 89–239 and PL 90–547. As a result of these many discussions and a good deal of thought about the matter, I'm convinced that HR 14486 would strengthen existing Regional Medical Programs and encourage their expansion in an orderly and logical manner.

I strongly favor the separate legislative authority for RMP as continued in your bill, though I would suggest incorporation of introductory language expressing the Administration desire and your own for closer coordination between RMP's and both the A and B agencies in CHP.

I approve broadening of the categorical limitations in H.R. 14486 and the new emphasis on prevention and rehabilitation. While there may be theoretical considerations favoring the complete decategorization of RMP as in S. 3443 and H.R. 15960, the Administration bill, such a change would make the program so diffuse as to be difficult to distinguish from CHP, would blur our objectives and would jeopardize our present volunteer support.

The National Advisory Council of RMP has proven to be an effective and invaluable policy-setting body for the RMP and, as you know, is made up of leaders in all fields of health and related activity. I think the additions to the NAC of persons described in your Section 7 (a) and (b) will strengthen the Council.

While I support the continuation of Comprehensive Health Planning as an important adjunct to the RMP and to other Federal, State and local health activities, I oppose the merger of RMP with CHP as proposed in S. 3443, the Administration's Health Services Improvement Act. The two agencies have the same ultimate goal—the improved quality and availability of health care for all. However, CHP, which is consumer oriented, deals with the broad policy aspects of planning, while RMP, provider oriented, deals with planning and implementing programs for improved personal health services. Though each has its own constituency and its own approach, the two agencies can work together cooperatively and effectively, and in most instances are doing so. There is reason to think that both agencies, but particularly CHP, are early enough in their development that their success would best be served by support and strengthening of the individual program, at least for the next several years. I think we will reach the ultimate goal of both sooner and with greater success if, for the present, they are allowed to continue separately but with every encouragement for coordinated activity.

Merger of these two and other Federal health programs may be desirable at some point in the future, but I think the consolidation as proposed in S. 3443 is untimely and poorly conceived. As you know, the RMP has stimulated an unprecedented involvement and support from the health related professionals, voluntary associations, leadership of health facilities and health-oriented members of the public. As it is written, S. 3443 would sufficiently change the direction of RMP away from its health provider, quality of care, action orientation that it jeopardizes the program and its volunteer support. It would also tend to increase rivalry between RMP and CHP, a rivalry which has been subsiding in the past year.

In summary, I support H.R. 14486 as good and logical legislation to extend and improve the RMP. Possibly the bill could be strengthened even further by introductory language describing the desirability of even closer coordination between the RMP, CHP, NCHS R & D, and NCHS.

Yours truly,

DONAL R. SPARKMAN, M.D., *Director.*

THE KANSAS STATE BOARD OF HEALTH,
Topeka, Kans., June 4, 1970.

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

DEAR REPRESENTATIVE STAGGERS: Since hearings on the legislation pertaining to comprehensive health planning and regional medical programs are now being held, the Kansas Coordinating Council for Health Planning would like to go on record as favoring simple extension of these pieces of legislation at this time, particularly since the legislation will run out at the end of this fiscal year.

The Council feels that the implementation of the present legislation is effective in Kansas and has begun to develop an orderly process for consideration of an improved health system. Under the present legislation, we have been concerned with a comprehensive approach to health planning which includes both the environmental concerns which relate to health as well as the health care delivery system. It is our feeling that the health status in any community is a function of *both* the quality and quantity of the medical services available and the environmental quality in that area. Some of the legislation which has been proposed puts an emphasis on new systems for delivering and financing health care. Though we realize that these are important considerations, we would like very much to emphasize the need for a total comprehensive health planning system.

We believe a simple extension of the present legislation could work effectively at present and that the cooperation that has been envisioned by some of the proposed legislation could take place through administrative means.

Sincerely yours,

(Mrs.) NORMA SATTEN, *Coordinator.*

MID-RIO GRANDE HEALTH PLANNING COUNCIL,
Albuquerque, N. Mex., May 29, 1970.

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

DEAR CONGRESSMAN STAGGERS: It has come to our attention that the House Interstate and Foreign Commerce Committee will begin hearings June 1st on the Administration's HSIA–70 (H.R. 15960) proposal. We also understand that an althernative proposal to be considered is an extension of the present Comprehensive Health Planning legislation, P.L. 89–749.

For some time, please note enclosed correspondence of December 2, 1969 to Secretary Finch, this agency has been concerned in respect to the Administration's position on comprehensive health planning. We have studied the proposed "Health Services Improvement Act of 1970" in the form presented to the Health Sub-committee of the Senate Labor and Public Welfare Committee. It is our opinion that the Administration's proposal detracts substantially from the concepts and philosophy of P.L. 89–749, under which existing areawide CHP organizations have been developed.

To allow the continued pursuit of the ideals set forth in P.L. 89–749, the Mid-Rio Grande Health Planning Council respectfully requests the extension of P.L. 89–749. This action is requested with the thought in mind that there is not at present the time necessary to adequately consider the ramifications of new legislation.

Respectfully yours,

JOE M. HENRY, *Chairman.*

MID-RIO GRANDE HEALTH PLANNING COUNCIL,
Albuquerque, N. Mex., December 2, 1969.

MR. ROBERT FINCH,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. FINCH: The Mid-Rio Grande Comprehensive Health Planning Project is a two year organizational project funded under Section 314(b) of PL 89–749. A grant application requesting funds to begin operational planning activities is presently being prepared.

There are several problems facing 314(b) agencies as they move from organizational to actual planning activities. The following two areas of concern reside at the Federal level:

1. PL 89–749 programs expire June 30, 1970, and as yet there is no public knowledge that DHEW has presented an extension proposal to Congress, and

2. The Office of Comprehensive Health Planning needs to be elevated in the DHEW organizational structure. The tremendous potential of PL 89–749 is diluted by positioning the office that administers it at a level that encourages fragmenttaion in planning activities at the Regional Office level.

The Congress must decide whether comprehensive health planning is a national goal. If it is, then adequate funding must be made available for CHP organizations to do their jobs. If comprehensive health planning is not to be a national goal, then local communities need to know what the limitations of PL 89–749 are to be.

It appears to many of us at the local level that Congress is looking to the Department of Health, Education, and Welfare for leadership in regards to the future role comprehensive health planning is to play in meeting the health needs of this Nation. A strong commitment on your part to support the ideas of PL 89–749 would be warmly welcomed at the local level.

Any insight you can share on what the future holds at the Federal level for comprehensive health planning will be greatly appreciated.

Respectfully yours,

JOE M. HENRY, *Chairman.*

AMERICAN HOSPITAL ASSOCIATION,
WASHINGTON SERVICE BUREAU,
June 12, 1970.

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

DEAR MR. CHAIRMAN: This letter is directed to you to present the views of the American Hospital Association on the several bills before your committee which deal with the Regional Medical Program and Comprehensive Health Planning Program.

We strongly supported the development of the original Heart Disease, Cancer and Stroke legislation and have, in numerous ways, encouraged the participation and cooperation of the hospitals of the nation in this program. Viewed in the context of its potential significance this program, which is known as the Regional Medical Program, has had a relatively short life to date and it is too soon to render a final judgment on its effectiveness. We continue to believe the program has great promise, however; and we support its continuation for a five year period.

The Regional Medical Program was initiated for the purpose of improving both the quality and the availability of health care services. It sought, via cooperative arrangements among the providers of health care, to bring the latest developments of medical and scientific research to people in all parts of the country. We believe the Congress acted wisely in limiting the program to the three disease entities named in the original legislation (Heart Disease, Cancer and Stroke).

This approach was intended to issure that major attention would be directed to those specific diseases which were of the greatest concern to the entire population. Speaking candidly, while some improvement has been noted, we believe the program is far from accomplishing its purpose. We would seriously question the wisdom of brining additional major disease categories into the program, thereby diffusing the effort further, until there has been much greater demonstration of accomplishment of the original goals.

We are pleased to note that several of the subject measures would provide for contract as well as grant authority to carry out the Regional Medical Program. Other proposals would authorize project grants for cooperative projects to be carried out by two or more Regional Medical Programs and joint funding of a project by two or more federal agencies as well as by two or more HEW administrative units. These provisions are very desirable and we urge their approval.

We also feel it would be a valuable improvement to provide authority for project grants to State Comprehensive Planning agencies to allow them to provide assistance in the development of comprehensive health plans with respect to areas not otherwise supported by areawide planning grants.

We further agree with the several proposals to include prevention and rehabilitation as integral parts of the program.

One area requiring corrective action, however, involves the language in the present law which states that Regional Medical Programs must not interfere with existing patterns in the organization of physician services. We feel this has proved to be detrimental to the development of the program and has hampered the achievement of the goals established for it. We, therefore, strongly urge the elimination of such restrictive language.

Another area of long-standing concern to hospitals involves the lack of coordination of activities under the Regional Medical Program and the Comprehensive Health Planning and Public Health Services Program. As presently constituted, they occupy overlapping and, in some instances, duplicative authority. This has prompted competitive activities for domination of the field and has occasioned considerable frustration on the part of the hospitals. We are highly pleased, therefore, that more than one of the measures under consideration take cognizance of this fact and we urge the adoption of those proposals which would affect a greater degree of coordination and, hopefully, cooperation between these two complementary programs. For example, a requirement that Section 314 state and areawide planning agencies have the opportunity to consider Regional Medical Program applications before they are recommended for approval would provide an important additional step in this direction.

It is highly essential, in our estimate, that the knowledge and experience of individuals intimately associated with the organization and administration of health services be made available to the Regional Medical Program National Advisory Council. Therefore, we support fully the proposed requirement that "health care administration" be represented on the National Advisory Council. Further, we would concur that official health and planning agencies should be represented on regional advisory groups for local regional medical programs. Conversely, we would likewise recommend Regional Medical Program representation on state and local Comprehensive Health Planning Councils.

Another significant proposal aimed at improved coordination of these programs involves the creation of a new single National Advisory Council on the Planning, Organization and Delivery of Health Care Services. The recommended Council would be assigned extremely broad responsibilities for coordination of numerous health programs, including the Regional Medical Program and the Comprehensive Health Planning and Public Health Service Program. The lack of a National Advisory Council for the Comprehensive Health Planning Program is a serious deficiency in the present law and we feel the establishment of a new National Advisory Council to function in respect to both programs is most desirable. Its function and proposed scope of authority is such, however, as to cause us concern with respect to its prospects for effective operation. Extreme care to its structure and composition will be needed if it is to function properly. Also, if the National Advisory Council for Regional Medical Programs is to be eliminated, as the proposal provides, we would recommend that the new National Advisory Council be given authority to review and recommend approval of both Regional Medical Program and Comprehensive Health Planning grants at the national level. There is no such provision in the proposals under consideration and we feel sure the Committee would want to remedy such an important shortcoming.

In conclusion, Mr. Chairman, we would like to say that the various measures before your committee contain a number of highly desirable provisions which, if implemented, could contribute importantly to the delivery of better health care throughout our nation.

We concur entirely with the modest increases in Regional Medical Programs and Comprehensive Health Planning funding as generally proposed and we commend your efforts to assure the development of sensible health facilities and service programs. We can only hope that the Administration will reconsider its appropriation requests and submit needful budget increases to meet its proper commitments in this vital area.

We appreciate the opportunity of expressing our views on these measures and request this statement be made a part of the record of your committee's hearings on them.

Sincerely,

KENNETH WILLIAMSON,
Deputy Director.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., June 9, 1970.

Mr. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare, House of Representatives, Washington, D.C.

DEAR MR. JARMAN: The American Nurses' Association affirms its support for the extension of the Regional Medical Programs as proposed in H.R. 14284. Regional Medical Programs have demonstrated an unusual capacity for stimullating cooperative local efforts in providing high quality medical care. They have been instrumental in bringing together the many health occupations involved in the care of heart, cancer, and stroke patients. The programs have also promoted and carried out activities for the updating of knowledge and continuing education for the many disciplines involved. In some communities RMP's have formed the nucleus for joint efforts in planning for the delivery of health care services.

We question the need for the Comprehensive Health Act as proposed in H.R. 15960. This bill includes only four of the multitude of health programs in the Department of Health, Education and Welfare. It would seem desirable to strengthen the comprehensive health planning efforts authorized by Congress in P.L. 90–174. This law was designed to aid states and local communities to develop their own plans for health services which would best meet their needs. These groups should be allowed to become operational before recommending that new acts be added to the present body of laws in the health field.

Since the Public Health Service Act was passed in 1935, many changes have occurred in the prevention and treatment of disease; and in the disease entities that are now prevalent. As each change came about, new laws, amending the Public Health Services Act, were passed. The categorical programs which resulted have produced many specialized independent parts rather than an interrelated whole.

It may seem inconsistent to support specialized programs such as the Regional Medical Program and the chronic disease program, yet seemingly criticize the categorical approach. What we are recommending is a comprehensive review of all health programs of the Department of Health, Education and Welfare and the realignment of existing programs into more effective components rather than a superficially plausible combination of programs as proposed in H.R. 15960. Until this is accomplished, the American Nurses' Association supports the extension of the Regional Medical Programs including "Part B—Chronic Disease Program" of H.R. 14284.

The American Nurses' Association also supports proposals that would establish a National Council on Health Policies. This country does not have a national health policy. With so many Federal agencies and departments involved in health programs, it is timely to establish a council to advise the President, set goals and make recommendations regarding health manpower, facilities and services.

Because nurses constitute the largest single group in the health field, a professional nurse should be appointed to such a council.

Sincerely,

EILEEN M. JACOBI, R.N., Ed.D.,
Executive Director.

NEW YORK STATE CANCER PROGRAMS ASSOCIATION, INC.,
Jamaica, N.Y., June 3, 1970.

HON. JOHN JARMAN,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building, Washington, D.C.

DEAR SIR: The New York State Cancer Programs Association strongly urges the continuation and expansion of the cancer control programs of the Division of Chronic Diseases which are part of the Regional Medical Programs service of the Health Services and Mental Health Administration. The Association has long been aware of the essentiality of theese programs in detecting cancer in the community hospitals and in strengthening the treatment cancer patients receive. In addition, the Bureau of Cancer Control is the nation's major agency that supports the training of clinical specialists and technicians required to detect and treat cancer. These specialists and technicians are already in critically short supply.

The importance of these cancer control programs was underscored and often singled out in the report issued by the President's Commission on Heart Disease, Cancer and Stroke. As you know, this Commission's recommendations were the basis for today's Regional Medical Programs.

At the Association's annual meeting on November 8, 1969, a resolution which was unanimously adopted stated that the cancer control programs should be continued and expanded. In passing this resolution, the Association wished to put the Congress of the United States on notice that they and the Administration would be responsible for terminating programs of demonstrated value which are proven daily to save lives. Although the Association members will continue to provide within their ability the best care they can, they don't want to be held responsible for the termination of these programs, but want the record to show that they took a position and made known their beliefs. In issuing the resolution, Dr. Barber, Secretary, stated clearly the view of the entire Association. He said, "The blame for needless death and suffering must be laid squarely at the doorsteps of our Senators and Congressmen."

We ask that this letter and the attached resolution of the Association be filed as part of the record in support of H.R. 14284 and H.R. 15135.

Sincerely yours,

GEORGE M. SAYPOL, M.D., *President.*

* * *

Whereas, cancer and its allied diseases is the second greatest cause of death and suffering among the citizens of the United States and,

Whereas, at present, early diagnosis and prompt treatment are the only known means of curing cancer or prolonging the useful life of those afflicted by this disease and,

Whereas, there exists and has existed, a critical shortage of physicians, nurses, technicians and other especially trained personnel, particularly and specially equipped to diagnose and treat cancer in its "curable" stages and,

Whereas, continuation and broadening of Federal support for existing cancer control and cancer training programs is mandatory to provide adequately trained personnel for the near future and,

Whereas, cessation of present training programs will result in needless loss of life and untold suffering and,

Whereas, this Association was formed for the sole purpose of improving the care and survival of the cancer patient.

Now, therefore be it

Resolved, That this Association and its members, jointly and severally, entreat the Congress of the United States to restore all deprived funds and to provide additional funds for expansion of cancer control and cancer training programs; and be it further

Resolved, That appropriated funds for cancer training and control be specifically earmarked for the aforementioned purposes, and be it further

Resolved, That the officers and directors of the New York State Cancer Programs Association be authorized and directed to take such steps as may be necessary to forcefully bring to the attention of Administration officials and legislators, the devastating effects of the discontinuance of the Cancer Control Training Program and, be it further

Resolved, That the officers and directors of the New York State Cancer Programs Association be given such powers as may be necessary to implement the foregoing resolution and, be it further

Resolved, That the members of this organization pray that they shall be held blameless for needless death and suffering of and by the cancer stricken victims, should the Congress fail to act on the aforesaid resolved.

Certified and true in substance as adopted by the Association at the Annual Meeting on 8 November 1969.

HUGH BARBER, *Secretary.*

UNITED COMMUNITY FUNDS AND COUNCILS OF AMERICA, INC.,
New York, N.Y., June 10, 1970.

HON. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare, House Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

DEAR MR. JARMAN: United Community Funds and Councils of America and its affiliates have been deeply involved with the implementation of areawide comprehensive health planning as provided for in Public Law 89–749 throughout the United States during the past two years. The partnership concept upon which the program is based has strong appeal to Americans who have serious concern about the health care crisis in our country. Voluntary citizen leadership intimately associated with the United Way has given considerable time to determine how best to implement comprehensive health planning on an areawide basis in over 300 communities. In addition, the United Way has invested well over $1 million in the program since its inception.

It appears that comprehensive health planning has now reached the level of development where it can contribute appreciably to the resolvement of pressing health problems in local communities across America. Many hours of serious deliberation have been devoted to establish the delicate balance between consumers, providers and government which is required if comprehensive health planning is to become a working reality. We believe that it would be a mistake to alter the legislation during this period of early operational development in view of the many difficulties which were encountered and resolved in devising community plans to implement the program. Any change in the program orientation at this time could lead to local confusion as to its ultimate goals and perhaps even destroy citizen confidence in it. Changes can and should occur in the comprehensive health planning structure, processes and goals. Such changes, however, should occur at the local level, be initiated by local citizenry and be relevant to local health needs and problems. We strongly urge the House Committee's support of the legislation for a three-year extension of both the Regional Medical programs (House Bill H.R. 14486) and Comprehensive Health Planning (H.R. 15895) introduced by Congressman Rogers.

I sincerely hope that every effort will be made to strengthen this important health planning program during this session of Congress. We will continue to do all that we can through our national office and our local affiliates toward accomplishing the partnership in health goals and objectives.

Sincerely yours,

WILLIAM ARAMONY,
Executive Vice President.

COMPREHENSIVE HEALTH PLANNING
COUNCIL OF WESTERN NEW YORK, INC.,
Buffalo, N.Y., April 15, 1970.

Hon. HARLEY STAGGERS,
Interstate Foreign Commerce Committee,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: We are writing to give you our joint impressions of H.R. 15960 (Health Services Improvement Act of 1970). Our comments are based on the attached reprint summary of the Administration's view of the purposes and effects of the proposed law.

The proposed legislation sets the stage for major changes in the concept of areawide comprehensive health plannng.

First, it sets the stage for a re-orientation of areawide comprehensive health planning from partnership between government and many *voluntary* community health planning programs to partnership between government and only extensions of the federal government. We have noted two places in the attached document which indicate this proposed re-orientation.

The proposed legislation also sets the stage, despite disclaimers to the contrary, for absorption of the regional medical programs by the comprehensive health planning programs. These programs have two distinct and separate roles. If these different programs can be made to appear similar in function through the implementation of the proposed legislation, one might logically conclude that duplication exists and propose the *apparently* necessary merger of two *apparently* similar planning agencies.

We are concerned that ultimate merger would lessen the effectiveness of each of our programs. The regional medical program has a planning component in order to carry out its mandated responsibility of enabling the medical profession to bring "science to service" through educational and demonstration projects. In contrast, the regional comprehensive health planning agency, by definition. is only a planning agency. It cannot carry out its planning responsibilities if it directly provides health services. If it were a provider of services, it would have a biased interest and be incapable of objectively evaluating, influencing, and coordinating diverse competitive programs.

We are also concerned that, even without a merger, *apparently* similar roles will undermine the existing cooperation between our two programs since the legislation proposes to support two leaders in each region who will compete to develop "functioning, effective consumer-oriented health care delivery systems."

In summary, we would like to note that it is entirely possible that most, if not all, of the Administration's stated objectives could be accomplished within existing legislative authority. This is certainly true regarding coordination within HSMHA of the programs covered by the proposed legislation. Therefore, it seems that extensions of the existing legislation, such as those proposed in Senator Yarborough's Bill #3355 and in Congressman Roger's Bill H.R. 15895. should be seriously evaluated in terms of these consequences of the Administration's bill.

Because of our shared conviction in this matter and while we are still allowed to collaborate rather than compete, we would like to testify jointly before your committee.

Very truly yours,

MITCHELL E. ROTH,
Executive Director.
JOHN R. F. INGALL, M.D.,
Director.

Enclosure.

MARCH 27, 1970.

HEALTH PLANNING MEMORANDUM—FROM COMMUNITY HEALTH, INC.

HSIA–70: THE ADMINISTRATION VIEWPOINT

Washington meeting

In an effort to create a climate of better understanding for its Health Service Improvement Act of 1970 (S. 3443; H.R. 15960), the Administration ran a well-organized briefing session for national agencies and others in Washington on March 13. Dr. Joseph English, HSMHA Administrator, led a wide-ranging discussion of the intent of the Act, again stressing the fact that it does not combine RMP and CHP activities, except within a single Title of Federal law. A summary of the Administration's view of the purposes and effects of the proposed law was distributed, and HPM is reprinting it verbatim along with a budget estimate distributing at the meeting. These items should give those with an interest in this program a clear picture of the Administration's intent.

Purposes

The major overall aim of the proposed "Health Services Improvement Act of 1970" is to make it possible for the Federal Government to step up the pace of action, in concert with the States and local public and private agencies, to move away from the present patchwork health care delivery system toward functioning, effective, consumer-oriented health care delivery systems.

The draft of the proposed legislation, together with the related recommendations for administrative action, analysis and evaluation and policy decisions,

reflects the Administration's determination to accomplish the following five purposes:

1. To conserve and protect the gains made toward the goal of improved organization and delivery of health care by the Regional Medical Programs, comprehensive health planning agencies, the National Center for Health Services Research and Development, and the National Center for Health Statistics.

2. To encourage these programs to continue those efforts which show promise of achieving the goal more rapidly and effectively;

3. to bring about improved coordination and cooperation among the four programs at the Federal level, thereby making clear the Federal intention that these programs should complement and support one another as they assist State and local public and private agencies;

4. to designate as leaders in a new thrust to develop more effective health care systems the Regional Medical Programs and the comprehensive health planning agencies; and, finally and most important;

5. to focus limited resources on health care systems building, a purpose which would be accomplished through experiments in selected places in the development of effective, integrated health care delivery systems which can serve as working models for other areas of the nation.

Assumptions

The assumptions which underlie these purposes are 10 in number:

1. The Federal Government has emphasized heavily the provision of aid to those who need health care, but has not paid sufficient attention to the matter of the way by which that care is organized and delivered to the consumer. The need to act to create improved systems of health care at the local level is critical, since the present patchwork is clearly inefficient, is pushing costs higher, does not provide care for all who need it, and is not responding fast enough to meet the urgent need for change.

2. The existing Federal programs designed to contribute to improved organization and delivery of health care, the Regional Medical Program, comprehensive health planning, and the National Center for Health Services Reearch and Development, have not made a coordinated effort among them aimed at the central problem of creation of an integrated, effective, consumer-oriented health care system, largely because they were not originally intended to do so. RMP has focused primarily on cooperative arrangements among providers of care in the areas of heart disease, cancer and stroke. CHP has concentrated primarily on planning, rather than development of health care systems. The National Center has concentrated primarily on research and demonstrations, rather than on system development.

3. If significant changes are to occur in time, before the critical situation grows still worse, new inter-governmental and public-private efforts to create effective, consumer-oriented health care systems are needed. The initiatives needed will not occur of themselves in the private sector, but require that the Federal government, jointly with the States and with local public and private agencies, take the lead under new legislative authority to develop the needed system.

4. There is no single answer or simple solution to the problem of how to bring about improved health care systems, but rather there exist multiple proposals for improving and developing systems. The Federal government is not committed to a single solution, and is prepared to experiment with a number of proposals for the purpose of developing a variety of models for potential use throughout the nation, at the State, regional, and area-wide levels.

5. Since there are agencies—Regional Medical Programs and comprehensive health planning agencies—which are now engaged in important aspects of planning and development, the most sensible use of resources dictates that these agencies should jointly be designated as the lead agencies to conduct experiments in the development of health care systems. The National Center for Health Services Research and Development should provide funds and technical expertise to assist these agencies in Washington and in the field with the experiments. The National Center for Health Statistics should cooperate with the above three agencies and with States and local agencies in the necessary research and development aimed at the design and implementation of a Federal-State-local health information system which would provide comparable health data to all planning and program agencies.

6. Since all four of the agencies affected are within the Health Services and Mental Health Administration, it should play the major role in coordinating

the efforts of these four agencies and in the design and conduct of the experiments.

7. The best way to communicate the dual intention both to conserve what has been accomplished to date and move aggressively to develop and build effective health care delivery systems is to propose legislation which places all the agencies directly concerned with improved methods and procedures for organization and delivery of health care in one title, with a single statement of purpose, a single authorization of purposes, and a single advisory council, all of which should contribute to clearer policy and improved coordination of effort, and therefore to a clearer understanding on the part of Congress and the public as to the nature and purpose of the programs.

8. Since rational decisions about organization and delivery of health care depend on good information about health resources and health status of the population, it is essential to begin construction of a Federal-State-local health information system which provides comparable data. Given that a determination remains to be made as to what data are needed for what purposes, and given that no design is now available for such a system, it is best to begin by performing, through the National Center for Health Statistics with the help of the National Center for Health Services Research and Development, the research and development necessary for the design of such a system and to make proposals at a later date for any needed legislative action and financing.

9. It is important that the gains made to date by the Regional Medical Program and comprehensive health planning agencies in the area of organization and delivery of health care should be conserved, protected, and supported in the future, both because what they have done in many cases is to lay the necessary groundwork for health care system building and because they have captured the imagination, enthusiasm and cooperation of a widely varying group of providers and consumers all across the country.

10. In order to facilitate cooperation between RMP and CHP agencies at the State, regional, and areawide levels, requirements need to be set forth in the law for review and comment and mutual participation in local advisory councils.

What the proposal does

The proposal, resting on the above assumptions and designed to accomplish the above purposes, does the following:

1. It places RMP, CHP, and NCHSR&D in one title, Title IX, and gives them a single statement of purpose, a single authorization section, separate appropriation statements, a single council, and requires a single annual report evaluating their accomplishments.

2. It continues both RMP and CHP, decategorizing RMP, strengthening the authority of the CHP agencies, and supporting both levels comparable or somewhat above the FY 1970 levels;

3. It provides that resources and attention be focused on the problem of development of models of the health care systems through joint efforts by RMP and CHP, assisted by NCHRS&D, with policy direction from the Office of the Assistant Secretary for Health and Scientific Affairs, and under the direction of HSMHA;

4. It proposes that half a dozen to a dozen places be selected, through negotiation with local RMP and CHP agencies, for experimentation in the development of health care systems;

5. It proposes that these experiments be designed, conducted, and evaluated by both the participants at the local level and by Federal officials, in a partnership effort, and that a variety of models be tested;

6. It proposes that out of this experience with experiments may well come several models of health care systems appropriate for various kinds and sizes of areas and populations throughout the nation;

7. It proposes that the National Center for Health Services Research and Development should participate in the experiments research support on what models are available for possible testing, through both financial and staff support for the experiments themselves, and through support for cooperative efforts by the NCHSR&D and the National Center for Health Statistics to do the needed research and development for the design of a Federal-State-local health information system;

8. It proposes that the scope of the national health survey be enlarged to include a broader health focus;

9. It proposes a series of administrative, analytical, evaluative, and policy steps which appear to be required if the proposal is to be made to work with greatest efficiency and effectiveness.

HEALTH SERVICES IMPROVEMENT ACT BUDGET ESTIMATES

	1969 actual [1]	Fiscal year 1970 estimate [2]	1971 estimate
Comprehensive health planning and services:			
314 (a) State planning	7,329	10,371	7,675
314 (b) Areawide planning	6,174	7,700	10,200
314 (c) Health planning training	3,186	4,125	4,125
Total planning	16,689	22,196	22,000
314 (d) Formula grants	65,642	90,000	90,000
314 (e) Project grants	75,851	82,782	[3] 109,500
Program direction	[4] 1,011	[4] 3,185	[4] 4,564
Total	159,193	208,163	226,064
Health services research and development:			
Grants and contracts	16,846	37,440	50,867
Direct operations	7,850	3,850	5,025
Program direction	1,390	1,212	1,511
Total	26,086	42,502	57,403
National health statistics:			
National vital and health statistics	6,860	8,633	9,358
State-Federal health statistics system			
Program direction	616	537	560
Total	7,476	9,170	9,918
Regional medical program:			
1. Regional medical programs:			
(a) Grants	72,365	73,500	79,500
(b) Direct operations	896	1,771	1,812
2. Technical assistance and disease control [5]		(18,287)	(13,168)
Regionalization activity of the RMP	2,038	1,795	1,805
3. Program direction including chronic disease control		(3,023)	
Program direction for regional medical programs	1,402	1,947	2,022
Total	78,701	79,013	85,139
Grand total	269,456	328,848	378,524

[1] Does not include budget item "Change in selected resources" for any of the programs.
[2] Program estimates are as they appear in the President's fiscal year 1971 budget and do not reflect final action on the fiscal year 1970 budget.
[3] Includes $30,000,000 transfer of funds and program responsbility for OEO.
[4] Total program direction of CHS.
[5] Includes chronic disease program.

MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES,
New York, N.Y., June 11, 1970.

Hon. JOHN JARMAN,
Committee on Interstate and Foreign Commerce,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN JARMAN: As Chief Medical Officer of Memorial Hospital for Cancer and Allied Diseases, which is the clinical unit of the Memorial Sloan-Kettering Cancer Center, I believe it my responsibility to present on behalf of the Medical Staff the following statement to support the continuation of the Regional Medical Program and the programs of the Division of Chronic Diseases, particularly those of cancer control.

The Center, composed of two operating units, Memorial Hospital for Cancer and Allied Diseases, and the Sloan-Kettering Institute for Cancer Research, is concerned with the advancement of both the art and science of cancer control by experts in all phases of theory and practice. To forward this purpose two major activities of the Center are teaching and the advancement of knowledge through research and investigation, both in the laboratory and in the clinic.

The Hospital through its teaching program has trained over 1,800 physicians and the Institute has trained an additional 800 scientists who are now serving throughout this nation and the world to ultimately control and eliminate cancer. It is the second most fatal disease in the United States. Many of these physicians and scientists hold influential and responsible teaching positions in medical schools and hospitals, thereby extending knowledge to many more medical personnel.

Approximately one-half of Memorial Hospital's medical staff hold an appointment in the Sloan-Kettering Institute thereby enabling them to apply the knowledge gained in the laboratory to the care and study of patients. All new full-time, full-salaried staff appointed to the Hospital are given an appointment and facilities for research in the Institute.

The Sloan-Kettering Institute, founded in 1945, was the first major institution to initiate a wide-scale research program dedicated to controlling and ultimately finding a cure for cancer. At the end of World War I the chances of survival for the cancer patient were almost non-existent. Before World War II, fewer than one in five patients was being saved, that is alive five years after first being treated; today one in three patients is being saved. It is estimated that if present knowledge were made available throughout the country, the figure could be one in two.

Nationally, the American Cancer Society reports an additional 100,000 American men, women and children could be saved each year were their cancers diagnosed early enough and treated with the methods available to us. As an example, cervical cancer, prevalent among women, is almost 100 per cent curable when diagnosed at an early stage through routine cytologic tests. The U.S. Public Health Service has long recognized this fact and has, with the limited funds available to it, supported cancer control detection and training programs that have obviously proved successful.

In 1945, Hodgkins disease, metastatic Wilms' tumor, choriocarcinoma and metastatic testicular tumors were incurable. Today, many patients afflicted with these formerly lethal diseases are being successfully treated and are able to return to normal and useful lives. Also, improved treatment of leukemia and other lymphomas lead investigators to believe that these diseases will be curable in an ever increasing number of patients.

Encouraging results are continually being achieved because there are institutions and scientists dedicated to the eventual prevention of cancer in man. The advances developed in our laboratories and subsequently through clinical studies permit us to determine quickly the effect of any particular treatment method.

Recognizing the importance of communicating results of improved treatment to other professionals Memorial Sloan-Kettering Cancer Center was encouraged and has participated in the Regional Medical Program, enacted by Congress in 1966.

A Regional Cancer Program is being conducted by Memorial Hospital in association with 34 other hospitals throughout the New York area. The program is under the auspices of the Associated Medical Schools of Greater New York and provides for the continuing education of physicians, nurses, social workers and radiation therapists. It is hoped that through seminars, conferences and consulting services Memorial Hospital may have a major influence in bringing about improved care of the cancer patients at these institutions.

However, if we and the other categorical centers are to continue to develop the new standards of excellence and to disseminate the knowledge we have obtained after years of experience, the training programs of the Division of Chronic Diseases are essential. They are a complement to the Regional Medical Programs. The Regional Medical Program Service has developed a national framework and plan for improving the standard of care those afflicted with the killer diseases receive and the Division of Chronic Diseases provides the professional and technical help needed to staff these regional programs.

The importance of the Division of Chronic Diseases' training programs was clearly seen by the President's Commission on Heart Disease, Cancer and Stroke in its recommendations that served as the basis for the Regional Medical Program. These programs were often cited and recommended for expansion. The specialists and technicians trained under them were in critically short supply at the time of the report. Today, the shortage is even more acute as people no longer consider good medical care a privilege but a right.

The Division's Bureau of Cancer Control is the only federal agency that supports the training of specialists and technicians in cancer control. As of last year, it supported 234 educational programs enabling 2,600 specialists to be trained in the detection of cancer, and in the care of cancer patients. Two of these programs were carried out at Memorial Hospital.

Cancer is no simple disease: the symptoms of a malignancy are so varied and insidious that only the best trained and specialized professionals can recognize them early enough to allow for possible control of the malignancy. Medical

knowledge is not enough, however. Technical knowledge is needed for the use of complicated devices such as X-ray producing machines, betatrons and radioactive Cobalt equipment, electron microscopes; as well as methods for handling and administering radioactive isotopes and highly toxic chemotherapeutic drugs, special surgical and rehabilitative procedures and microscopic diagnostic methods. The need for trained personnel to detect and treat cancer will not decrease but increase in the foreseeable future.

Because of the public health aspects of these training programs they must be supported by federal funds. In addition, it is difficult to attract people to these arduous specialties, many of which involve the emotional strains of day to day contact with cancer patients. Such programs can be carried out only in a limited number of centers where the expertise in such techniques and equipment already exists. Such centers, as well as the public from which come the trainees, need the incentive of financial government support to understake educational programs whose purpose is not to be of direct service to the training institutions themselves, but to enlarge the nation's pool of cancer specialists, with the aim of upgrading the capabilities in cancer detection and care of other non specialized, public and private medical centers.

Every dollar held back from cancer control and training programs is equivalent to sentencing someone to unimaginable suffering and death. And, because of the long term consequences of eliminating training programs, the toll will not only be taken from among us but from among the generations to come.

There is a strong argument against any delay in enacting legislation; already many trainees in cancer control have had to terminate their studies because of lack of financial support; the specialized professionals teaching them are stopping or curtailing their teaching activities as funds run out. By 1971, the training centers will have lost both students and teachers.

Moreover, we should not forget what was the legislative intent of the Congress when it created categorical programs; they were to identify clearly and give recognition to, programs benefiting the most unfortunate and easily forgotten of our citizens—people sick with cancer, the mentally retarded, the neurologically handicapped, etc. Therefore, training funds should be appropriated now and should be clearly earmarked for cancer and the other categorical diseases.

We have seen that when this nation focuses its resources and talents on a goals—it can reach the moon. This is no less true for controlling cancer. Cancer will be conquered. The question is, does this nation want to stop it in this decade or sacrifice the lives of millions more by delaying cancer's ultimtae elimination for some future generation?

Being a part of a Center devoted to the control and treatment of cancer in all its forms, I have day to day contact with the suffering that cancer inflicts and the problems it presents. I hope that my testimony has imparted to you the necessity of legislative support for cancer control measures and the allotting of funds with which to carry out our program.

Sincerely yours,

EDWARD J. BEATTIE, M.D.,
Chief Medical Officer.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., May 6, 1970.

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

DEAR MR. CHAIRMAN: Enclosed is a letter I received from Dr. Lewis Nobles, President of Mississippi College, Clinton, Mississippi, in reference to the Regional Medical Programs.

I certainly feel that Dr. Nobles' letter contains several worthwhile recommendations. Accordingly, I would appreciate your having Dr. Nobles' letter incorporated into the files of the Interstate and Foreign Commerce Committee for consideration at the appropriate time during hearings on the Regional Medical Programs.

Thanking you, I am,
Sincerely yours,

CHARLES H. GRIFFIN, M.C.

MISSISSIPPI COLLEGE,
OFFICE OF THE PRESIDENT,
Clinton, Miss., April 30, 1970.

Hon. CHARLES GRIFFIN,
House of Representatives,
Longworth Building, Washington, D.C.

DEAR CHARLIE: I wanted to write in regard to Public Law 89–239 as amended by Public Law 90–574 which deals with the Regional Medical Programs and also the bills that have been filed currently with regard to the extension of these programs. These are H.R. 14284 filed by Mr. Staggers, H.R. 15135 filed by Mr. Cramer, H.R. 14486 filed by Mr. Rogers, S. 3355 filed by Senator Yarborough, and S. 3443 filed by Senator Javits.

These comments are based on information which has come to my attention as Chairman of the Regional Advisory Group of the Regional Medical Program for the State of Mississippi. On the basis of my conversation with a number of people interested in this program as well as many of those involved in a part-time or voluntary capacity with any number of health associations.

Based on my experience with various medical programs over the last two decades, I believe it is fair to state that there has been a greater involvement of people on a voluntary basis in the Regional Medical Programs than in any other other social program of recent vintage. The program thus far has enjoyed unusually strong support from health related professions, the voluntary associations, the leadership of health facilities, and health oriented members of the public. For a program of this magnitude and its unique objectives, relatively little adverse reaction has apparently been generated. At this point in time a strong public base from which to operate has been built in a majority of the regions but it has been developed upon the basis that certain specific objectives exist within the program. *Any abrupt change in these objectives will tend to destroy the program's base and, therefore, in my judgment, its effectiveness.*

The changes in the purposes of the program as set forth in Section 900(A) of S. 3443 raises the first problem that I would like to discuss with you. Although the changes might seem slight, it would appear that the legislative intent and philosophy that might very well follow from this change could have a major impact on the program.

Generally the thrust of the Regional Medical Program to date has been to improve the overall quality of care available to the public. The thrust for "improving the quality of care" appears to be changed in section 900 to "the improved organization and delivery of health services." Section 900(B)(1) speaks of improving the quality of care; however, it combines with this the "distribution and efficiency" of health services. Those actively involved in the program cannot help but interpret the new approach in Section 900, especially when considered with other features of the bill, to represent a very substantial change in the direction of the program, and they further interpret this change as one which may depress their interest in participating in the program.

A fact that appears self-evident at this point is that it would be most difficult, if not impossible, to take a program that is built to a large extent upon volunteers, and whose methods are based on voluntary cooperative arrangements, and then twist its main thrust from having the highly specialized professional help the less specialized health professional improve the quality of care to one where the the main thrust is directed toward the reorganization of the delivery of health care.

I am not arguing that no need exists to reorganize the delivery of health care. What I am saying is that, although a man may be a good chess player, one cannot necessarily conclude that he would be an equally good quarterback. So far as the Regional Medical Program is concerned, S. 3443 represents a new ballgame and for the most part a new set of players.

Furthermore, Section 900 of the Public Health Service Act currently is devoted to the purposes of the Regional Medical Program. In S. 3443 all of this language is amended out and substituted for it is most of the language in the "purpose" section 2(A) of P.L. 89–749. It may be that an overzealous comprehensive health planning partisan wielded a heavy and secret hand in the last moment drafting of this bill. Certainly, the latest changes before introduction reflect in my judgment an unrealistic appraisal of the Regional Medical Program in most local situations. Add to this the changing of the phrase "heart disease, cancer, stroke,

and related diseases" to "diseases and impairment of man" and it becomes virtually impossible to differentiate between comprehensive health planning purposes from Regional Medical Program purposes.

Two seemingly separate programs with nearly identical purposes may have certain advantages but the situation also presents several disadvantages. First, comprehensive health planning and Regional Medical Programs had difficulty in relating to each other's community activities in the early months of program implementation. As time passed and experience was gained soon working relationships were established where the programs were sufficiently mature. It became apparent that there could and should be a strong coordinated relationship between these two activities at the area-wide B-Agency level. These relationships have developed with a minimum of suspicion and hostility and in most cases are beginning to produce coordinated results. This is due primarily to the fact that those involved have developed a more precise understanding of the purposes and legislative intent of the two programs. Now we find in S. 3443 the purposes of both programs hopelessly confused since they seem to be more identical and less clearly defined. We can only assume from this that the eventual intent may be to merge the programs.

If merger of the two programs is the end being sought, perhaps complete merger at this time might be more desirable since it would certainly prevent the kind of tensions that will develop between those active at the community level in the programs over the next few years. With this kind of vague language there is apt to be many struggles for positions consuming much of the energies and resources of both programs and leaving the public totally confused in the process. Although the Secretary of HEW might be able to write regulations refining the roles of the two programs, the time and energies wasted and the frictions created meanwhile would be a pathetic waste unnecessarily perpetrated on those most needful of these services.

The most significant loss to the total effort, if merger is the end result, would be the medical schools and the highly specialized providers. As the name implies CHP is a community oriented program. On the other hand, the Regional Medical Programs provide a bridge between the medical school and the community. The Regional Medical Program has drawn the schools and their teaching centers into the community and in this sense the two programs complement each other in a very constructive way. Historically the medical schools have never become deeply involved in a state oriented health effort as an A-Agency relationship would require, and I cannot help but believe that a Regional Medical Program type bridge is essential to their continued involvement.

The additional fact that Regional Medical Program projects must be submitted to both the A-Agency and B-Agency "for review and comment" prior to their submission for funding places the Regional Medical Program in a vulnerable position. Since it is possible for 10 per cent of the appropriation to be transferred from RMP to CHP, it is not unreasonable to assume that someA-Agencies might give preference to CHP programs in order not to have 10 per cent of their appropriations transferred from their funds to RMP funds, or conversely there might even be a tendency to delay proposals in order to have funds available from the other programs transferred to CHP. I am not suggesting that anyone would do this deliberately; however, subconsciously it would always be a factor that would create suspicions. It could not help but impair the effectiveness between the personnel of the two programs.

The fact that S. 3443 creates a single advisory council for all four programs represents another problem. From the point of view of sound public administration it appears to be an unbelieveable bad way to construct any program. Any single council that attempts to advise on four programs and work with four administrations on these programs is bound to be overly subscribed and as a result torn between the programs and the administrators concern. There certainly would appear to be a conflict of interest involved and it would seem that such council would spend far more time arguing over the special interests involved rather than giving essential advice concerned with conducting the programs.

The fact that this bill provides for experiments in certain areas of the United States in the combining of the programs is perhaps the paramount indication of its actual intent. In addition to this the only "new money" in the proposal is the $10 million that would be provided for these experiments. In order to obtain any of these new monies which would be earmarked for very specific purposes, the region would have to agree to something which it might not be ready to accept

and would certainly have to do some things not in accordance with the original intent of the law; namely, that the community or region should have a voice in its destiny in these programs.

Also, the project approval mechanism set forth in S. 3443 causes major concern. Those involved in the Regional Medical Programs certainly have no objections to an advisory council which would assist the secretary in developing a national health policy. Great concern is expressed, however, over the elimination of the National Advisory Council of the Regional Medical Program. This council has consisted of eminent people in the health field and with a great many different points of view. These views have been reflected in policy decisions and program leadership at the national level.

In all honesty it must be stated that the majority of those with whom I have talked prefer the wording of S. 3355 (Senator Yarborough's bill). To S. 3355 I would like to see added an extension of CHP as set forth in the present Rogers bill (H.R. 15895).

Nothing in the above should be construed to indicate that those who have been active in the Regional Medical Programs do not endorse the continuation of CHP. In fact, I believe that all of us support the continuation of this program wholeheartedly. Our only hope is that the continuation of the two programs can be accomplished in a realistic manner.

Sincerely,

LEWIS NOBLES, *President.*

BAYLOR COLLEGE OF MEDICINE,
TEXAS MEDICAL CENTER,
Houston, Tex., May 31, 1970.

Hon. JOHN JARMAN,
Health Subcommittee, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

MY DEAR MR. JARMAN: I deeply regret that circumstances beyond my control prevent me from appearing personally before the Health Subcommittee, Interstate and Foreign Commerce Committee hearing on H.R. 15960, H.R. 14284, and H.R. 15135, but I should like to set forth my reactions to these bills for consideration by the Committee.

I fully support H.R. 14284 and H.R. 15135 for a number of reasons. The RMP originally was a long range program to improve the quality of medical care for three kinds of major illness responsible for 70% of the deaths in this country and for considerable premature and chronic disability. Fifty-five Regional Medical Programs developed on local initiative and covering the entire United States became fully operational only this year. The program is now at a critical stage of development, and these bills will give it the impetus it needs to achieve its proposed objectives. At this time, when the volume of new knowledge continues to expand rapidly, the RMP is urgently needed to carry these advances to the bedside of patients.

RMP is a sound program based on the concept that reform in medicine takes time, patience, persuasion, and leadership, not revolutionary self-righteousness. It has brought together for the first time representatives of all aspects of health into one organization. It has identified the medical equipment needed in a community and helped obtain it. It has taught medical personnel how to use the equipment they had. It has worked harmoniously with different institutions and communities to improve the availability of medical services for those who could not previously obtain it. In the midst of prevailing fear and confusion, it has earned the good will of health care providers and represents the only real partnership for health. Changing the direction of this important program at this time would result in loss of the nation's investment in RMP thus far.

Increasingly more effective equipment and technics are becoming directly available, but all physicians are not trained to use them. Proper treatment for heart disease, cancer, and stroke would save many lives, more anguish, and tremendous sums of money and would greatly enhance economic productivity. The proposed legislative extension, which authorizes a new and separate training grant authority, will give RMP greater latitude in fostering training programs to meet national demands for certain types of critical health manpower. The objective of these programs is to integrate specialized advanced concepts, skills, and procedures into the existing system of medical care and thus to make the latest me-

dical developments accessible to all our people. The proposed training authority will give RMP a greater capacity for accelerating the application of new concepts and technics from the specialized centers to other regions.

These bills recognize that RMP can make an important contribution to improving the system of primary health care by ascertaining the special needs of individual regions and discovering the special capabilities of individual centers of excellence. The Regional Medical Program has already proved its effectiveness in enabling the federal government to work constructively with the private sector to improve the quality of health care for everyone.

On the other hand, H.R. 15960 seems to ignore the prime contributions of RMP. By placing RMP, CHP, and CHPSR and D in one title, the bill destroys the efficacy of RMP as a bridge to private practitioners. It seems injudicious to submerge a program like RMP, with specific objectives and useful approaches to those objectives, in a bill that includes other elements. Moreover, many feel that CHP has done nothing constructive to date, but has instead aroused suspicion among the very people whose trust is needed. Furthermore, the people who work in the medical system may find the New Health Services Section objectionable.

As I pointed out earlier, I do not believe we are ready for complete decategorization, as recommended in H.R. 15960, although extension to include all diseases may be desirable at some future date. The local medical community and the public are not quite ready to accept the abstract concept of comprehensive health planning, whereas they readily understand delivery of specific services for specific diseases.

H.R. 15960 fails to mention any funding levels or the manner of distribution among the three programs. Moreover, the advisory council recommended by the bill seems to have little authority, and it is difficult to know who would authorize the expenditure of money. Furthermore, the bill's proposal to establish a single advisory council is undesirable because such a council cannot deal constructively with the wide diversity of elements in these three separate programs.

By emphasizing centralization and federal or regional supervision, H.R. 15960 tends to alienate the practicing physician, driving a wedge between him and his university colleagues. It would be highly undesirable to reverse the present wholesome trend, in which the practicing physician has become deeply involved in RMP and, for the first time, is beginning to collaborate with the academic community. RMP, in fact, is the only program that has been successful in achieving such collaboration.

H.R. 15960 ignores the problem of overlapping of regional offices, political boundaries, existing RMP regions, and CHP regions. If this matter is not properly handled, it could set regionalization back another decade.

No one would question the need to reorganize the delivery of health care, but I do not believe that the best means of accomplishing this is to merge RMP with CHP. It would be almost impossible to change a program that uses largely volunteers, and methods based on voluntary cooperative arrangements, from the highly specialized professional help to one directed primarily toward reorganization of delivery of health care. Most of the present participants in RMP will feel that this major change in direction will give them little reason to continue. If this occurs, four years of planning and development, and several million dollars, as well as the good will and cooperation that has developed between the medical schools and the profession, will have been largely wasted.

It seems highly improbable that delivery of medical care will be reorganized to any great degree through the use of volunteers or voluntary cooperative arrangements, especially when the funds available are so out of proportion with the task to be accomplished. Reorganization will be achieved by making it more profitable to provide care in certain ways, by making it unprofitable to provide it in other ways, and by providing incentives for structural change. Our antiquated licensing laws must be changed, since resources will have to be devoted to both new and old levels of manpower development.

In the delivery of health care, quality must be uniform from area to area, especially among the various levels of functioning manpower. It is as important to maintain quality in any system as to reorganize a system to meet changing needs. RMP has been a major factor in elevating and equalizing the quality of care for all people, and this is the aspect of the problem that H.R. 15960 deemphasizes. It focuses on organization and delivery rather than on quality.

I sincerely hope that I may have an opportunity to meet with you when I am in Washington June 10.

Yours sincerely,

MICHAEL E. DEBAKEY, M.D.

THE UNIVERSITY OF NORTH CAROLINA,
SCHOOL OF PUBLIC HEALTH,
Chapel Hill, June 9, 1970.

Congressman JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN JARMAN: I would like to make the following statement regarding the Comprehensive Health Planning bills which have recently been reviewed before your subcommittee. I respectfully request that my remarks be included in the record.

The University of North Carolina is one of 18 educational institutions which are receiving partial and essential support for the training of health planners. This federal support was authorized by PL 89–749 in farsighted recognition of the need for personnel with the necessary knowledge and skills. The health planning agencies are beginning to make their impact on improving the delivery of health services, and on protecting the environment. However, the shortage of skilled manpower is at present a major constraint on our ability to increase more rapidly our effectiveness as planners. It is therefore of immediate and long term importance that the training programs for health planners be at least continued at their present level. Most of the universities are only now beginning to graduate qualified health planners.

There is an additional way in which the training programs need to be protected. If the budgets for training personnel and for the state and areawide planning agencies are all included in one line item of the budget and authorization there is a danger that training may receive less financial support than at present. My apprehension is based upon the increasing demands made by planning agencies for support as they increase in number and competence, and the political pressures that they can exert. Unless there are separate budget items and authorization for training it would be possible to reduce training expenditures by administrative action. This should be avoided.

I would apprecate any assistance you can render in maintaining the long range benefits of this educational program. If there is any additional information you require, I should be happy to provide it.

Sincerely yours,

HARRY T. PHILLIPS, M.D.,
Director, Training Program for Health Planners.

(Whereupon, at 12 noon, the subcommittee adjourned.)

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