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

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON
OR AND PUBLIC WELFARE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

S. 3355

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

S. 3443

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

AND RELATED BILLS

APPENDIXES

Part 2

Printed for the use of the Committee on Labor and Public Welfare

U.S. GOVERNMENT PRINTING OFFICE
41-780 WASHINGTON : 1970

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Cover Letter Sent to Witnesses and Other Health Professional Agencies and Individuals

United States Senate
COMMITTEE ON
LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

Dear ---:

As you know, I introduced on behalf of all the Republican members of the Labor and Public Welfare Committee, of which I am ranking minority member, and Senators Scott, Brooke, and Goodell, the Administration's bill -- S. 3443 -- entitled the "Health Services Improvement Act of 1970."

This legislation would integrate the regional medical programs, the comprehensive health planning and services program and the national center for health services research and development to improve the organization and delivery of health services.

Unfortunately, the late introduction of the measure did not provide the witnesses at the hearings on regional medical programs or other interested parties ample opportunity to study this legislative proposal and give the Committee the benefit of their expert evaluation of the bill. Accordingly, I am enclosing a copy of S. 3443 and my introductory remarks, explaining in some detail the purposes of the bill, and would appreciate your giving us the benefit of your comments on the legislationfor the hearing record.

Thank you for your courtesy and cooperation.

With best wishes and appreciation,

Sincerely,

Jacob K. Javits

BLUE CROSS ASSOCIATION,
Chicago, Ill., April 2, 1970.

Senator JACOB K. JAVITS,
Senate Office Building,
Washington, D.C.

DEAR SENATOR JAVITS: On behalf of the Blue Cross Association, an organization which represents the 75 Blue Cross Plans in the United States, I am pleased to have the opportunity to respond to your request for comments on S. 3443, the "Health Services Improvement Act of 1970."

This bill is a comprehensive piece of legislation dealing with the extension of the program authority for the Partnership for Health Program, the Regional Medical Programs, and the National Center for Health Services Research and Development. Most importantly, it also creates administrative machiney to coordinate these programs among themselves and with the National Center for Health Statistics.

Historically, the Blue Cross Association and its Member Plans have supported the planning of health facilities and services. Many Plan executives have recogized this important activity and have taken the leadership in forming and serving on planning agency boards. Member Plans commonly make considerable financial and professional contributions to planning agencies and some Plans require hospitals to conform with local or areawide needs as determined by planning is one of the major avenues to the achievement of a rationalization of our nation's health care systems.

Within this context, the Association supports each of the programs considered in this bill. Our concern has been that the planning efforts of Regional Medical Programs and Comprehensive Health Planning, along with the health planning components of Hill-Burton, Model Cities, and the Office of Economic Opportunity, have not been appropriately coordinated at the federal level. The lack of a clear determination of the purposes and interrelationships of these programs at the federal level has at times slowed the evolution of planning and led to what may be a destructive competition among planning programs at the local and state level. Thus, we fully support those passages of the bill which seek to bring about the essential coordination of RMP and CHP at the federal level, by having one title, statement of purpose, national advisory group and annual report. This allows the programs to maintain their separate identities, but under needed management structures.

The Association also supports the sections of the bill which provide for increased flexibility by authorizing joint project fundings, a 10% fund transfer authority for the Secretary, and interregional grants under the Regional Medical Programs. We also support the language of the bill which allows Regional Medical Programs to continue its categorical approach and expand the categorical diseases beyond those now covered, without Congressional action being necessary. The Act also emphasizes health care delivery rather than environmental concerns and in the view of the magnitude of the problems of providing health services, this is appropriate.

The Blue Cross Association also supports the notion that Comprehensive Health Planning should have the right to comment on grant requests to Regional Medical Programs. It is our view that every area of the country should have an areawide planning agency that is broadly representative of providers and consumers which serves to develop areawide health goals, systematically accumulate and distribute facts concerning needs and resources, and assist in the process of coordinating the planning efforts of individual health institutions and agencies. Thus, we regard the agency described in Section 314 (b) of P.L. 89–749 and in Section 922 of S. 4443 as the primary focus for integration and coordination of all health planning.

Health planning is a neighborhood as well as a state and national concern. To be effective, every health service provider must plan and have a continuing relationship with an areawide planning agency which can be of valuable assistance in this effort. The goal of the areawide agency, the state agency, and national agencies concerned with planning should be ito invest the individual institution's planning with the broadest responsibility and to coordinate these efforts for the total community.

In conclusion, the Blue Cross Association supports the programs and the efforts to coordinate them as represented in this bill. If planning is to make its maximum contribution toward reorganizing the fragmented health delivery system, it is essential that the federal government coordinate its efforts and give adequate funding support to local, state and regional planning efforts.

Very truly yours,

WALTER J. MCNERNEY, *President.*

HARVARD MEDICAL SCHOOL,
Boston, Mass., March 30, 1970.

HON. JACOB JAVITS,
The U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: S. 3443, the Health Services Improvement Act of 1970, which you recently introduced is a terribly important piece of legislation.

While the enactment of Regional Medical Programs and Comprehensive Health Planning by the 89th Congress offered the first major step in thinking about health programs on a regional basis, the operation of these programs has been handicapped by their lack of coordination with one another and with the National Center for Health Services Research and Development. Your proposed legislation would immensely improve the operating framework for these programs, permitting extensive coordination at all levels, substantial savings in overhead costs and less complicated mechanisms for bringing these services to the people.

For those of us in medical education who are greatly concerned about the delivery of health services to people, this legislation would represent a significant forward step.

Sincerely,

ROBERT H. EBERT, M.D., *Dean.*

AMERICAN FEDERATION OF LABOR AND
CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington, D.C., March 17, 1970.

HON. JACOB K. JAVITS,
U.S. Senate,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR JAVITS: I wish to thank you for your letter of March 9, 1970 and for the enclosures including S. 3443. It is an interesting bill which eliminates the contradictions contained in P.L. 89–749 and P.L. 89–239, which laws provide funds for improving the health delivery system, but "without interferring with the patterns or the methods of financing, of patient care or professional practice..." We are very happy that S. 3443 removes this unsupportable inconsistency.

S. 3443 would also give the various planning agencies a clear mandate to utilize Federal funds for the purpose of developing more efficient and effective health delivery systems. I do feel there is undue emphasis on "innovation." I favor new and innovative approaches to delivering health care services, but I feel it is important to place more emphasis on applying what we already know. It is indeed hard to improve on the delivery model which is hospital based, which services an enrolled population through conveniently located outpatient centers and which incorporates nursing home and home health services as an integral part of the total operation. Comprehensive payments (prepayment) covering all necessary health services are a necessary concomitant of the program. Only in this way will the delivery system have the necessary incentive to utilize less expensive forms of treatment in lieu of hospitalization. I should add that the medical staff should be full time.

We are in accord with Sec. 901, establishing a National Advisory Council on Planning Organization and Delivery of Health Services. We feel it is imperative to establish national goals which goals must necessarily be implemented on a local level. It is our impression that the RMP and CHP planning agencies have been floundering around without direction. However, I believe that the Council should include a majority of consumer representatives.

We are in accord with Sec. 925, which does not require approval, and thereby veto power, over project grants for health services development. Based on admittedly fragmentary information it is our belief that despite the formal requirement in the law requiring majority consumer representation, most of the planning agencies (New York would be an exception) have been dominated by the providers. Moreover, many agencies are only geting under way and have not demonstrated that they are qualified to perform this function. The requirement of Sec. 925 that the appropriate planning agency have an opportunity for review and comment on a grant proposal avoids the problem, and we support it as written.

I have some suggestions for improvements in S. 3443. Sec. 912 apparently does not require a majority of consumers on the RMP advisory councils. We think this should be corrected.

While I welcome the specific inclusion of poverty and minority representatives on the various planning bodies, I still think that "consumer" has to be better defined. Bankers, industrialists, wives of physicians hardly identify with the consumer interest. Yet, it is precisely such "consumers" who are being placed on advisory committees to the various planning agencies. Also, third parties with a financial interest in the delivery of health services are being identified as "consumer" representatives.

If consumers are going to have any "clout" on health advisory committees, I feel they should be duly selected representatives of consumer organizations such as labor, farmers, senior citizens, consumer cooperatives as well as organizational representatives of poverty and minority groups. Otherwise so-called "consumer representatives" may not be consumer-oriented and therefore will not advance consumer interests in health care.

As I know you are aware, one of our major problems in developing more rational health delivery systems is fragmented financing. The hospital, nursing home and practitioners are only paid for "doing their own thing" without regard to the effect on other health institutions. In our opinion, more rational and comprehensive financing is an integral part of the problem of organizing health services. I therefore enclose H.R. 15779, a bill to establish National Health Insurance, introduced by Congresswoman Martha Griffiths, as well as her statement on her bill from the Congressional Record and a copy of the AFL–CIO Executive Council statement endorsing her National Health Insurance proposal.[1]

Sincerely yours,

BERT SEIDMAN,
Director, Department of Social Security.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., March 18, 1970.

Hon. JACOB K. JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: Thank you for your letter of March 9, 1970, with enclosures about S. 3443 and for the similar letter to Dr. Crosby, Director of the American Hospital Association in Chicago.

In a letter I addressed to Senator Yarborough as Chairman of the Senate Labor and Public Welfare Committee under date of February 26, 1970, I presented on behalf of the American Hospital Association certain views and comments regarding both S. 3443 and Senator Yarborough's bill, S. 3355. I requested that letter be made part of the record of the Committee's hearings and I sent copies of the letter to each member of the Senate Health Subcommittee. Enclosed is another copy of my letter. You will note that starting with the last paragraph on page 2, the remainder of the letter is devoted to various aspects of S. 3443.

Thank you again for inviting comments from the AHA on S. 3443 and for your consideration of the Association's views.

Sincerely,

KENNETH WILLIAMSON, *Deputy Director.*

Enclosure.

Copy of letter to Chairman Yarborough of the Committee on Labor and Public Welfare concerning the Regional Medical Program Extension (S. 3355) and the Administration's Health Services Improvement Bill (S. 3443).

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., February 26, 1970.

Hon. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is directed to you to present the views of the American Hospital Association on two bills which are presently under consideration by your committee.

One of the bills, S. 3355, the Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970, which you introduced, deals in the main with the future of the Regional Medical Program and provides a five year extension of this program with a number of significant changes.

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[1] May be found in the files of the subcommittee.

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 the 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 form any complete judgment as to its effectiveness. We continue to believe the program has great promise and we support its continuation for a five year period. We believe the Congress acted wisely in limiting the program to the specific disease categories named in the original legislation. Such an approach directed major attention to three disease entities which are of concern to the entire population. The statement you made, Mr. Chairman, when you introduced S. 3355, succinctly sets forth the very laudable purpose of the Regional Medical Program as envisioned in Public Law 89-239. You said that in the law, "Emphasis was placed on the development of cooperative arrangements among the providers of health care to improve the quality and availability of care." We believe this means getting care to the public and speaking candidly must point out that the program is far from accomplishing this purpose. We, therefore, seriously question the wisdom of bringing additional major disease categories into the program, thus diffusing the effort, until there has been much greater demonstration of accomplishment of the basic purpose intended by the original legislation.

We are pleased to note your bill provides for contract as well as grant authority to carry out the Regional Medical Program, and we also think it is desirable to include prevention and rehabilitation as integral parts of the program, as your bill would do.

With regard to the provisions of S. 3355 dealing with the composition of regional advisory groups for local regional medical programs, we agree that official health and planning agencies should be represented on such advisory groups. We fully support the provisions of your bill in this regard.

Turning to the National Advisory Council on Regional Medical Programs, we also support fully the requirement in your bill that "health care administration" be represented on the National Advisory Council. It is highly essential that the knowledge and experience of individuals intimately associated with the organization and administration of health services be named to the Regional Medical Program National Advisory Council.

We have for some time been quite concerned about lack of coordination of activities under the Regional Medical Program and the Comprehensive Health Planning and Public Health Service Program. We feel that Section 7 of your bill provides an important initial step in the coordination of these two programs by requiring Section 314 (b) areawide planning agencies have the opportunity to consider Regional Medical Program applications before they are recommended for approval.

Before your Committee also is the Administration's Health Services Improvement Bill, S. 3443, which was introduced by Senator Javits. It is pertinent to note at the outset that this bill is much broader in scope than S. 3355. In fact, S. 3443 deals with four health programs—the Regional Medical Program, the Comprehensive Health Planning and Public Health Services Program, the Health Services Research and Development Program, and the activities of the National Center for Health Statistics.

The bill completely rewrites Title IX of the Public Health Service Act, decategorizing the Regional Medical Program and establishing broader goals for it. The language in the present law which states regional medical programs must not interfere with existing patterns in the organization of physician services has proved to be detrimental to the development of the program and has hampered the achievement of the goals established for the program. We therefore, strongly approve the elimination of such restrictive language as provided for in S. 3443.

At the present time hospitals are frustrated by the duplication and overlapping authority existing in the Comprehensive Health Planning and Public Health Services Act and the Heart Disease, Cancer, and Stroke Act. The manner in which these two programs are presently being operated encourages competitive activities for domination of the field. We are glad that S. 3443 recognizes the potential conflict existing at the local, State, and Federal levels. However, we reiterate our strong belief that every effort should be made to eliminate the existing overlapping and confusion, and we would urge that the law be amended so that planning under the two programs will be brought into conformity.

We note that S. 3443 would provide for review and comment on Regional Medical Program operational grant applications by both State and areawide health planning agencies. The bill also provides for Regional Medical Program representation on State and local Comprehensive Health Planning Councils and requires official health planning agency representation on Regional Medical Program Regional Advisory Councils. Further, the bill would establish a single National Advisory Council on the Planning, Organization, and Delivery of Health Services which would be assigned extremely broad responsibilities for coordination of numerous health programs, including the Regional Medical and Comprehensive Health Planning and Public Health Service Programs. All of these provisions of S. 3443 are important steps in the coordination of these two programs.

Section 922 of S. 3443 provides 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. This provision, we feel, is a valuable improvement.

We approve the proposal for establishment of a National Advisory Council having authority over the Comprehensive Health Planning and Public Health Services Program. The lack of such a council is a serious deficiency in the present law. Under S. 3443 the present Advisory Council for the Regional Medical Program would be eliminated. The proposed new National Advisory Council on the Planning, Organization, and Delivery of Health Service would function in respect to all programs under the new Title IX of the Public Health Services Act. The language of the bill describing the role and function of this proposed National Advisory Council is so broad and encompasses so many other health activities in which the Federal Government is involved that we become concerned as to whether the Council can be effective. We further note that there is no provision in the bill for an advisory council to review and recommend the approval of grants at the national level prior to the making of grants under these various programs. This we feel is a serious shortcoming.

The proposal of the Administration contains a number of most desirable provisions which could contribute importantly to the development of better health services throughout our nation and which would without doubt be in the interest of the public. Several committees of the Congress are struggling with the problem of inflation of health care costs and are looking to the legislative proposals before your committee to provide assurances in respect to sensible health facilities and services programs. We strongly endorse the development of planning pertaining to the health field. However, we must express our deep concern that here again the Administration is offering a lot of great promises to the public, but on the other hand appears to be unwilling to request appropriations of the funds necessary to fulfill such promises, as reflected in the Fiscal Year 1971 HEW budget submitted to Congress last month.

We appreciate the opportunity of expressing our views on these bills and request this statement be made a part of the record of your committee's hearings on them.

Sincerely yours,

KENNETH WILLIAMSON,
Deputy Director.

CALIFORNIA COMMITTEE ON REGIONAL MEDICAL PROGRAMS,
San Francisco, Calif., April 3, 1970.

Hon. JACOB K. JAVITS,
U.S. Senate,
Committee on Labor and Public Welfare,
Washington, D.C.

DEAR SENATOR JAVITS: Thank you for your letter of March 3rd requesting my comments on S. 3443 entitled "Health Services Improvement Act of 1970." Since the hearing which was held on February 17th and 18th before the Senate Subcommittee on Health which had before it both S. 3443 and S. 3355, a considerable amount of discussion has taken place between the various Coordinators of the 55 Regional Medical Programs and other persons involved in the program in a part-time or voluntary capacity. The comments presented below represent, to the greatest degree possible, a consensus of opinions about certain important aspects of S. 3443. We have made every effort to make our comments in a constructive sense, and it is the intent of this letter to convey the problems with S. 3443 as seen from the point of view of an activist at the community level in the RMP programs.

Based on my experience in public programs over the past decade, I believe it is fair to state there has been a greater involvement of people on a voluntary basis in the Regional Medical Programs than in any other social program of recent vintage. The program thus far has enjoyed unusually strong support from the 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 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 built 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, 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 we would like to discuss. Although the changes might seem slight, certainly the legislative intent and philosophy that would follow from this change could be major.

Generally, the thrust of the RMP 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 in direction as one which may depress their interests in participating in the program.

A fact that seems 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 main thrust is directed towards the re-organization of the delivery of health care. This is, in fact, what S. 3443 seems to be aiming at, even though it never states this specifically. Most of those presently involved will interpret this as a major change in direction. The majority will conclude that the program is no longer of interest to them and will see little reason to participate. If this occurs, four years of planning and development, and several millions of dollars, (to say nothing of the good will and cooperative spirit that has developed between the medical schools and the professions) will have been largely wasted.

We are *not* arguing that no need exists to re-organize the delivery of health care. What we are saying is that, although a man may be a good chess player, one cannot conclude that he necessarily would be an equally good quarterback. So far as RMP is concerned, S. 3443 represents a new ball game and, for the most part, a new set of players.

It also seems highly unlikely that the delivery of medical care will be reorganized to any great degree through the use of volunteers of any type, or through the use of voluntary cooperative arrangements, especially when the funds available are so out of proportion with the task to be accomplished. Re-organization, if it comes, will be brought about by manipulating the dollars which purchase care, 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 have to be changed, since in many cases they preclude any substantial reorganization, and far greater resources will have to be devoted to both new and old levels of manpower development.

In this total picture there will always be a need to mantain a uniform level of quality from area to area, from facility to facility, and especially among the various levels of functioning manpower. Maintenance of quality in any system is as important as reorganizing a system to meet changing needs. RMP to date has developed as one of the major factors in upgrading and maintaining a more nearly equal quality of care for the public, regardless of where they might reside, and it is this aspect of the total problem that we feel S. 3443 de-emphasizes. The emphasis seems to be all on the means of "organization and delivery"—not on what is being delivered. Quantity without quality at any price is hardly worth the effort.

Furthermore, Section 900 of the Public Health Service Act currently is devoted to the purposes of RMP. 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. (Those among us who are of a more suspicious nature suspect that an overzealous CHP partisan wielded a heavy and secret hand in the final, last moment drafting of the bill. Certainly the last changes before introduction reflect an unrealistic appraisal of RMP and most local situations.) Add to this the changing of the phrase "heart disease, cancer, stroke and related diseases" to "diseases and impairments of man" and it becomes virtually impossible to differentiate CHP purposes from RMP purposes.

Two seemingly separate programs with nearly identical purposes may have certain advantages, but this situation also presents several disadvantages. First, CHP and RMP had difficulties in relating to each other as community activities in the early months of program implementation. As time passed and experience was gained, sound working relationships were established where the programs were sufficiently mature. It became apparent that there should be a strong, coordinated relationship between RMP and CHP at the areawide 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 devolped 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 more identical and less defined. We can only assume that the eventual intent is to merge the programs.

If merger of the two programs is the end being sought, complete merger at this time might be more desirable, since it would prevent the kind of tensions that will develop between those active at the community level in the programs over the next two years. With this kind of vague language, there is apt to be many struggles for position, consuming much of the energies and resources of both programs, and leaving the public totally confused in the process. Although the Secretary might be able to write regulations defining the roles of the two programs, the time and energies wasted, and the frictions created in the meantime, would be a pathetic waste unnecessarily perpetrated.

The most significant loss to the total effort, if merger based on CHP purposes is the end result, would be the medical schools and the highly specialized providers. The majority of the medical schools have never looked upon CHP and its purposes as relating directly to them. As the name implies, they view CHP as a "community-oriented" program. RMP, on the other hand, provides the bridge between the medical school and the community. RMP, and its original purposes, drew the schools and their teaching centers into the community; and in this sense, the two programs complemented 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 an RMP type bridge is essential to their continued involvement.

The additional fact that RMP projects must be submitted to both the A-agency and B-agency "for review and comment" prior to their submission for funding places the RMP program in a vulnerable position. Since it is possible for 10 percent of the appropriation to be transferred from RMP to CHP, it is not unreasonable to assume that some A-agencies might give preference to CHP programs in order not to have 10 percent of their appropriation 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 create serious tensions between the personnel of the two programs, and any delay on the part of the A-agency would sooner or later be interpreted as a deliberate delay for the purposes of protecting their own economic position.

The fact that the Bill creates a single advisory council for all four programs represents another problem. From the point of view of sound public administration, it is an unbelievably bad way to construct any program. Any single council that tries to advise on four programs and work with four administrators of those programs is bound to be overly subscribed and, as a result, torn between the programs and the administrators concerned. Each administrator would have a tendency to lobby the council if important decisions are to be made between the programs in order to obtain equal treatment for his program. When com-

petition of this kind develops between the administrators, there is a tendency to spend a far greater amount of time in lobbying the individual council members than in doing the constructive things necessary to administering the program. These certainly will be conflicts of interests involved, and it would seem that such a council would spend far more time arguing over the special interests involved than in giving worthwhile advice on conducting the programs.

The fact that the 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. This could be described as incentive money, or it could be described as "bribery". In order to obtain any new monies, which incidentally would be earmarked for very specific purposes, the region would have to agree to something for which it might not be ready to accept and certainly might have to do things not in accordance with the original intent of the law; namely that the community or region should have some voice in its destiny.

Also, the project approval mechanism set forth in S. 3443 causes major concern. Those involved in RMP 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 RMP. This Council has consisted of iminent people in the health field with a great many different points of view. These views have been reflected in policy decisions and program leadership at the national level, and the synthesis that has taken place has provided a high caliber atmosphere in which policy and program direction could be decided. To eliminate this group from overseeing and providing direction for the program would be a great loss. Although it does not state specifically in the Bill that the decision on the projects would be referred to the regional HEW offices, many believe that this is what is in store. Those active in the program cannot help but conclude that it would be difficult to obtain the same kind of input in the decisions on projects in this manner as has been obtained from the present council.

In all honesty, it must be stated that the vast majority of the coordinators and lay people with whom this has been discussed prefer the wording of S. 3355 (Yarborough).

To S. 3355, they would like to see added an extension of CHP as set forth in the present Rogers Bill (H.R. 15895). To this could be amended the language for extension of Health Services R&D as stated in S. 3443. Additional language then could be added expanding Health Statistics and relating it more directly to the CHP extension.

Certainly language indicating an emphasis upon "the improved organization and delivery of health services" would not be objected to if the present language in Section 900 relating to RMP was retained. We would prefer that the categories be broadened by using the wording in S. 3355, since this provides greater encouragement to voluntary associations for participation in the program and it limits the confusion with CHP.

The opinion on the insertion of the term "construction" is divided, but there is need for indication, if it is retained, that this does not apply to the creation of large centers and facilities.

We believe that the CHP relationship should be at the B-agency level and the function should be to coordinate the planning efforts of RMP, OEO, Childrens Bureau, Model Cities, and other local health planning efforts from the inception of the concept to the final planning efforts.

Most of those involved would prefer retention of the non-interference clause because it hasn't created that much of a problem, and they would prefer the inclusion of primary care as stated in S. 3355.

Most approve joint funding as stated in S. 3443, with some indication that the intent here is to permit the program with the most resources involved to be the overall manager.

Nothing in the above should be construed to indicate that those active in RMP do not endorse the continuation of CHP. In fact, we 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.

We would be happy to discuss some of these points in further detail with you if you wish.

Sincerely,

PAUL D. WARD, *Executive Director.*

NEW YORK UNIVERSITY,
GRADUATE SCHOOL OF PUBLIC ADMINISTRATION,
New York, N.Y., April 3, 1970.

HON. JACOB JAVITS,
Senator from New York,
Senate Office Building, Washington, D.C.

DEAR SENATOR JAVITS: This is in reference to Senate Bill 3443 to modify the existing legislation on the regional medical care program and comprehensive health planning. My major concern has to do with the trainee grants for university programs in comprehensive health planning which have been included in Section (c) of 89–749.

In reading your Bill I am not clear about the administrative location of the trainee grants. Is it your intention that they would follow the research program into the Department of Research and Development? In this connection I would like you to know that the program in the Graduate School of Public Administration is developing very well. Out of a student body of a little over 500, we have 190 students studying health administration and organization. This makes ours one of the significant programs by size and we believe it is significant by reason of quality because we have been able to assemble an outstanding faculty. The program is just getting underway and will need substantial support in order to become well established. We hope we can depend upon your support.

While we are not directly involved in the administration of regional medical care and regional comprehensive health planning, we urge reconsideration of a change in function for RMP at this time. We believe it would be in the interests of developments in which the administration has expressed interest for better provision of medical care if the RMP program could remain as it is for at least another year.

Sincerely,

MRS. HELEN C. HILLING,
Professor of Public Administration.

STATE UNIVERSITY OF NEW YORK AT STONY BROOK,
HEALTH SCIENCES CENTER,
Stony Brook, N.Y., April 6, 1970.

HON. JACOB K. JAVITS,
U.S. Senate, Washington, D.C.

DEAR SENATOR JAVITS: I am sorry for the delay in responding to your generous offer that I make some comments on the Administration's Bills S. 3443 and H.R. 15960. The mail strike and my desire to await the most recent meeting of the National Advisory Council have conspired to produce the delay.

Looked at strictly from the point of view of the Regional Medical Programs as they now exist, Senator Yarborough's bill S. 3355 would provide the necessary updating and would cause the least disruption of the present functioning of the Division of Regional Medical Programs. However, I do not feel that we can continue to operate two programs such as the Regional Medical Programs and the Comprehensive Health Planning, without a higher degree of administrative coordination and programmatic interpenetration of these and other programs in the health care field.

For this reason, I have long held the view that an effective *modus vivendi* and a new set of relationships among these programs is desirable. The Administration bill attempts to move in this direction, and, hence, I believe that it could be a constructive step.

What I am concerned about is that the bill give greater assurance that the very significant contributions of Regional Medical Programs will not be lost in the endeavor. My concern is not with the "identity" of Regional Medical Programs but rather with the very special flavor it has brought to the whole realm of planning for health care in the United States. I would suggest that it is those very special contributions which are also essential to the achievement of the objectives and the spirit of S. 3443.

I would like to list here those features of Regional Medical Programs which are essential to any coordinated attempt to improve the delivery of health services in our nation and which should not be lost in the new legislation. These are also the features which can be most useful in bringing about the cooperative

arrangements of public and private endeavor, of professional and nonprofessional efforts, and of governmental agencies, which are so much needed to provide a unity of perspective to the now-fragmented federal efforts in the health care field.

These are the features to which I refer as exemplified in Regional Medical Programs:

1. It emphasizes local initiative. Programs are generated locally, are designed to meet the needs of communities as seen by those communities. In this way, the participation of a large variety of individuals with a stake in the outcome of the Program can be assured.

2. RMP has created a cooperative network involving voluntary, governmental, university, and other agencies interested in health. This network of relationships did not exist before. It is an extremely useful mechanism through which all other programs can funnel. If it is lost, it will have to be regenerated.

3. In a way which hardly could have been anticipated, the practicing physician has become deeply involved in Regional Medical Programs. He has begun to work with members of the academic community in a collaborative effort, which no other program has been able to achieve thus far. In my opinion, the administration bill, which has put a great emphasis on centralization and on direction from "above" or at least from regional offices, tends to alienate the practicing physician and drive a wedge between him and his university colleagues. This would be tragic, since both the practicing and the academic communities must be even more involved if we are to expect improvements in health care delivery.

4. Regional Medical Programs are gradually achieving significant degrees of local visibility. This is essential to acceptance by the practicing community and by the consumer who, after all, always wants to see some concrete manifestation of the tax dollar in his own community.

5. One very strong feature of Regional Medical Programs which has served to crystallize the interests of many diverse people is its mission orientation. The emphasis on heart disease, cancer, and stroke has served to pull many elements in the community together around a common interest. It is more difficult to deal with the abstract concept of comprehensive health planning, even though we all realize how important this is. The mission orientation has not hampered the use of RMP for wider purposes when appropriate to the spirit of the existing legislation.

6. Regional Medical Programs represents, as far as I know, the only viable example of a truly regionalized approach, which has been more talked about than actualized for three decades. Regional Medical Programs is not confined to state and political lines, but rather covers market areas and patient distribution. This is a very potent factor in achieving regionalization of facilities and personnel.

7. Regional Medical Programs has not made a frontal assault on the existing health care system. It is dedicated to improving methods in delivering health care. We all know that if we are to improve care, we must change many aspects of the existing system. However, Regional Medical Programs has wisely avoided any implication that *all* features of the present system must go. It promises to be more effective in changing patterns of care than a revolutionary system would be.

These are some of the major features of Regional Medical Programs which must be preserved in any new legislation. This is not to deny the need for new legislation which could combine the best features of RMP and CHP. I have been in favor of integrating these programs for a long time. To continue in the present mode is to foster mounting conflict between the two.

S. 3443 enhances the highly attractive aspects of Comprehensive Health Planning: (a) its much broader orientation and attention to all facets of the community and environment which contribute to health, and (b) its strong consumer representation, which I believe is healthy, but which must be developed so that the professional and the consumer can strike a balance between their special interests and their dedication to the community welfare.

Any viable new legislation should take into account the strong points of both programs and optimize them in a new organizational format. To neglect this point is to make it harder to achieve the very purposes of the new legislation, namely, improved delivery of services through a better working arrangement between all of the resources and personnel now dedicated in piecemeal fashion to bettering the health of the American people.

S. 3443 does recognize Regional Medical Programs as an identifiable program with certain special features. The details of the review process, functions of

the new council, the systems of program and project review are yet to be spelled out. I hope, in the process of this delineation, that the several points to which I have alluded may be taken into account and further secured. They will thereby make more certain the actualization of the hopes in the Administration's bill.

Thank you very much for the opportunity to make these comments.

Sincerely,

EDMUND D. PELLEGRINO, M.D.
Vice President for the Health Sciences,
Dean, School of Medicine.

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS,
Chicago, Ill., April 8, 1970.

Hon. JACOB K. JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: Thank you for giving us the opportunity to comment on S. 3443.

We endorse the intent of S. 3443 to extend, improve and integrate comprehensive health planning (CHP), regional medical programs (RMP) and the national center for health services research and development (NCHSR) by placing them under a single title of the Public Health Services Act, giving them a common statement of purpose, a single advisory council and a single annual report. We believe it is highly desirable to reverse the current trend of proliferating poorly coordinated government health and health planning programs and that S. 3443 may be a step in the direction of reversing that trend.

However, we do not clearly understand how S. 3443 will produce effective integration of the three separate entities (CHP, RMP, NCHSR) in their day-to-day operations. Indeed, the fact that RMP must get approval from CHP for budgeted projects when they are not subordinate to CHP organizationally could result in less not greater cooperation and coordination.

We also endorse the intent of S. 3443 to focus on developing improved health care delivery systems by conducting experiments and demonstrations in consumer oriented health care systems involving a variety of approaches recognizing the enormous variety of local conditions and needs. We feel strongly that such experiments should also include improvements in the open panel solo or group practice delivery system. If changes in our health care system are to make the system more consumer oriented then certainly these changes cannot ignore the current popular choice of our consumers—individual and open panel group practice. Even in areas where there are outstanding closed panels consumers most often choose the open panel system. We hasten to add that we encourage closed panel practice and other innovations to the extent that they maximize competition in the American tradition of permitting the consumer to be the ultimate judge of the relative merits of the various alternatives.

Experiments in improving open panel solo or group practice could include (1) grants and loans to groups of doctors to establish open panel groups (2) payments based on diagnosis, i.e., a flat fee for treatment of pneumonia (3) payments based on capitation (4) increased use of paramedical personnel to include prenatal and postnatal care and delivery by midwives instead of physicians, etc.

We are somewhat concerned that S. 3443 would change the basic purpose of the Regional Medical Program from clinical demonstrations to treatment programs. We cannot clearly visualize the role Regional Medical Programs would perform in the realm of treatment or in the realm of improving the organization of health care.

We wholeheartedly endorse the development of a federal-state-local system of health information and statistics which is a necessary resource for effective planning and operations of improved health systems. The National Association of Blue Shield Plans and Blue Cross Association are currently working on such an integrated information system for the nation's Blue Shield-Blue Cross Plans and we would be happy to discuss this concept or any other matter with you or your staff.

Respectfully yours,

NED F. PARISH, *Executive Vice President.*

LOUISIANA STATE UNIVERSITY MEDICAL CENTER,
New Orleans, La., March 19, 1970.

Hon. JACOB K. JAVITS,
Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: I very much appreciate your invitation to comment on the Administration's bill—S. 3443 entitled the "Health Services Improvement Act of 1970", which you introduced along with many other Senators. I will try to limit my comments to a few substantive areas rather than give a detailed critique.

S. 3443 consolidates in one bill continuation authority for three very important programs. A single statement of purpose is given. A single authorization of appropriations section is given, a single national advisory council for all three programs is provided. In addition, the Regional Medical Program is decategorized (covering diseases and impairments of man). These and other changes lead to consolidation of these programs around the central theme of improving the organization and delivery of health services.

I have no question in my mind that these three programs should be extended and well supported, and I believe the recognition of the relationship between these three programs is meritorious.

But I have grave reservations about the merit of consolidation of the statement of purpose, appropriation authority, and advisory council into one. It is putting too many eggs in one basket at a time when we really don't know specifically how to get hold of the medical care problem.

While the purposes of the Regional Medical Program and Comprehensive Health Planning are interrelated, they are different. The Regional Medical Program has as its purpose the development and support of arrangements between institutions, principally medical centers and hospitals so that the latest diagnostic and treatment techniques can be applied. In effect, its purpose is to improve the quality of health services by speeding up the flow of knowledge to application.

Comprehensive Health Planning, on the other hand, has the purpose of developing and implementing the planning process at the regional and State level in an attempt to find more efficient development and use of health resources. Comprehensive Health Planning should assist metropolitan New York for example, in making the wisest choices of investment between hospital beds, nurse training programs, nursing homes or the myriad of other investment decisions necessary in the health field for the benefit of a community.

Comprehensive Health Planning is just as related to depreciation allowance under the medicare reimburement formula or to a grant for a teaching hospital to expand the manpower pool in an area as it is to Regional Medical Program.

Certainly all of these programs could be drawn under the umbrella of improving the delivery of health services, but I believe that that obscures a multiplicity of more specific purposes at a time when specificity is badly needed. And when there are more specific purposes for each program, then there should be provided authority for each purpose and an advisory council for each purpose.

I believe this is the most substantive comment I can make. I am well aware of the consistent support and commitment you have given to the health programs of this Nation. It is in that spirit that I submit these comments to you.

Thank you for the opportunity.

Sincerely yours,

WILLIAM H. STEWART, M.D.,
Chancellor, LSU Medical Center.

HARVARD MEDICAL SCHOOL,
Boston, Mass., March 19, 1970.

Hon. JACOB JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: Per your request—for the hearing record.

I am pleased to expressed my strong support for S.3443, "Health Services Improvement Act of 1970."

This bill, if enacted, should yield substantial benefit to the American people by providing a vehicle for administrative coordination of Comprehensive Health

Planning, Regional Medical Programs and the National Center for Health Services Research and Development. Since legislation was enacted establishing each of these programs, it has been clear that the whole might be much more than the sum of the parts. At present, each has an administrative superstructure of its own, and there is unnecessary conflict of both objectives and program operation. S.3443 will improve and clarify the operation of these programs. It will help to eliminate duplication of effort and will focus on the improvement of health care delivery systems.

An important secondary gain—and a real one—is the effect of this legislation on conservation of manpower. The most critical shortage in the health field is that of people competent to plan and operate health programs and to assess their effectiveness. S.3443 will permit the reallocation of this manpower in a highly constructive and useful fashion.

Sincerely,

SIDNEY S. LEE, M.D.,
Associate Dean for Hospital Programs,
Harvard Medical School.

AMERICAN ACADEMY OF COMPREHENSIVE HEALTH PLANNING,
Baltimore, Md., March 20, 1970.

Hon. JACOB K. JAVITS,
Committee on Labor and Public Welfare,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR JAVITS: Thank you very much for your cordial letter of March 9 regarding S.3443 entitled "Health Services Improvement Act of 1970." The Academy was indeed sorry for the late introduction of the measure and not having the opportunity to appear as a witness at the hearings. We have submitted comments on the Bill to the Chairman for inclusion in the record and a copy is attached for your information.

If the Academy can be of further assistance, please do not hesitate to call upon us.

We believe the importance of continuing the Comprehensive Health Planning program is absolute top priority, as it offers at this point in time the greatest potential in helping to solve many of the critical health problems facing the United States today.

Sincerely,

EUGENE H. GUTHRIE, M.D.,
Chairman of the Board.

AMERICAN OPTOMETRIC ASSOCIATION,
Washington, D.C., March 20, 1970.

Hon. JACOB K. JAVITS,
U.S. Senate, Committee on Labor and Public Welfare, New Senate Office Building, Washington, D.C.

DEAR SENATOR JAVITS: Thank you for your letter of March 9, 1970, requesting my comments on S. 3443, the Health Services Improvement Act.

The American Optometric Association filed a statement with the Committee on Labor and Public Welfare concerning its views on S. 3355 (Senator Yarborough's bill) and S. 3443, your proposal. At the time of filing, however, we did not have the benefit of the comprehensive summary you provided in the March 9, 1970 letter.

We feel that your proposal has considerable merit and would greatly reduce the fragmentation of these health programs.

Based upon the language of S. 3443 and the summary of the Act you supplied, the major concern of the American Optometric Association, is the possibility that the regional medical plan would dominate comprehensive health planning.

For example, your bill would create a National Advisory Council with no specific guidelines provisions as to the participants. As comprehensive health now functions, it utilizes all available manpower and resources, such as those offered by the independent health profession of optometry.

Also the language decategorizing the specific areas of function of the regional medical program to permit regional medical to cover "diseases and impairments of man" is too broad. It may permit those functioning in the existing regional

medical program to extend their scope of activity to overlap in such a way that it would impair the integrity and definitive areas of responsibility now performed under comprehensive health planning.

As pointed out in our statement, optometry certainly supports any legislation that would improve the health care delivery system, but we have certain reservations about legislation with such broad outlines.

We would favor some specific committee guidelines that the Advisory Council be composed of those present participants in the two programs from the fields of medicine, osteopathy, dentistry, optometry and podiatry and that these persons would serve as a bridge for the implementation of your proposal with the two existing programs.

This would provide a total integration of the existing programs and serve as a practical working basis from which an effective health care delivery system can be provided to the American public.

Thank you for the opportunity to express my views.

Cordially,

RICHARD W. AVERILL, *Director.*

THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
New York, N.Y., March 30, 1970.

Hon. JACOB K. JAVITS,
Committee on Labor and Public Welfare,
Washington, D.C.

DEAR SENATOR JAVITS: Thank you for giving me the opportunity to express my approval of the objectives of S. 3443, which you recently introduced.

My specific comments are attached in a form I hope is suitable for the hearing record.

Sincerely yours,

CARL L. ERHARDT, ScD.,
Chairman, Vital and Health Statistics Monographs.

Enclosure.

COMMENTS ON S. 3443, 91ST CONGRESS, 2ND SESSION

I am presently Chairman of the Committee on Vital and Health Statistics Monographs, sponsored by the American Public Health Association. Since I am not a member of the Association's staff, my remarks are not intended to represent the Association's policy toward this legislation. Until last December, when I retired, I was Director of Planning for Health Intelligence of the Health Services Administration of the City of New York. Prior thereto, I had been Associate Director, Office of Program Planning, Research and Evaluation and previously Director of Statistics for the Department of Health of the City of New York for twenty years. Hence, I am familiar with the activities that are encompassed in this proposed legislation.

I am heartily in favor of the integration of related programs whose uncoordinated existence leads to inefficiency and competition for scarce professional personnel and even to duplication of program content. However, my professional career has been concentrated in the fields of biostatistics and epidemiology. Therefore, I limit my remarks to these aspects of the proposed legislation.

My interests lie especially in the brief proposed new subsection (b) of Section 305 of the Public Health Service Act (lines 7 to 11 on page 38 of S. 3443). This new subsection focuses on a long neglected need to bolster efforts to improve existing systems of information and statistics and to develop new systems as required to fill present gaps. Facts demanded as essential to planning at local, State, and national levels are sadly lacking or deficient. Accomplishments of programs are too frequently measured, moreover, in terms of personnel activities (i.e., number of patients seen, number of visits made) rather than in terms of the effect of the programs on the health of the people involved. The latter has frequently been neglected because it is an uncommonly difficult task and often expensive. Research on evaluation methods is essential and funds are required for experimentation and demonstration of methods.

The vital statistics system, often criticized, is still the mainstay of public health agencies but suffers grievously from lack of support for experimentation

and demonstration of new methods to update a system of ancient vintage. Lack of any national support automatically results in a low priority for the vital statistics program at State and local levels in competition for limited resources with service programs for which matching funds are mandated.

It is important to emphasize that, despite such difficulties, many States and some local agencies have been investing their own meagre funds in attempts to meet the needs considered in S. 3443 but without coordination with a national system and without the financial assistance that could speed development, testing and adoption of new systems and procedures, both locally and more widely. Such endeavors are highly significant, since they mean that adoption of S. 3443 and appropriate funding of these activities will yield benefits in relatively short order that will be magnified beyond the investment the Congress provides. Ideas are germinating but yet lack the Federal component in this field. Let me give a few examples.

THE POPULATION HEALTH SURVEY

In 1964, New York City started its Population Health Survey, financed completely with municipal funds. Its purposes are to assess the health problems of the population and their effect on the people, to determine the utilization of existing neighborhood facilities by neighborhood residents and the extent to which they must, or prefer, to go elsewhere for medical care, to measure the impact of programs initiated on receipt of medical care and on health, and, incidentally, to estimate population changes and mobility. Obviously, such information is pertinent to planning programs and evaluating their effects. The data produced have been eagerly sought by the Regional Medical Program, by the Health and Hospitals Planning Council of Southern New York, by city and State agencies as well as by the Health Services Administration of the city. However, analyses and publication of badly needed current data lag for lack of a small amount of additional support for such purposes, a particularly frustrating situation.

The city's Department of Health has had the welcome advice of the National Center for Health Statistics in connection with the local Survey but requests for national expertise to aid in review of the design and operation of the survey have been unavailing because of lack of adequate staff in the Center for such a cooperative activity. Other household surveys are in operation, as, for example, the integrated local surveys under State sponsorship in Michigan. Without question, the foundations for local, State, and Federal cooperation already exist; the opportunity needs but to be grasped.

VITAL STATISTICS

New York City has long been recognized to have much information nowhere else available on a community-wide basis regarding births, fetal losses, and deaths in the city. For forty years, data have been available for small areas within the city. Planning school construction relies heavily on knowing the numbers of births among residents of such circumscribed small areas. Moreover, small area data enable identification of the three-fold infant mortality rate among blacks as compared to whites and the excess mortality in poor neighborhoods as compared to areas where well-to-do reside. It was the latter observation that led Dr. George James, when he was New York City Commissioner of Health, to indict poverty as the third leading cause of death.

To produce neighborhood data requires that for each birth and death record filed a clerk must look up the residence address to determine the health area, an expensive proposition. New York City has been working for several years on a computer system to do this job at less expense. Such a system would be applicable in all census-tracted areas throughout the country. But other priorities have prevented full development. Cooperative assistance and some financing could make this system a reality.

Surveillance systems for the occurrence of congenital malformation to serve an early warning of unsuspected reactions such as produced by thalidomide are being sought. Birth records in most areas of the United States ask a question about congenital malformations, but evaluation of quality of the data, and experimentation with alternate procedures for obtaining the information are needed. Yet, specific proposals for undertaking these inquiries and demonstrations in the City of New York have been impossible to fund. Arrangements authorized by S. 3443 would make such funding possible if DHEW agreed on the merits.

Family planning programs are widely financed by Federal funds. The Congress will want stable facts to determine the effect of such programs. Such facts must derive from the vital statistics system. In some places, exaggerated claims of program effectiveness based on small numbers have been made. In response to the request of the director of the family planning program in New York City, we designed a study to compare, over time, the experience in areas with family planning programs to that in areas without such programs. Yet, we were unable within budgeted allotments to produce the pertinent data which a vital statistics program should produce on demand. Other funds had to be sought.

In this connection, I point out that the National Center for Health Statistics reimburses the City of New York only for costs of preparing microfilm copies of all its vital records that are then used to produce information fundamental to national needs. The revenue of less than $10,000 a year barely covers salaries for two clerks in an organization that budgets nearly 180 employees for the registration and processing of vital records and an additional 40 statisticians for design and analysis. A substantial portion of the salaries of such personnel are involved in assuring that all vital events are registered, that information about them is complete and accurate, and that it is in a form usable both locally and nationally. When one considers the huge sums that must be spent to collect ad hoc essential data for a national census, for example, the Federal reimbursement to States for data on vital statistics is miniscule. Steps toward more realistic payment for local service to the Federal program must be taken. S. 3443 will help furnish a basis for determining a more realistic manner for distributing financial responsibility for collection of facts essential on local, State and Federal levels. In the interim, some funds can be provided through the mechanism the bill proposes.

Other examples may be given of activities outside the Federal establishment that require funds for follow-up to work out practical applications. These examples illustrate what can be done in partnership with minimum outlay of funds. In New York City, several hospitals joined the Department of Health in testing the feasibility of producing, coincidentally with typing of the birth certificates, a paper tape containing all the information on the certificate. This paper tape could then be used for direct input to a computer, saving costs of coding and key punching. Solution of problems identified in that project may now be sought in a follow-up experiment in Virginia, using magnetic tape as an advanced mode in preference to the paper tape.

At the same time, Illinois has embarked on trials of optical scanning processes and character recognition devices to streamline procedures and minimize costs. Ohio has designed a completely new format for a certificate that would allow the document itself when completed on a special typewriter to be read mechanically for direct input to a computer. A small subcommittee from various States of a Study Committee of the National Center for Health Statistics has reviewed the system developed for the Bank of America in San Francisco for automatic central maintenance of accounts of its depositors in many branches. A real advantage of this system is that the equipment used can recognize ordinary type faces rather than requiring the peculiar ones used on bank checks now. Such a system, combined with the Ohio proposals, could lead to modernization of the vital statistics system throughout the country and save money eventually at every government level. But these ideas will be discouraged if no funds can be made available to pursue them.

Clearly, State and local agencies are not neglecting their obligations. They are already initiating experiments on which the Federal government can build to develop comparable health information and statistics at all three levels. Because of the great need for new, modern and cost-saving systems, States and local governments will proceed perforce with their own development of such systems, but slowly and independently. The result will be a melange of uncoordinated, unintegrated systems that will confuse, fail to contribute to national needs, and provide less than is possible to the States and localities.

I am in favor of the passage of S. 3443 as a major contribution toward development of rational coordination of an essential health information and statistical system. The subject matter of Section 3 of the bill is so urgent that the Congress should pass Section 3 during the present session, even though further time is deemed necessary to deliberate on the policy issues involved in the other proposals contained in the bill.

HEALTH PLANNING ASSOCIATION
OF THE CENTRAL OHIO RIVER VALLEY,
Cincinnati, Ohio, March 12, 1970.

Hon. JACOB JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: As President of the Association of Areawide Health Planning Agencies, I am pleased to respond to your letter of March 9, 1970 in regard to S. 3443 entitled, "The Health Services Improvements Act of 1970."

Several of us were privileged to be in attendance when the briefing took place on February 16 on the proposal by officials of the Department of Health, Education and Welfare. We will also be present at the second session scheduled for March 15, 1970 in Washington, D.C.

We have appointed a special task force under Symond Gottlieb, President Elect, to prepare a position statement on the proposed legislation. It will be sent to you and the committee for consideration as soon as it is available.

As a matter of record, we would like to introduce a previous statement entitled, "Position Statement for Legislative and Administrative Strengthening of Comprehensive Health Planning," adopted by our Association on February 4, 1969.

If you will notice that several features of the proposed legislation are included as our statement. I personally believe that there is apprehension over the combining of the various programs into one single legislative base at this time. There are 113 agencies currently funded under P.L. 89–749 and its amendments and the potential is at least 200. While the intent of the legislation is most worthy, many of the local communities are just beginning to address themselves to the major issues.

On behalf of the Board of Trustees, I wish to thank you for this privilege. We will send you our statement on S. 3443 as soon as it is available.

Sincerely yours,

EDWARD A. LENTZ, *President.*

Enclosure.

POSITION STATEMENT FOR LEGISLATIVE AND ADMINISTRATIVE STRENGTHENING OF COMPREHENSIVE HEALTH PLANNING

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 pluralistic 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 Sections 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 administrative 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 nation's 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 no easy task to develop such definitions with an adequate measure 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 which 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, areawide, 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 and 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 performance 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 area 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.

Furthermore, 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 personal 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 developmental 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 324(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 allowance 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 personel will undoubtedly icrease. 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 approriate 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 organization.

(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 be-

tween them and the regional offices and the central office of the Department of Health, Education and Welfare and after approriate 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 departmental units in a manner that is supportive of national healt holicies 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 which 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 amendement 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 as 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 organization techniques, e.g., governing board, membership corporations, advisory boards, advisory councils, general and/or special advisory committees, liaison committees, ad hoc committees, task forces, point 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.

BAYLOR COLLEGE OF MEDICINE,
DEPARTMENT OF NEUROLOGY,
TEXAS MEDICAL CENTER,
Houston, Tex., March 10, 1970.

Senator JACOB K. JAVITS,
U.S. Senate Committee on Labor and Public Welfare
Washington, D.C.

DEAR SENATOR JAVITS: Thank you for you letter of March 3, 1970. My congratulations on your S. 3443 bill entitled "Health Services Improvement Act of 1970." I have read this over and consider the bill a useful instrument with regard to better defining the relationships between the regional medical programs, the comprehensive health planning and services program and the national center for health services research and development to improve the organization and delivery of health services.

The composition of the Advisory Council membership should be better defined; presumably this would include experts in heart disease, cancer and stroke, as well as carefully chosen lay experts. The Advisory Council seems unusually large and unwieldy. A body of about 12 to 14 would seem more practical. Apart from these details, the legislation seems to be well considered.

May I take this opportunity, Senator Javits, to express the admiration of myself and many of my colleagues for the sincere and devoted interest you have taken in legislation dealing with the health care of our nation, one of the most vital concerns of the Legislature at this time.

With my best wishes and thanks for your courteous consideration.

Sincerely yours,

JOHN STIRLING MEYER, M.D.,
Professor and Chairman.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., February 27, 1970.

Hon. JACOB K. JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: Attached is a copy of the statement submitted today to Senator Yarborough, Chairman of the Senate Committee on Labor and Public Welfare, which sets forth the views of the American Hosiptal Association on S. 3355 and S. 3443. These two bills are presently under consideration by the Health Subcommittee on which you serve and the more than 6,600 hospitals and other patient care institutions we represent will appreciate your consideration of the Association's views as set forth in the enclosure.

Very sincerely,

KENNETH WILLIAMSON, *Deputy Director.*

Enclosure.

Hon. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare, U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is directed to you to present the views of the American Hospital Association on two bills which are presently under consideration by your committee.

One of the bills, S. 3355, the Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970 which you introduced deals in the main with the future of the Regional Medical Program and provides a five year extension of this program with a number of significant changes.

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 the 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 form any complete judgment as to its effectiveness. We continue to believe the program has great promise and we support its continuation for a five year period. We believe the Congress acted wisely in limiting the program to the specific disease categories named in the original

legislation. Such an approach directed major attention to three disease entities which are of concern to the entire population. The statement you made, Mr. Chairman, when you introduced S. 3355, succinctly sets forth the very laudable purpose of the Regional Medical Program as envisioned in Public Law 89-239. You said that in the law, "Emphasis was placed on the development of cooperative arrangements among the providers of health care to improve the quality and availability of care". We believe this means getting care to the public and speaking candidly must point out that the program is far from accomplishing this purpose. We, therefore, seriously question the wisdom of bringing additional major disease categories into the program, thus diffusing the effort, until there has been much greater demonstration of accomplishment of the basic purpose intended by the original legislation.

We are pleased to note your bill provides for contract as well as grant authority to carry out the Regional Medical Program, and we also think it is desirable to include prevention and rehabilitation as integral parts of the program, as your bill would do.

With regard to the provisions of S. 3355 dealing with the composition of regional advisory groups for local regional medical programs, we agree that official health and planning agencies should be represented on such advisory groups. We fully support the provisions of your bill in this regard.

Turning to the National Advisory Council on Regional Medical Programs, we also support fully the requirement in your bill that "health care administration" be represented on the National Advisory Council. It is highly essential that the knowledge and experience of individuals intimately associated with the organization and administration of health services be named to the Regional Medical Program National Advisory Council.

We have for some time been quite concerned about lack of coordination of activities under the Regional Medical Program and the Comprehensive Health Planning and Public Health Service Program. We feel that Section 7 of your bill provides an important initial step in the coordination of these two programs by requiring Section 314 (b) areawide planning agencies have the opportunity to consider Regional Medical Program applications before they are recommended for approval.

Before your Committee also is the Administration's Health Services Improvement Bill, S. 3443, which was introduced by Senator Javits. It is pertinent to note at the outset that this bill is much broader in scope than S. 3355. In fact, S. 3443 deals with four health programs—the Regional Medical Program, the Comprehensive Health Planning and Public Health Services Program, as well as the Health Services Research and Development Program, and the activities of the National Center for Health Statistics.

The bill completely rewrites Title IX of the Public Health Service Act, decategorizing the Regional Medical Program and establishing broader goals for it. The language in the present law which states regional medical programs must not interfere with existing patterns in the organization of physician services has proved to be detrimental to the development of the program and has hampered the achievement of the goals established for the program. We therefore, strongly approve the elimination of such restrictive language as provided for in S. 3443.

At the present time hospitals are frustrated by the duplication and overlapping authority existing in the Comprehensive Health Planning and Public Health Services Act and the Heart Disease, Cancer, and Stroke Act. The manner in which these two programs are presently being operated encourages competitive activities for domination of the field. We are glad that S. 3443 recognizes the potential conflict existing at the local, State, and Federal levels. However, we reiterate our strong belief that every effort should be made to eliminate the exising overlapping and confusion, and we would urge that the law be amended so that planning under the two programs will be brought into conformity.

We note that S. 3443 would provide for review and comment on Regional Medical Program operational grant applications by both State and areawide health planning agencies. The bill also provides for Regional Medical Program representation on State and local Comprehensive Health Planning Councils and requires official health planning agency representation on Regional Medical Program Regional Advisory Councils. Further, the bill would establish a single National Advisory Council on the Planning, Organization, and Delivery of Health Services which would be assigned extremely broad responsibilities for coordination of numerous health programs, including the Regional Medical and Comprehensive Health Planning and Public Health Service Programs. All of these provisions of S. 3443 are important steps in the coordination of these two programs.

Section 922 of S. 3443 provides 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. This provision, we feel, is a valuable improvement.

We approve the proposal for establishment of a National Advisory Council having authority over the Comprehensive Health Planning and Public Health Services Program. The lack of such a council is a serious deficiency in the present law. Under S. 3443 the present Advisory Council for the Regional Medical Program would be eliminated. The proposed new National Advisory Council on the Planning, Organization, and Delivery of Health Services would function in respect to all programs under the new Title IX of the Public Health Services Act. The language of the bill describing the role and function of this proposed National Advisory Council is so broad and encompasses so many other health activities in which the Federal Government is involved that we become concerned as to whether the Council can be effective. We further note that there is no provision in the bill for an advisory council to review and recommend the approval of grants at the national level prior to the making of grants under these various programs. This we feel is a serious shortcoming.

The proposal of the Administration contains a number of most desirable provisions which could contribute importantly to the development of better health services throughout our nation and which would without doubt be in the interest of the public. Several committees of the Congress are struggling with the problem of inflation of health care costs and are looking to the legislative proposals before your committee to provide assurances in respect to sensible health facilities and services programs. We strongly endorse the development of planning pertaining to the health field. However, we must express our deep concern that here again the Administration is offering a lot of great promises to the public, but on the other hand appears to be unwilling to request appropriation of the funds necessary to fulfill such promises, as reflected in the Fiscal Year 1971 HEW budget submitted to Congress last month.

We appreciate the opportunity of expressing our views on these bills and request this statement be made a part of the record of your committee's hearings on them.

Sincerely yours,

KENNETH WILLIAMSON, *Deputy Director.*

COMMUNITY SERVICE COUNCIL
OF JEFFERSON COUNTY, INC.,
Birmingham, Ala., March 26, 1970.

Senator JACOB K. JAVITS,
U.S. Senate,
Committee on Labor and Public Welfare,
Washington, D.C.

DEAR SENATOR JAVITS: Thank you for your letter of March 9th. I did attend a meeting in Washington at the invitation of Dr. Joe English to become informed concerning the Health Improvement Act of 1970. It sounds exciting. There is a real question concerning the ampleness of the budget suggested for planning when you relate it to a 93 billion dollar health service industry in 1975.

This Bill has come up so suddenly that when it was presented in a hurry to our 47 member Board of Directors representing all cross sections of community life in the five county area surrounding Birmingham, they refused to take a position concerning the legislation until there was ample opportunity for consideration by our Community Health Planning Commission. We are, therefore, involved in a process locally which will culminate with a final recommendation of the group on April 15th. We hope that this time lag will not in any way be too late, but it is the best the group is willing to do as they don't like to take positions concerning anything which has not been discussed fully within our total groups.

We are enthusiastic about the partnership for health program. It is the first time in this area that doctors, lawyers, business men, the poor, the middle class and the rich have gathered around the same table to discuss their hopes, dreams, and frustrations concerning their health needs and programs. The Commission is vital and we are dedicated to continuing it. Planning is a must and in some form we are certain that it will continue toward a more intelligent approach to our health problems.

We trust that this will help some now, and that a more satisfactory appraisal by our total group will be forthcoming after April 15th.

Cordially,

GEORGE E. RICE, *Executive Director.*

THE MASSACHUSETTS GENERAL HOSPITAL,
Boston, Mass., April 14, 1970.

Hon. JACOB JAVITS
The U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: Per your request—for the hearing record.

I am pleased to express my strong support for S. 3443, "Health Services Improvement Act of 1970."

This bill, if enacted, should yield substantial benefit to the American people by providing a vehicle for administrative coordination of Comprehensive Health Planning, Regional Medical Programs and the National Center for Health Services Research and Development. Since legislation was enacted establishing each of these programs, it has been clear that the whole might be much more than the sum of the parts. At present, each has an administrative superstructure of its own, and there is unnecessary conflict of both objectives and program operation. S. 3443 will improve and clarify the operation of these programs. It will help to eliminate duplication of effort and will focus on the improvement of health care delivery systems.

An important secondary gain—and a real one—is the effect of this legislation on conservation of manpower. The most critical shortage in the health field is that of people competent to plan and operate health programs and to assess their effectiveness. S. 3443 will permit the reallocation of this manpower in a highly constructive and useful fashion.

Sincerely yours,

JOHN H. KNOWLES, M.D., *General Director.*

UNIVERSITY OF CALIFORNIA,
SAN FRANCISCO MEDICAL CENTER,
San Francisco, Cal., April 15, 1970.

Hon. JACOB JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: Thank you for your letter of March 3, 1970, requesting my comments on S. 3443, entitled "Health Services Improvement Act of 1970." I have given this bill careful consideration and have reviewed my ideas on this matter with Mr. Paul Ward, Executive Director, California Committee on Regional Medical Programs. I know Mr. Ward has recently forwarded to you his detailed comments regarding S. 3443. I share some of Paul's deep concerns about certain aspects of the approach, although I am strongly in favor of your and the Administration's effort to bring together in one coherent bill major programs related to improvement of the organization and delivery of health services.

My concerns begin with the statement of purpose. 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 removed and the language substituted is similar but the purposes stated are significantly different from those in Section 2. (a) of P.L. 89–749. We have been working on a redraft of this section which includes some of the original and, I think, very important purposes of 89–749. I believe it must also include language relating to RMP, which has made such a significant contribution.

In addition, we have tried to put together a bill with this overall statement of purpose which incorporates what I believe to be the best features of S. 3443, of S. 3355 which was introduced by Senator Yarborough to extend the Regional Medical Programs and those of the bill to extend comprehensive health planning as set forth in the present Rogers bill (H.R. 15895). The bill as we envision it would carry the broad statement of purpose; a major section dealing with the extension of RMP (essentially as introduced by Senator Yarborough and described in S. 3443); a section on comprehensive health planning and public health programs (essentially as introduced by Paul Rogers in H.R. 15895); fol-

lowed by a section on research and demonstration, as in your bill, as well as the section on the annual report and the cooperative system of health information and statistics, as you propose; and, finally, a section related to joint funding of projects.

I believe the individual National Advisory Council should be maintained and the National Advisory Health Council should function as originally envisioned with the exception that it report to and work with the Assistant Secretary for Health and Scientific Affairs, rather than the Surgeon General. Its primary purpose is to advise on health policies and I do not see any benefit in elevating the Regional Medical Program Council to a function which would essentially duplicate that of the National Advisory Health Council.

I would be pleased to discuss these matters with you or members of your staff. I will be writing to Senator Yarborough and I hope that Mr. Ward and I can be of some assistance to you and Senator Yarbrough in developing a bill that includes the strengths of the major proposals. We very much appreciate your continuing support for matters relating to health and medical education.

With best personal wishes.

Sincerely yours,

PHILIP R. LEE, M.D., *Chancellor.*

ALLIANCE FOR REGIONAL COMMUNITY HEALTH, INC.,
St. Louis Mo., April 22, 1970.

Hon. JACOB K. JAVITS,
U.S. Senate, Committee on Labor and Public Welfare,
Washington, D.C.

DEAR SENATOR JAVITS: I want to thank you for your letter of March 9, 1970, in which you enclosed a copy of Senate Bill 3443 and requested any comments our agency might have relating to the Bill.

Please do not think that the delay in responding to your letter was because of lack of interest. I felt that your Bill was one which should be presented to our Board of Directors for its opinion. Therefore, this response was delayed until after our Board of Directors meeting. I am pleased to inform you that the following resolution was passed by a unanimous vote of the Directors.

Resolved, that we, the Alliance For Regional Community Health, Inc., the areawide comprehensive health planning agency for the metropolitan St. Louis bi-state area, hereby support the Health Services Improvement Act of 1970 (HR 15960 introduced by Representative Staggers and Senate Bill 3443 introduced by Senator Javits at the 91st session of Congress) and would like to propose that the 70% of the funds reserved for Health services in communities of the states be distributed on the basis of population.

The Board expressed two concerns regarding the Bill and I thought I would share them with you. First, it was felt that the Bill should emphasize environmental health as part of comprehensive health planning. Second, comprehensive health planners should be specifically included in the membership of the National Advisory Council on the Planning, Organization and Delivery of Health care system(s).

Again, I would like to express my appreciation for having had the opportunity to respond to your letter regarding Senate Bill 3443.

Sincerely yours,

ROBERT A. PARKER, *Director.*

BAYLOR COLLEGE OF MEDICINE,
TEXAS MEDICAL CENTER,
Houston, Tex., April 29, 1970.

Hon. Senator JACOB K. JAVITS,
U.S. Senate, Committee on Labor and Public Welfare, Old Senate Office Building,
Washington, D.C.

DEAR SENATOR JAVITS: Since receiving your letter of March 3, 1970, inviting my comments on S. 3443 entitled, "Health Services Improvement Act of 1970," I have been out of the city a great part of the time, which accounts for my delayed reply.

The various coordinators of the 55 Regional Medical Programs and other part-time or volunteer workers have discussed this bill extensively since the hearing before the Senate Subcommittee on Health in February. The following comments about certain problems inherent in S. 3443 and certain advantages of

S. 3355 are representative of the consensus of active participants in the RMP programs.

The RMP originally was a long range program designed to improve the quality of medical care for three kinds of major illnesses 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 this year. These programs have been strongly supported by the health related professions, the voluntary associations, the leaders of health facilities, and health-oriented laymen. In view of the magnitude and unique objectives of RMP, the program has had minimal opposition. It is now at a critical stage of development, and at this time when the volume of new knowledge continues to expand rapidly, RMP is urgently needed to bring these advances to the patient's bedside.

RMP is a sound program based on the concept that reform in medicine takes time, patience, persuasion, and leadership. It has brought together for the first time representatives of all aspects of health services into one organization. It has identified the medical equipment needed in a community and helped obtain it. It has taught medical personnel proper use of the equipment they have. 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. Changing the direction of this important program at this time would result in loss of the nation's great investment in RMP thus far. The program now has a firm public foundation from which to operate, based on certain specific objectives. Abrupt change in these objectives will tend to destroy the program's base, and therefore its effectiveness.

Although the changes in the purposes of the program, as outlined in Section 900 (A) of S. 3443 might seem slight, the resulting legislative intent and philosophy could have major implications. The objective of the RMP program thus far has been to improve the general quality of available health care. Section 900 would change "improving the quality of care" to "improved organization and delivery of health services." Section 900 (B) (1) refers to improving the quality of care, but it combines with this the "distribution and efficiency" of health services. Active workers in the program, especially when considered with other features of the bill, object to altering the direction of the program sufficiently to make them lose interest in participating in the program.

Obviously, 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. This appears to be the objective of S. 3443, even though it does not state this specifically. Most of the present participants in the program 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.

No one would question the need to reorganize the delivery of health care, but we do not believe that the best means of accomplishing this is to merge RMP with CHP. RMP is one program, and S. 3443 represents a new program and a new group of participants.

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 in many cases they preclude any substantial reorganization, and far greater 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 S. 3443 de-emphasizes. It focuses on organization and delivery rather than quality.

Because renal disease is a major cause of death and disability among persons in the very prime of life, it should be included in the program. The categorical focus of RMP has been particularly valuable in its developmental phase and should be retained until the program has been fully developed, and health care in specific diseases has been significantly improved. Then it might prove ad-

visable to extend the program to development of total health care services. Decategorization at this time would heighten the skepticism of medical school faculties hospital personnel, and practitioners about HEW and Congress at a time when trust is most needed.

Increasingly more effective equipment and technics are becoming directly available, but many physicians are not trained to use them. Proper treatment for heart disease, cancer, and stroke would save many lives, much anguish, and tremendous sums of money and would greatly enhance economic productivity. The legislative extension proposed in S. 3355, authorizing 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 medical developments accessible to all our people. This proposed training authority in S. 3355 will therefore give RMP a greater capacity for accelerating the application of new concepts and technics from the specialized centers to other regions.

S. 3443 seems to ignore the prime contributions of RMP. By placing RMP, CHP, and CHPSR and D in one title, it 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. 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.

S. 3443 does not mention any funding levels or the manner of distribution among the three programs. The advisory council that it recommends seems to have little authority, and it is difficult to know who would authorize the expenditure of funds. 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.

Section 900 of the Public Health Service Act currently is devoted to the purposes of RMP. S. 3443 substituted for it is similar to the "Purpose" Section 2. (a) of P.L. 89–749. Moreover, changing "heart disease, cancer, stroke, and related diseases" to "diseases and impairments of man" makes it virtually impossible to differentiate CHP purposes from RMP purposes.

Two separate programs with almost identical purposes may have a certain advantages but such separation also presents several disadvantages. First, CHP and RMP had difficulties in working together as community activities in the early months of implementation. The programs that were sufficiently mature eventually were able to work together. It became apparent that there should be a strong, coordinated relationship between RMP and CHP at the areawide 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.

By emphasizing centralization and federal or regional supervision, this bill tends to alienate the practicing physician, driving a wedge betewen 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 is the only program that has been successful in achieving such collaboration.

S. 3443 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.

Any new legislation should include the strong features of RMP and CHP in the best possible organizational structure. If such legislation is based on the experience of RMP and CHP, it should result in improved delivery of the best available health services through a better working arrangement between all resources and personnel now dedicated individually to improving the health of the American people.

Sincerely yours,

MICHAEL E. DEBAKEY, M.D.

Appendix B

THE UNIVERSITY OF TEXAS MEDICAL SCHOOL AT SAN ANTONIO,
DEPARTMENT OF PATHOLOGY,
San Antonio, Tex., March 26, 1970.

Hon. RALPH YARBOROUGH,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: In view of the proposed legislation to bring kidney disease within the scope of the Regional Medical Program we feel that our recent work here may provide you and your staff with information that may be of some value in support of the Bill at present before the Congress.

Working under contract no. HSM–110–69–273 with the Department of Health, Education, and Welfare, Kidney Disease Control Program, Division of Chronic Disease Programs, a combined group from the Departments of Pathology, Obstetrics and Gynecology, and Urology at this medical school have been screening patients who attend a cervical cancer screening center for evidence of infections of the urinary tract. The study is based at the Robert B. Green Memorial Hospital of the Bexar County Hospital District in San Antonio, where for some time now a large cervical cancer screening program for South Texas has been carried on under the direction of Dr. John W. Simpson, with the support of Public Health Service and Regional Medical Program grants.

The aims and current activities in the study are the early detection of infections of the urinary tract in a high-risk population, namely women of childbearing age; treatment of the infection; and follow-up of the patient with the facilities of the Bexar County Hospital District with a view to prevention of chronic kidney infection and irreversible kidney disease at a later date.

Our results in the early stages of this study, which so far has involved some 800 women, have revealed a startlingly high number in whom largely symptomless and unsuspected infections have been detected first by screening methods and then confirmed by more precise techniques. About 13% of women who have attended the cervical cancer detection clinic have been shown to have urinary tract bacterial infection as judged by the recognized criteria. This rate is about 2½ times the national average for women of childbearing age. The majority of women in this study are from low income families and many are Mexican-Americans.

These results appear to us to support the need for including kidney diseases within the scope of the Regional Medical Program. They raise the problem of what to do with the patients in whom infection is detected. A large number of patients who otherwise would not have reason to seek medical care for kidney disease now require investigation, treatment, and follow-up in the strained facilities of hospitals such as those of the Bexar County Hospital District (Bexar County Hospital and Robert B. Green Memorial Hospital, San Antonio). By the end of 1970, at the anticipated rate of patient screening, we can expect to add some 500 patients to the already overloaded outpatient commitment of these hospitals together with the accompanying financial burden. The current contract however, is concerned only with the detection of the cases of women with urinary tract infection. There is no financial support for the diagnostic studies, treatment and long-term follow-up of these patients detected by the study and the diagnostic studies are often complex and expensive.

The situation seems to us to dramatize the need for two types of research and development support:

1. Research into treatment of symptomless urinary tract infections to determine what is not yet known, namely whether early treatment of these patients will in the long term result in significant reduction in the number of patients who develop irreversible kidney disease.

2. Demonstration type of research in which tried methods of rapid, accurate and economic population screening for early detection of urinary tract infection can be worked out and made available for general use.

In conclusion we would reaffirm our hope that Kidney Disease will be brought into the scope of the Regional Medical Program and will be adequately funded to support programs of this sort.

Yours sincerely,

ALEXANDER W. MCCRACKEN, M.D.,
Associate Professor,
Department of Pathology.
CHARLES U. MAUNEY, Ph. D.,
Assistant Professor,
Department of Pathology.
HOWARD M. RADWIN, M.D.,
Associate Professor of Surgery (Urology),
Chief, Division of Urology.
JOHN W. SIMPSON, M.D.,
Associate Professor,
Department of Obstetrics and Gynecology Project Director.

LOUISIANA REGIONAL MEDICAL PROGRAM,
New Orleans, La., April 2, 1970.

Senator RALPH YARBOROUGH,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: As Chairman of the Regional Advisory Group of the Louisiana Regional Program, I have had occasion to examine the several pieces of legislation which have been introduced into the current session of Congress affecting Public Law 89–239 as amended.

S. 3355 (Heart Disease, Cancer, Stroke and Kidney Disease Amendments of 1970) as introduced by you on 29 January 1970 reflects a depth of knowledge and understanding of the current status of Regional Medical Programs as well as many constructive ideas which should contribute in a very positive fashion to the ultimate benefit of the consumer public.

I strongly support your Bill (S. 3355) as representing the appropriate legislation by which Public Law 89–239 should be further amended and extended.

In reviewing S. 3355, I respectfully suggest that you give consideration to the following areas which might be improved by appropriate amendment.

1. New Construction Authority.—Section 5; Section 902 F. I would suggest that this section authorize only minor essential alteration by construction and that major new construction continue to be specifically excluded.

2. Relationship to other Planning Bodies.—I would suggest that projects and programs which are developed under Public Law 89–239, as amended, not *require* prior *review* and *approval* by other planning agencies (89–749) but rather that *review* and *comment* be invited. The reasoning here is that the absolute *requirement* for approval might overly complicate and prolong the review process.

3. Contract Authority.—The contract authority for DRMP should be limited to a figure not to exceed 5% of the total grant which is authorized for implementation of the entire national program.

4. Joint Funding.—In reviewing all the legislation relating to the extension of Public Law 89–239. I find that one section of S. 3443 (Mr. Javits) seems worthy of consideration for being included as an amendment to S. 3355. The section under consideration is Section 943 of S. 3443 which should significantly simplify the administrative procedure incident to joint funding.

It is my considered opinion that amendment in the above areas would significantly improve S. 3355 as it applies to the administration of the Regional Medical Program in Louisiana.

Thanking you for the privilege of offering these suggestions for modifying the legislation which extends Public Law 89–239 as amended, I remain

Sincerely,

CHARLES B. ODOM, M.D.,
Chairman, Regional Advisory Group.

UNIVERSITY OF CALIFORNIA,
SCHOOL OF MEDICINE, DEPARTMENT OF SURGERY,
San Francisco, Calif., February 25, 1970.

Hon. SENATOR RALPH YARBOROUGH,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I want to take this opportunity to tell you how much I enjoyed testifying before your committee for S. 3355 on February 17. In addition, I want to congratulate you on sponsoring such an important bill because I believe that this is the best area for establishing a regional approach to clinical problems. In the area of kidney disease control, the recent developments of dialysis and transplantation can best be delivered at the present time on a regional basis and I venture to say that even if we had unlimited funds we would still have to have a regional approach. In fact, it appears to me that Regional Medical Programs will really develop with kidney disease control in time.

I can truly tell you that the deep human understanding of this problem as exemplified by your questioning was impressive and I very much hope that you will continue this activity in the Senate. I believe this bill will bring to the American public the fruits of research efforts over the last 50 years and that it is critical that the regional approach be taken in this area.

I congratulate you on such an important measure which will go a long way in relieving the frustration that we, as doctors, face in treating patients with end-stage renal disease. It is indeed frustrating for us to stand by and see our patients die when we know that two proven forms of therapy exist which could save their lives.

Sincerely yours,

SAMUEL L. KOUNTZ, M.D.,
Associate Professor of Surgery.

COMMUNITY CARDIOVASCULAR COUNCIL,
Savannah, Ga., February 20, 1970.

Senator THOMAS F. EAGLETON,
U.S. Senator from Missouri,
Senate Office Building, Washington, D.C.

DEAR SENATOR EAGLETON: I am writing to you in regard to my testimony which I presented to you on February 18, 1970.

I would like to re-emphasize to you that unless your committee outlines the specific structure of the Chronic Disease Programs and the Heart Disease and Stroke Control Program, these programs will be dead the instant Senator Yarborough's legislation is passed. As recently as today, Dr. Van Hoeck in Dr. English's office called notifying me that our contract with the United States Public Health Service was broken because of the withdrawal of personnel.

I would like to thank you for your kind attention during my testimony and if you require any further information, please contact me.

Very sincerely,

JAMES C. METTS, Jr., M.D., *Chairman.*

KIDNEY FOUNDATION OF NORTHERN CALIFORNIA,
San Francisco, Calif., March 11, 1970.

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: As a member of the Senate Subcommittee on Health, you recently heard testimony in support of S. 3355, submitted by you, which extends Regional Medical Programs to include kidney disease.

The Kidney Foundation of Northern California is vitally concerned with the passage of this bill. We, probably more than any other group, are faced almost daily with the heart rending fact that we must tell people they will have to die simply because of lack of funds for staff and facilities for kidney transplantation and treatment with the artificial kidney. It seems almost criminal to us that the richest nation in the world would allow 8,000 to 10,000 of its citizens to die each year—most of them ages 25 to 40—simply because of a shortage of the

dollars which could save their lives. We feel that S. 3355 is a giant stride toward achieving the goal of life for these unfortunate victims of kidney disease and urge you most strongly to assist its passage from your committee to the Senate floor with a "Do Pass" recommendation.

I made these statements not only as a private citizen, but also as President of the Kidney Foundation of Northern California officially representing the views and desires of our more than two thousand members and their families. We urge you most intensely to give every possible assistance to the passage of this most important legislation.

Sincerely,

BERNARD O. MURRAY, *President.*

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS,
Washington, D.C., March 27, 1970.

HON. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: I am writing on behalf of the Association of State and Territorial Health Officers in support of your bill, S. 3355, the Heart Disease, Cancer, Stroke and Kidney Disease Amendments of 1970. We support this legislation and urge its enactment.

As you know, the Administration, in its proposal to extend the regional medical program legislation, has also requested the extension of authorities to continue the comprehensive health planning and services program as well as the health research and demonstration program. All three programs have as their ultimate objective the improvement of the health status of our citizens. We would recommend that S. 3355 be amended to provide for the programs encompassed by S. 3443, the Administration proposal.

This Association is most concerned because the authorization for appropriations as originally proposed for the comprehensive health planning and services legislation has fallen far short of the recommendations. This has interfered not only with the provision of needed public health services but also with the successful implementation of the legislation that instituted the "bloc" grant approach. The non-categorical aspect of this legislation is negated by two earmarkings under Section 314(d) of the Public Health Service Act. We recommend that they be abolished. The first specifies that a minimum of 15 percent of the "bloc" grant be spent for mental health services. As you can recognize, an increase in the bloc grant for mental health services means that 85 percent must be spent for nonmental health purposes. In addition, the provisions of Section 314(d) of the PHS Act set aside 70 percent of the funds for the provision of services in communities. In many cases this requirement interferes with achieving an optimum level of health in the individual States. Further, if an HEW proposal is approved requiring that all local health jurisdictions meet Federal merit system regulations, local public health departments not in compliance would be unable to benefit from the bloc grant allotment.

If the Committee approves legislation to extend the comprehensive health planning and services program, ASTHO would recommend that State health departments be given the responsibility of executing areawide planning in those sections of the State where no areawide planning authority can be established. This amendment would give recognition to the fact that many counties and small communities do not have the resources for establishing areawide planning agencies. Their need for such planning, however, is no less severe.

We appreciate this opportunity to comment on S. 3355. We respectfully request that these remarks be made a part of the printed record of hearings.

Sincerely yours,

ALFRED L. FRECHETTE, M.D., *President.*

WASHINGTON/ALASKA REGIONAL MEDICAL PROGRAM,
Seattle, Wash., April 9, 1970.

HON. RALPH W. YARBOROUGH,
Chairman, Subcommittee on Health,
U.S. Senate,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I write to support S3355, your bill to extend and amend Title IX of the PHS Act, the Heart, Cancer, Stroke and Kidney Disease Amendment of 1970, 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 S3355.

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 extension of PL 89–239 and 90–574. As a result of these many discussions and a good deal of thought about the matter, I'm convinced that S3355 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 stated in your bill, though I would find acceptable some introductory langauge expressing the Administration desire and your own for closer coodination between RMP's and both the "A" and "B" agencies of CHP.

I approve the broadening of the categorical limitations in S3355 and the new emphasis on prevention and rehabilitation. The addition of kidney disease to the heart, cancer and stroke categories is logical and timely, and the improvement of care for kidney disease patients will fit well into the existing RMP framework and the linkages which have been developed. While there may be theoretical considerations favoring the complete decategorization of RMP as in S3443, 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 language in Section 900(c) of S3355 promoting regionalization and relations between primary care and specialist care and the attention to improve services in those areas with limited health services is an important addition to the present RMP law.

The availability of contract authority will prove advantageous in certain complicated and sophisticated activities including those projects involving extensive interregional areas and in large scale surveys at clinical field trials.

Language in S3443 which would authorize the designation of one administrative unit within HEW to act for several in administering funds from multiple Federal sources seems desirable, and I recommend your consideration of adding this feature to S3355.

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 6, Section 903(b), will strengthen the Council and give it better community orientation. While CHP would benefit from a NAC, I strongly oppose the combined NAC described in S3443 as a poor administrative arrangement and one which would so enlarge and diversify the goals as to make the mission of this Council almost unmanageable.

I think I understand the reasons for including new construction authority in S3355, but there was opposition to this aspect of your bill from some members of the Regional Advisory Committee on the Washington/Alaska RMP on the grounds that construction is not a high priority item for RMP's and might use funds which could be utilized more effectively for other purposes. Opposition may reflect the distrust expressed previously for the plan for construction of medical centers.

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 S3443, the Administration's Health Services Improvement Act.

Merger of these two and possibly other Federal health programs may be desirable at some point in the future, but I think the consolidation as proposed in S3443 is untimely and poorly conceived. As you know, the RMP has stimulated

an unprecedented degree of 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, S3443 would sufficiently change the direction of RMP away from its health providier, quality of care, action orientation that it would jeopardize 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 S3355 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 closer coordination between the RMP, CHP and NCHS R&D. Other changes mentioned are relatively minor.

I am pleased to note the names of Senators Magnuson and Jackson from our State among the distinguished group of senators who introduced S3355.

Yours truly,

DONAL R. SPARKMAN, M.D., *Director.*

REGIONAL MEDICAL PROGRAM FOR MARYLAND,
Baltimore, Md., April 15, 1970.

Re: *S. 3355.*

Senator RALPH YARBOROUGH,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR YARBOROUGH: As Chairman of the Advisory Group for the Maryland Regional Medical Program, I wish to indicate support for S. 3355. It is our opinion that your bill is by far the best of all bills introduced to date for Regional Medical Programs, and hope that it will soon be brought to committees for consideration and approval. It is our belief that your bill is clear, concise, and presents an adequate funding schedule.

Sincerely,

M. SHAKMAN KATZ,
Chairman, Regional Advisory Group for Maryland.

ALABAMA REGIONAL MEDICAL PROGRAM,
Birmingham, Ala., April 20, 1970.

Senator RALPH YARBOROUGH,
U.S. Senate,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing to indicate my approval of S. 3355. I feel that the Regional Medical Program is a unique one, and would like to see its basic concepts and specific objectives preserved. It has done much to enlist the voluntary participation of health professionals in all the allied health fields, and in this area certainly has played an important part in bridging the gap between the medical schools and the practicing physicians and the allied health fields. It is beginning to make possible the widening of the University walls to cover the entire area. I feel that the program is just getting started and it will be tragic to see it sidetracked after so much time and effort has been spent by so many people, the majority of which was on a voluntary basis.

The other bill under consideration S. 3443, while well intended, would seem to make major changes in direction of this program, and under the circumstances it would probably be difficult to maintain the very large volume of voluntary participation which has characterized the program thus far. In this area there is a very healthy relationship between CHP and RMP, each performing a very vital function at the local level, and I would hate to see the objectives of these two programs confused such as I believe would occur in S. 3443.

I have discussed this with several of my colleagues in this area, and I believe that most of them feel the same way that I do. I did feel it important that we let you know our feelings in this area.

Sincerely yours,

R. R. MCBRIDE, M.D.,
Chairman, Regional Advisory Group.

SOUTH CAROLINA MEDICAL ASSOCIATION,
Florence, S.C., April 27, 1970.

Senator RALPH YARBOROUGH,
Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR SENATOR YARBOROUGH: This is to advise that as one who has been active in the Regional Medical Program in South Carolina, I have been most interested in considering the various Bills which have been introduced into the House and into the Senate to provide for the continuation of these Programs. The Bill which you have introduced, S. 3355, extending the Programs with some broadening of the categories which it is believed will be of considerable value and in areas in which we are interested is one the medical profession can support.

It is most important that the interest of the medical profession, the voluntary health agencies, and interested citizens be maintained, and certainly the categorical emphasis of the original legislation has enabled the focus of community interest to be soundly and effectively developed.

It is my belief, and certainly the belief of many others with whom I have talked, and our sincere hope that your Bill will be passed so that the fine cooperative relationships which now exist in our State will continue.

Operational programs under the Regional Medical Program were first funded in August of 1968. Currently there are nineteen (19) fully operational and four (4) partially operational programs which have already made significant impact throughout the State in bringing to the physicians and to their patients improved care in heart disease with significant lowering of mortality in acute myocardial infarctions, improved educational activities for practicing physicians, nurses and those in the allied health field, including programs for dentists. A beginning has been made in providing for hemodialysis and renal transplant program in conjunction with the Medical University, and improved diagnosis and cancer treatment through cooperative arrangements have been achieved. Because of the enthusiasm and interest, several of the programs have already become self-supporting, and it is believed as funds are used to introduce these into other areas, that eventually nearly all the programs as new activities will be continued by community interest and support.

Sincerely,

WILLIAM L. PERRY, M.D., *President.*

SOUTH CAROLINA MEDICAL ASSOCIATION,
Florence, S.C., April 27, 1970.

Hon. RALPH YARBOROUGH,
Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR SENATOR YARBOROUGH: As one who has been concerned in the Regional Medical Program in South Carolina, I have been interested in the various Bills which have been introduced in the House and the Senate to provide for continuation of the Program. Your Bill—S. 3355—extending the Program with some broadening of the categories would seem to offer considerable improvement in areas in which the medical profession is interested and which it could support.

It is my sincere hope that your Bill will be passed so that the excellent cooperative relationships which have been developed in our State may continue.

There are now nineteen (19) fully operational and four (4) partially operational programs which have already made significant impact throughout the State in bringing to the physicians and their patients improved care in heart disease with significant lowering of mortality and improved educational activities for physicians, nurses, and those in allied health fields. Because of the enthusiasm and interest, several of the programs have already become self-supporting and as funds are used to introduce these into other areas, it may be that nearly all the programs can eventually be continued through community interest and support.

Sincerely yours,

M. L. MEADORS.

HEALTH-CARE AND REHABILITATION SERVICES
OF SOUTHEASTERN VERMONT, INC.
Springfield, Vt., April 28, 1970.

Hon. RALPH YARBOROUGH,
Senate Office Building, Washington, D.C.

DEAR MR. YARBOROUGH: As one of the few surviving Democrats in Vermont, I take the liberty of writing to you concerning the pending decision on the Health Services Improvement Act, S. 3443.

Ours is, as you see from the enclosed brochure, a small, voluntary agency whose main aim is to make some sense of the proliferation of specialized public and private health-service programs and, without reliance on Federal grants, to create a network of truly comprehensive health services, beginning with early detection and treatment of birth defects, and ending with aid in self-care and geriatic services to senior citizens.

In a State with low population density (42 per square mile in Vermont as against 36.4 in Texas), problems exist that must be only too familiar to you. Medical skills are concentrated in the big cities, and the non-urban population is left with hospitals that are too antiquated and small to afford the specialized equipment of modern technical advances in medicine, and with a fast-shrinking number of super-annuated General Practitioners, functioning as family physicians with patient loads that leave them no time to keep abreast of modern surgical or pharmacological developments.

If, in this setting, programs are enacted into law that continue the by now almost traditional limitations to "heart, cancer and stroke," it means that these already medically underprivileged areas are usually ineligible for participation in these Federally financed programs, and the funds continue to go to the big cities and to support the already over-expanded hospitals that are currently eating up our Medicaid and Medicare funds to the detriment of sound over-all health-care services.

We have no axes to grind in this matter—we merely are abashed to find the U.S., the most powerful and richest nation, far down in rank on life expectancy among the industrial countries of the world, far up on the scale of infant mortality—and Vermont doing on both counts worse than the country as a whole.

The reason, as we see it, lies in the fact that Federal funds, under the various program restrictions, go into the far north-west corner of the State, to the large hospital complex of the University of Vermont in Burlington, or across the State line, to the Dartmouth Medical School in New Hampshire, while in the two counties in the southeast corner of the State, we limp along with a rate of 55 General Practitioners per 1,000 population for a total of 80,000 people.

We therefore most earnestly urge you to permit S. 3443 to become truly a Health Services *Improvement* Act by making it comprehensive in scope and eliminating the artificial limitation to certain disease categories, which appear currently being favored by some members of the Committee.

American has shown in other areas: The atom bomb, the moon shot, the conquest of polio, to name but a few—what dramatic successes can be achieved when only there is a sense of "Mission," a sense that this is "a great undertaking," if only "almost everybody knew that this job, if it were achieved, would be a part of history. That it was an unparalleled opportunity to bring to bear the basic knowledge and art of science for the benefit of this country," as one of our greatest scientists said in relation to the atom bomb. Let us apply this same "sense of mission" to the project of making America the healthiest nation on earth. It deserves no less.

Sincerely,

BERNARD W. SCHOLZ, *President.*

MISSISSIPPI COLLEGE,
Clinton, Miss., April 30, 1970.

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I want 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 Mt. 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 social program of recent vintage. The program thus far has enjoyed unusually strong support from the 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 his 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 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 the 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 days. 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 defining 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 became 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 percent of the appropriation to be transferred from RMP to CHP, it is not unreasonable to assume that some A-Agencies might give preference to CHP programs in order not to have 10 percent 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 unbelievably 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 elimina-

tion 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.

I should like as a member of the Regional Advisory Group of our Regional Medical Program in Mississippi to commend you on your bill which retains separate legislative authorization for the Regional Medical Program and provides a new emphasis on regionalization so as to improve primary care and its relationship to specialized cases.

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.*