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PUBLIC HEALTH SERVICE ACT EXTENSION, 1977

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HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

S. 754

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND THROUGH THE FISCAL YEAR ENDING SEPTEMBER 30, 1978, THE ASSISTANCE PROGRAMS FOR HEALTH SERVICES RESEARCH; HEALTH STATISTICS; MEDICAL LIBRARIES; CANCER CONTROL PROGRAMS; THE NATIONAL CANCER INSTITUTE; HEART, BLOOD VESSEL, LUNG, AND BLOOD DISEASE PREVENTION AND CONTROL PROGRAMS; THE NATIONAL HEART, LUNG, AND BLOOD INSTITUTE; AND NATIONAL RESEARCH SERVICE AWARDS; AND FOR OTHER PURPOSES

AND

S. 755

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND THROUGH THE FISCAL YEAR ENDING SEPTEMBER 30, 1978, THE ASSISTANCE PROGRAMS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES, MIGRANT HEALTH, COMMUNITY HEALTH CENTERS, HEMOPHILIA PROGRAMS, NATIONAL HEALTH PLANNING AND DEVELOPMENT AND HEALTH RESOURCES DEVELOPMENT; TO AMEND THE COMMUNITY MENTAL HEALTH CENTERS ACT TO EXTEND IT THROUGH THE FISCAL YEAR ENDING SEPTEMBER 30, 1978; AND FOR OTHER PURPOSES

FEBRUARY 23, 1977

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PUBLIC HEALTH SERVICE ACT EXTENSION, 1977

WEDNESDAY, FEBRUARY 23, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 4232 Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Schweiker.

Senator KENNEDY. The subcommittee will come to order.

On September 30, 1977, many of our most significant health programs are due to expire. They include the assistance programs for migrant health, community health and community mental health centers, hemophilia, health planning, and biomedical research. Under the provisions of the Budget Act, to insure continued funding of these programs, committee action must be completed by May 15.

In order to meet this time requirement and at the same time give the Congress and the new administration a reasonable period of time to develop proposals for substantive improvements in these important programs, I introduced legislation yesterday which will extend these assistance programs for 1 year without any substantive changes. I am happy to note that these bills are cosponsored on a bipartisan basis by a host of Members of the Committee on Human Resources, including the distinguished Chairman of the Full Committee, Senator Williams, and the ranking minority members of it and the Subcommittee on Health and Scientific Research, Senator Javits and Senator Schweiker.

[The texts of S. 754 and S. 755 follow:]

(1)

IN THE SENATE OF THE UNITED STATES

FEBRUARY 22 (legislative day, FEBRUARY 21), 1977

Mr. KENNEDY (for himself, Mr. SCHWEIKER, Mr. WILLIAMS, Mr. JAVITS, Mr. RANDOLPH, Mr. PELL, Mr. NELSON, Mr. HATHAWAY, Mr. RIEGLE, and Mr. STAFFORD) introduced the following bill; which was read twice and referred to the Committee on Human Resources

A BILL

To amend the Public Health Service Act to extend through the fiscal year ending September 30, 1978, the assistance programs for health services research; health statistics; medical libraries; cancer control programs; the National Cancer Institute; heart, blood vessel, lung, and blood disease prevention and control programs; the National Heart, Lung, and Blood Institute; and National Research Service Awards; and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. (a) This Act may be cited as the "Health
4 Services Research, Health Statistics, Medical Libraries, Bio-
5 medical Research and Research Training Extension Act of
6 1977".

1 (b) Whenever in this Act an amendment is expressed
2 in terms of an amendment to a section or other provision,
3 the reference shall be considered to be made to a section or
4 other provision of the Public Health Service Act.

5 SEC. 2. (a) Section 308 (a) (2) is amended by strik-
6 ing out "September 1" and inserting in lieu thereof "Decem-
7 ber 1".

8 (b) The first sentence of section 308 (i) (1) is amended
9 by (1) striking out "and" after "1975," and (2) striking
10 out the period at the end of the sentence and inserting in
11 lieu thereof ", and such sums as may be necessary for the
12 fiscal year ending September 30, 1978."

13 (c) Section 308 (i) (2) is amended by (1) striking out
14 "and" after "1975," and (2) striking out the period at the
15 end of the sentence and inserting in lieu thereof ", and such
16 sums as may be necessary for the fiscal year ending Septem-
17 ber 30, 1978."

18 SEC. 3. Section 390 (c) is amended by (1) striking
19 out "and" after "1975," and (2) striking out the period
20 after "1976" and inserting in lieu thereof ", and such sums
21 as may be necessary for the fiscal year ending September 30,
22 1978."

23 SEC. 4. Section 409 (b) is amended by (1) striking out
24 "and" after "1976," and (2) striking out the period at the
25 end thereof and inserting in lieu thereof ", and such sums as

1 may be necessary for the fiscal year ending September 30,
2 1978.”.

3 SEC. 5. Section 410 (C) is amended by (1) striking out
4 “and” after “1976;” and (2) striking out the period at the
5 end thereof and inserting in lieu thereof “, and such sums as
6 may be necessary for the fiscal year ending September 30,
7 1978.”.

8 SEC. 6. Section 414 (b) is amended by (1) striking out
9 “and” after “1976,” and (2) striking out the period at the
10 end thereof and inserting in lieu thereof “, and such sums
11 as may be necessary for fiscal year 1978.”.

12 SEC. 7. The first sentence of section 419B is amended
13 by (1) striking out “and” after “1976,” and (2) striking out
14 the period at the end thereof and inserting in lieu thereof “,
15 and such sums as may be necessary for fiscal year 1978.”.

16 SEC. 8. The first sentence of section 472 (d) is amended
17 by (1) striking out “and” after “1976,” and (2) striking
18 out the period at the end thereof and inserting in lieu thereof
19 “, and such sums as may be necessary for fiscal year 1978.”.

S. 755

IN THE SENATE OF THE UNITED STATES

FEBRUARY 22 (legislative day, FEBRUARY 21), 1977

Mr. KENNEDY (for himself, Mr. SCHWEIKER, Mr. WILLIAMS, Mr. JAVITS, Mr. RANDOLPH, Mr. PELL, Mr. NELSON, Mr. HATHAWAY, Mr. RIEGLE, and Mr. STAFFORD) introduced the following bill; which was read twice and referred to the Committee on Human Resources

A BILL

To amend the Public Health Service Act to extend through the fiscal year ending September 30, 1978, the assistance programs for comprehensive public health services, migrant health, community health centers, hemophilia programs, national health planning and development and health resources development; to amend the Community Mental Health Centers Act to extend it through the fiscal year ending September 30, 1978; and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SHORT TITLE; REFERENCE TO ACTS

4 SECTION 1. (a) This Act may be cited as the "Health
5 Services, Hemophilia and Health Planning and Development
6 Extension Act of 1977".

1 (b) Wherever in title 1 an amendment or repeal is
2 expressed in terms of an amendment to, or repeal of, a
3 section or other provision, the reference shall be considered
4 to be made to a section or other provision of the Public
5 Health Service Act. Wherever in title II an amendment is
6 expressed in terms of an amendment to a section or other
7 provision, the reference shall be considered to be made to
8 a section or other provision of the Community Mental
9 Health Centers Act.

10 TITLE I—AMENDMENTS TO THE PUBLIC HEALTH
11 SERVICE ACT

12 SEC. 101. (a) Section 314 (d) (7) (A) is amended by
13 (1) striking out “and” after “1976,” and (2) striking out
14 the period at the end thereof and inserting in lieu thereof
15 “, and such sums as may be necessary for fiscal year 1978.”.

16 (b) Section 314 (d) (7) (B) is amended by (1) strik-
17 ing out “pragraph (1)” and inserting in lieu thereof “para-
18 graph (1)” ; (2) striking out “and” after “1976,” ; and
19 (3) striking out the period at the end thereof and inserting
20 in lieu thereof “, and such sums as may be necessary for fiscal
21 year 1978.”.

22 SEC. 102. (a) Section 319 (h) (1) is amended by (1)
23 striking out “and” after “1976,” in the first sentence there-
24 of ; (2) striking out the period at the end of the first sentence
25 thereof and inserting in lieu thereof “, and such sums as may

1 be necessary for fiscal year 1978.”; and (3) striking out
2 “for the next fiscal year” in the second sentence thereof and
3 inserting in lieu thereof “for the next two fiscal years”.

4 (b) Section 319 (h) (2) is amended by (1) striking
5 out “and” after “1976,” in the first sentence thereof; (2)
6 striking out the period at the end of the first sentence thereof
7 and inserting in lieu thereof “, and such sums as may be nec-
8 essary for fiscal year 1978.”; and (3) striking out “fiscal
9 year 1977” in the third sentence thereof and inserting in
10 lieu thereof “fiscal years 1977 and 1978”.

11 (c) Section 319 (h) (3) is amended by striking out
12 “and” after “1976,” and (2) striking out the period at the
13 end thereof and inserting in lieu thereof “, and such sums as
14 may be necessary for fiscal year 1978.”.

15 SEC. 103. (a) Section 330 (e) (1) is amended by strik-
16 ing out “subsection (e)” in the first sentence thereof and
17 inserting in lieu thereof “subsection (c)”.

18 (b) Section 330 (e) (2) (D) is amended by striking
19 out “agney” and inserting in lieu thereof “agency”.

20 (c) Section 330 (g) (1) is amended by (1) striking
21 out “and” after “1976,” and (2) striking out the period at
22 the end thereof and inserting in lieu thereof “, and such
23 sums as may be necessary for fiscal year 1978.”.

24 (d) Section 330 (g) (2) is amended by (1) striking
25 out “and” after “1976,” and (2) striking out the period

1 at the end thereof and inserting in lieu thereof “, and such
2 sums as may be necessary for fiscal year 1978.”.

3 SEC. 104. (a) Section 1131(f) is amended by (1)
4 striking out “and” after “1976,” and (2) striking out the
5 period at the end thereof and inserting in lieu thereof “,
6 and such sums as may be necessary for fiscal year 1978.”.

7 (b) Section 1132(e) is amended by (1) striking out
8 “and” after “1976,” and (2) striking out the period at the
9 end thereof and inserting in lieu thereof “, and such sums
10 as may be necessary for the fiscal year 1978.”.

11 SEC. 105. (a) The fourth sentence of section 1503(b)
12 (1) is amended by inserting “established” after “Councils”.

13 (b) The first sentence of section 1511(a) is amended
14 by inserting “except as provided in section 1536” after
15 “throughout the United States”.

16 (c) Section 1511(a)(3)(B) is amended by indenting
17 the four lines beginning with “if the Governor” and ending
18 with “of this subsection” to line up with “(ii)”.

19 (d) Section 1512(b)(3)(B)(i) is amended by strik-
20 ing out “subsections (e), (f), and (g)” and inserting in
21 lieu thereof “subsections (e), (f), (g), and (h)”.

22 (e) The first sentence of section 1512(c) is amended
23 by striking out “agencies’” and inserting in lieu thereof
24 “agency’s”.

25 (f) The last sentence of section 1513(a) is amended

1 by striking out "(b) through (g)" and inserting in lieu
2 thereof "(b) through (h)".

3 (g) Section 1513 (b) (2) (B) is amended by striking
4 out "are responsive" and inserting in lieu thereof "is
5 responsive".

6 (h) Section 1513 (b) (2) (C) is amended by striking
7 out "which take into account" and inserting in lieu thereof
8 "which takes into account".

9 (i) Section 1513 (d) is amended by striking out
10 "system" each place it occurs and inserting in lieu thereof
11 "systems".

12 (j) Section 1515 (d) is amended by striking out
13 "health services area" and inserting in lieu thereof "health
14 service area".

15 (k) Section 1516 (c) (1) is amended by (1) striking
16 out "and" after "1976," and (2) striking out the period
17 at the end thereof and inserting in lieu thereof ", and such
18 sums as may be necessary for fiscal year 1978."

19 (l) Section 1521 (d) is amended by striking out "Na-
20 tional Health, Policy, Planning," and inserting in lieu thereof
21 "National Health Planning".

22 (m) Section 1523 (c) is amended by striking out
23 "paragraph (4), (5), (6), or (7)" and inserting in lieu
24 thereof "paragraph (4), (5), or (6)".

1 (n) Section 1525 (c) is amended by (1) striking out
2 "and" after "1976," and (2) striking out the period at
3 the end thereof and inserting in lieu thereof ", and such
4 sums as may be necessary for fiscal year 1978."

5 (o) The first sentence of section 1526 (a) is amended
6 by inserting "grants" after "the Secretary may make".

7 (p) Section 1526 (e) is amended by (1) striking out
8 "and" after "1976," and (2) striking out the period at
9 the end thereof and inserting in lieu thereof ", and such
10 sums as may be necessary for fiscal year 1978."

11 (q) Section 1534 (d) is amended by (1) striking out
12 "and" after "1976," and (2) striking out the period at the
13 end thereof and inserting in lieu thereof ", and such sums as
14 may be necessary for fiscal year 1978."

15 (r) Section 1536 (a) (2) is amended by striking out "the
16 Trust Territories in the Pacific Islands" and inserting in lieu
17 thereof "the Trust Territory of the Pacific Islands, the North-
18 ern Mariana Islands".

19 (s) Section 1536 (b) (4) is amended by striking out
20 "chief executive office" and inserting in lieu thereof "chief
21 executive officer".

22 SEC. 106. (a) Section 1602 (5) is amended by striking
23 out "section 1503" and inserting in lieu thereof "section
24 1603".

1 (b) The first sentence of the last paragraph of section
2 1602 is amended by striking out "supports" and inserting in
3 lieu thereof "support".

4 (c) Section 1603 (a) is amended by striking out "sec-
5 tion 1602 (a)" each place it occurs and inserting in lieu
6 thereof "section 1602".

7 (d) Section 1603 (a) (6) is amended by striking out
8 "paragraph (4)" and inserting in lieu thereof "paragraph
9 (5)".

10 (e) Section 1604 is amended by striking out "section
11 1602 (a)" each place it occurs and inserting in lieu thereof
12 "section 1602".

13 (f) Section 1604 (b) (2) (A) (i) is amended by strik-
14 ing out "section 1602 (a) (2)" and inserting in lieu thereof
15 "section 1602 (2)".

16 (g) Section 1604 (e) is amended by striking out "ap-
17 proved" and inserting in lieu thereof "approved".

18 (h) The first sentence of section 1610 (a) is amended
19 by striking out "section 1513" and inserting in lieu thereof
20 "section 1613".

21 (i) Section 1613 is amended by (1) striking out "and"
22 after "1976," and (2) striking out the period at the end
23 thereof and inserting in lieu thereof ", and such sums as
24 may be necessary for fiscal year 1978."

1 (j) Section 1620 is amended by striking out "Septem-
2 ber 30, 1977" each place it occurs and inserting in lieu
3 thereof "September 30, 1978".

4 (k) Section 1622 (e) (2) is amended by striking out
5 "and" after "1976," and (2) striking out the period at
6 the end thereof and inserting in lieu thereof ", and Septem-
7 ber 30, 1978."

8 (l) Section 1633 (14) is amended by striking out "title
9 XIV" and inserting in lieu thereof "title XV".

10 (m) Section 1640 (d) is amended by striking out "and"
11 after "1976," and (2) striking out the period at the end
12 thereof and inserting in lieu thereof ", and such sums as
13 may be necessary for fiscal year 1978."

14 SEC. 107. Section 314 (c) is repealed.

15 TITLE II—AMENDMENTS TO THE COMMUNITY

16 MENTAL HEALTH CENTERS ACT

17 SEC. 201. (a) The second sentence of section 202 (c)
18 is amended by striking out "recommeinded" and inserting
19 in lieu thereof "recommended".

20 (b) Section 202 (d) is amended by (1) striking out
21 "and" after "1976," and (2) striking out the period at the
22 end thereof and inserting in lieu thereof ", and such sums as
23 may be necessary for the fiscal year 1978."

24 SEC. 202. (a) Section 203 (d) (1) is amended by (1)

1 striking out "and" after "1976," and (2) striking out the
2 period at the end thereof and inserting in lieu thereof ", and
3 such sums as may be necessary for fiscal year 1978."

4 (b) Section 203 (d) (2) is amended by (1) striking
5 out "1977" and inserting in lieu thereof "1978" and (2)
6 striking out "1976" and inserting in lieu thereof "1977".

7 SEC. 203. Section 204 (c) is amended by (1) striking
8 out "and" after "1976," and (2) striking out the period at
9 the end thereof and inserting in lieu thereof ", and such sums
10 as may be necessary for fiscal year 1978."

11 SEC. 204. Section 205 (c) is amended by (1) striking
12 out "and" after "1976," and (2) striking out the period at
13 the end thereof and inserting in lieu thereof ", and such sums
14 as may be necessary for fiscal year 1978."

15 SEC. 205. The last sentence of section 206 (d) is
16 amended by striking out "ninetieth" and inserting in lieu
17 thereof "one hundred and twentieth".

18 SEC. 206. Section 213 is amended by (1) striking out
19 "and" after "1976," and (2) striking out the period at the
20 end thereof and inserting in lieu thereof ", and such sums as
21 may be necessary for fiscal year 1978".

22 SEC. 207. Section 228 is amended by (1) striking out
23 "and" after "1976," and (2) inserting after "1977," "and
24 such sums as may be necessary for fiscal year 1978".

1 SEC. 208. Section 231 (d) is amended by (1) striking
2 out "and" after "1976," and (2) striking out the period
3 at the end thereof and inserting in lieu thereof ", and such
4 sums as may be necessary for fiscal year 1978."

Senator KENNEDY. None of the programs I am proposing to extend is perfect. Each one, however, has been important in making an effort to meet a portion of the health needs of the American people.

I know that the constituencies affected by these programs have proposed numerous substantive changes in them. These proposals deserve serious consideration on their merits, and I want to assure them that such consideration will be forthcoming in the months ahead when each of these programs is substantively reevaluated.

I look forward to working with the administration and the public in determining what improvements can be made in each of these programs.

I am pleased that Dr. Dickson and his colleagues from HEW are with us this morning to give us the administration's view of the legislative approach I have proposed.

Dr. Dickson, do you want to introduce your associates, please?

STATEMENT OF JAMES F. DICKSON III, M.D., ACTING ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DALE SOPPER, ACTING ASSISTANT SECRETARY FOR LEGISLATION, DHEW; HAROLD MARGULIES, M.D., DEPUTY ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DHEW; EDWARD D. MARTIN, M.D., DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES, HEALTH SERVICES ADMINISTRATION, DHEW; DONALD S. FREDRICKSON, M.D., DIRECTOR, NATIONAL INSTITUTES OF HEALTH, DHEW; THOMAS F. A. PLAUT, PH. D., DEPUTY DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, DHEW; AND HARRY CAIN, DIRECTOR, HEALTH PLANNING

Dr. DICKSON. From the left, Senator, Dr. Harry Cain, Bureau of Health Planning and Resource Development; Dr. Harold Margulies, Deputy Administrator, Human Resources Administration; Dr. Donald S. Frederickson, Director, National Institutes of Health.

And on my right is Dale Sopper, Acting Assistant Secretary for Legislation; Dr. Edward Martin, Director, Bureau of Community Health Services; And Dr. Thomas Plaut, Deputy Director, National Institute of Mental Health.

I have a statement for the record, Senator, and also some very brief opening remarks that I would like to make.

Senator KENNEDY. We will hear them. We want to hear you a little bit on the health budget as well. We will hear you on the legislation, first, and then we will ask a few questions on that, and then come back to the other matter.

Dr. DICKSON. We are here today, initially, to discuss the extension of the various Federal health program authorities for fiscal year 1978 that are contained in S. 754 and S. 755.

There are some 18 health areas that require extension of authority that we do wish to continue supporting, ranging from health planning and health services research to migrant health centers, among

others. We will be pleased to go through them individually or however you may choose.

We do believe that an appropriate way to deal with these issues at this point in the congressional authorizing cycle and very early in this administration is simply to extend these health programs for 1 fiscal year at authorization levels which are consistent with the President's fiscal year 1978 budget. This will allow the administration the opportunity to make a thorough assessment of these programs and as a result of this process to develop recommendations for changes which it believes would be desirable.

The 1-year extension of these authorities will enable us to continue our activities without disruption, and we strongly support this effort.

Those are the remarks I have to make, Senator.

We will be pleased to respond to your questions.

Senator KENNEDY. As I indicated, I introduced two bills yesterday, that extend the expiring programs without major modification. In order to maintain flexibility, I set authorization levels at such sums as may be necessary.

Now that the budget is out, what is your position as to the level of authorizations?

Dr. DICKSON. It would be desirable to have the level of authorizations tailored to the request of the President.

Senator KENNEDY. What does that mean?

Dr. DICKSON. Authorization levels to cover the amount that he has suggested.

Senator KENNEDY. Are you suggesting anything above that or just at that level or what do you have in mind?

Dr. DICKSON. At that level, sir.

Senator KENNEDY. You do not want to put it a little bit above that, do you? [Laughter.]

Basically, as I understand the administration's position, they support the 1-year extension which would give them an opportunity to examine these programs in detail and hopefully work with us on the committee to try and deal with the substantive issues in due course.

What we are attempting to do is to provide the 1-year period which will give the administration the opportunity to examine in considerable detail various provisions of the legislation, shape and form them in a way which will complement the health insurance program which will be coming forth—you do not bring us any news about that, do you?

Dr. DICKSON. None.

Senator KENNEDY. The President said he would submit a proposal before the end of the year. We will be looking forward to it.

I think all of us understand the importance of interrelating these various programs with any kind of health security.

The real problem we faced over the period in the past has been the financing on the one side and delivery on the other. We have to bring these matters together.

That is really what we are intending to do. That is the position of the administration, as I understand it.

Dr. DICKSON. We strongly support what you just said.

Senator KENNEDY. I think that makes sense, and what we are going to do, as I understand it, both from our committee and from the administration's point of view, is to use this period of time to evaluate the various recommendations on substantive changes that will be made from a number of different groups that are dealing with these issues, and are living with these programs day by day. You are going to look at those substantively. We are going to examine those substantively. We are going to keep our doors open, welcome suggestions, recommendations, modifications, and so that when we come to grips with it, by the end of this year and the early part of next year, we will really be able to make the kinds of adjustments which are necessary.

Dr. DICKSON. Yes; over the past 3 weeks the administration has been pretty much consumed by budgetary considerations. At this time, the Secretary is trying to move energetically into his planning process for 1979. He has indicated that he will be sharing with you, essentially, the proposed legislative agenda as it emerges.

Senator KENNEDY. We will look forward to working closely on those programs.

Possibly the other staff members have particular questions which they will submit to you or make a part of the record.

Dr. DICKSON. Fine.

Senator KENNEDY. If we could talk to you a little bit about the funding priorities that come from the administration. I had a very good conversation with the Secretary some time ago about some of the areas of priority that we had in terms of the health budget, and I have enjoyed a good exchange with the Secretary as he has been attempting to fill the very important position of the Assistant Secretary. That, I know, is a matter of great importance to the Department. I think it must be to Secretary Califano, as well as to the President. I know that he has been focusing on that issue.

But, nonetheless, I would like to review some of the specifics of the budget with you this morning. I would be less than frank not to say that I am disappointed with regard to a number of programs which I think can help the administration in an important way in dealing with the issues of cost controls.

I read, this morning, the efforts to be made by the administration in terms of setting hospital costs ceilings, which I think is a constructive and positive step forward in attempting to deal in part with the very complex issue of escalating health care costs.

I look forward to studying in great detail that particular proposal.

But we find out that, for example, in the health planning area, minus the construction, you are proposing, for 1978, just about the same figure as last year. Am I correct?

Dr. DICKSON. Yes.

Senator KENNEDY. Then the figure is less than what the administration's budget was for 1977 including the supplemental which would total \$146 million. Am I correct in that?

Dr. DICKSON. Yes; that is right.

Senator KENNEDY. Do you want to talk about that a little bit?

Dr. DICKSON. I think it is a general statement I can make, and it applies not only to the health planning area, but also to other areas, such as startup of new mental health clinics.

Senator KENNEDY. No new mental health centers will be started.

Dr. DICKSON. I think my remarks relate to the reasons it is not. They will be made in the same frame.

The administration generally wants to make possible restorations back to the current services levels from the reduced levels that were proposed by the previous administration.

I think that is the way the administration is approaching that. Clearly, at the same time, there were constraints on the resources available, but I do not think that is the major issue. That applies to the planning moneys.

Senator KENNEDY. A recent report, as I understand it, was done for the Congressional Budget Office which touched on health planning.

Dr. DICKSON. Yes.

Senator KENNEDY. It indicates that the planning law is the key option available at this time to control costs.

This is so because the health facility planning legislation includes provisions that control the number of facilities, supports State efforts to set hospital rates, and so on.

With the rather bold action that has been taken by the administration in terms of setting a ceiling, for hospital costs which I again support, it seems to me that on the one hand you are moving forward and on the other hand you are standing still in the area of attempting to get some control on the cost of facilities and services.

I was just wondering what the thinking was.

Dr. DICKSON. I think the point you make is a very important one. Clearly, one is not going to get after the matter of general cost containment in health by just dealing with the hospital situation. For example, there are many other variables in the picture, particularly the role that the health systems agency might play in both cost containment at large, but particularly with respect to the hospital issue that is now before us. It is not unreasonable to think that the hospital issue might be approached in terms of doing it on a region-by-region basis. Some of the health systems agencies are developing faster than others, and for health system agencies to engage in regional consideration of hospital costs is going to be difficult business. So some of them might be able, in the coming year, to get into that consideration of cost. We are aware of that.

At the present time, as the plans are being elaborated for containment of hospital costs, the question of the role of the health systems agency is very much at the forefront. However, I have to go back to the remarks I made at the beginning, indicating that the general policy that was followed, in the most general sense, make restorations back to the current services level from the reduced level that was proposed by the previous administration and not to expand during the period of examination. That is true with respect to the moneys. But in the spirit of which you are bringing up the health systems agencies, the containment of costs, we do recognize that, and it will be subject to early consideration.

Senator KENNEDY. Do I understand then that the administration recognizes the importance of the planning process and its role in terms of cost controls, and the budgetary decision should not be interpreted as a negative feeling of the administration toward the planning legislation.

Dr. DICKSON. Yes.

Senator KENNEDY. I think that the planning function is one that just cannot be missed in terms of cost controls in long-range thinking.

I am hopeful that we will be able to have the concept of planning that is included in the legislation and which you have talked about here this morning reflected in the terms of increased commitment by the administration in the funding process.

Now, as for HMO's, it is basically, again, just a holding action. We have talked about the building of some competition in the delivery of health care systems. We saw modification in terms of the regulations last year in order to encourage the existence of more HMO's.

I was extremely reluctant to see that because I did not feel that if we are going to move into a national health insurance system, that those kinds of variations or adjustments were necessary. But, nonetheless, we had a very significant debate within our own committee about that particular issue. But we made adjustments and changes to try and bring some new life into the whole HMO program, and you virtually have stabilized it going from \$15 million in 1976 to \$18 million in 1978.

Dr. DICKSON. I think the principle is the same, but I would like to make a comment. I said before the issue of containment of health care costs clearly involves six to eight major variables. They include the matter of the financing mechanisms. They include the matter of allocation of resources at the local level. They include the matter of utilization and how that is done. Matters of malpractice, naturally, which happens with respect to the technology that has developed that is useful in health care is also included. Across that broad spectrum, clearly, the matter of containment of hospital costs is being taken as an initial first step, but at the same time, we are looking broadly at the problems that relate to containment of costs and prominent among those happens to be the issue of health maintenance organizations for the purposes of competition, and whatever, playing an important role in containment of costs. So, we have not forgotten that as a part of a larger picture. It is just some of the money is not there.

Senator KENNEDY. That is right. We are all concerned, figures of \$7 billion to \$9 billion a year for defensive medicine is unacceptable. The malpractice issue needs serious attention. I am sure this administration will attempt to deal with it.

The 50 States all have different statutes being promulgated by State insurance commissioners that have very little, if any, knowledge, about the health implications of this issue. I realize it is difficult to get a consensus, but I put in bills last year in an attempt to begin building a consensus.

Getting back to HMO's, they really do offer an important alternative in the health care system besieged by rising costs. We have seen, for example, in my own State, the caring for medicaid recipients cost 30 percent less in an HMO than in a fee-for-fee service system. That is 30 percent less. When we are trying to control costs, it seems to me that HMO's offer an important opportunity that cannot be adequately taken advantage of with \$15 million or \$18 million. And, as you are doing your review, this is something to think about. We ought to give it a good run. You cannot do it with \$18 million. Then we ought to take a look at it and give it a thorough evaluation, in terms of quality and cost control. But once again, it seems to me we are missing an opportunity.

Dr. DICKSON. There are two things I would like to say.

First, the 3 weeks the administration has had to revise the previous administration's overall budget, is a very short time to determine how it interrelates.

Essentially, we have a Ford budget with this administration, here and there where it is possible, signaling some new directions, as with children and immunization and in cost containment.

A second point has to do with the issue of malpractice. As an information item, I would just like to note to you that the work that Dr. Roger Egberg has been doing in trying to survey this situation and come up with some alternative solutions to it, will be pulled together in June of this year. I think it will be an interesting input to the deliberations of your committee.

Senator KENNEDY. We will look forward to it.

I would hope that you do the kind of cost analysis, that I know is done since we have heard about it before this committee which compares the cost of HMOs with the fee-for-service system.

Now, in the health manpower area—we are not supposed to call it health manpower any more—in the Health Professions Act—there has been a very modest increase in the National Health Service Corps scholarship program from \$22 million to \$40 million. I am afraid that with less money put into those scholarship programs than is needed, and as universities raise their tuitions, what we are going to see is that the people that are going to be able to afford to go to medical school are only going to be the rich kids.

We have attempted to make an important effort to insure that in the area of medical training, it is expanded to include minorities and women unless we have a scholarship program that is really going to reach out and include those that are most hardpressed financially, we are going to be back where we were 10 or 15 years ago in terms of medical education.

Dr. DICKSON. I do consider this an important area. The administration's budget for 1978 is essentially a 100-percent increase over the 1977 level. But in actual cents that may not appear enough. It is an increase over the present year, going from \$22 million to \$40 million. It was felt that was as much as they wanted to put forward at this time while they were evaluating the overall interrelationships of the National Health Service scholarship program with other manpower efforts.

Senator KENNEDY. It has been, I think, very well run. My experience with it has been that it is a first-rate program. There is a great deal of hope for it in the future.

As for community mental health centers, this will be, the first budget in recent times where we would not be able to build one new—

Dr. DICKSON. I did not hear you when you started, Senator.

Senator KENNEDY. For community mental health centers, this is, basically, a no growth budget, is it not?

Dr. DICKSON. I think, as I understand you, there were 90 new centers being planned.

Senator KENNEDY. That's community health centers, is it not? If you want, let's talk about community health centers and then we will come back to mental health centers.

Dr. MARTIN. In section 330, community health center budget, the President has proposed starting 90 new centers, and is proposing an additional \$14 million above that to increase services within community health centers. The increase will serve as a focus to expand very significantly the activities related to adolescent health, particularly to high-risk adolescents.

Access to care, as well as the quality of services provided will be expanded as a result of the President's request.

Senator KENNEDY. I think that the latter program is very valuable and worthwhile. I think it makes sense from both a health and a financial point of view.

What are you planning in terms of new neighborhood health centers this year?

Dr. MARTIN. We presently have 302 community health centers in addition to, of course, 97 migrant centers. We are planning to start 120 integrated projects in 1977 combining different authorities with National Health Services Corps.

Senator KENNEDY. You have the resources for it in the budget?

Dr. MARTIN. Yes, sir.

Senator KENNEDY. What are the number of applications, qualified applications?

Dr. MARTIN. We actually are generating in priority areas numbers of applications that we end up approving 100 percent. We anticipate somewhere between 130 to 140 applications this fiscal year. The way we now do the programing is that we work with the grantee so that they are not turned down on a technical basis.

For example, underserved communities, characteristically, have difficulties on those applications. We anticipate 130 to 140 this year in particularly high-impact areas, and it will be difficult to estimate for fiscal year 1978.

Senator KENNEDY. Migrant health centers have virtually stabilized. Is that correct?

Dr. MARTIN. The actual number of centers is stabilizing, but the mechanism by which we are increasing the service to migrants reflects an increase of almost 100,000 additional migrants being served by beginning to incorporate service to migrants across categorical programs. Instead of serving migrants in 90 or 100 centers, the administration is proposing ambulatory centers up and down the migrant stream. In addition to that effort, the \$30 million being requested, and improved management efficiencies will result in a 25-percent increase in the actual numbers of migrants receiving care within the system.

Senator KENNEDY. Would you please give us a note on this, including, as well, what you are going to do, what you see as the increase in the number of people served, and how that is going to be done. I would like to get that as part of our record so we can follow that a little bit.

Dr. DICKSON. I think we have given this area a good deal of thought in the past year, and it has become apparent that to be effective here you have to extend beyond just using 319 authority; it has to be much broader. I think it will be much more effective, even though there is still \$30 million being used for this. We will get that to you, Senator.

[The following material was subsequently supplied:]

MIGRANT HEALTH PROGRAM

Currently, there are 700,000 migrant farmworkers and their dependents who follow the crops. An additional 2 million seasonal farmworkers live in areas where the migrants work.

In 1978 we anticipate providing services to 334,000 migrants and 165,000 seasonal farmworkers. We also plan to expand the number of high-impact areas served by providing care to migrants in ambulatory health care centers funded by other Bureau of Community Health Services authorities, including community health centers. We will continue to emphasize improvements in management efficiency for all projects.

Senator KENNEDY. You have got \$30 million in the 1977 appropriation, and the administration has proposed the same for 1978. What are you going to do about the 60,000 more people who need services?

Dr. DICKSON. Dr. Martin.

Dr. MARTIN. In that particular program, there are still significant improvements in efficiency and effectiveness. For example, the community health center program, with a fixed budget between fiscal year 1974 and fiscal year 1976 for a fixed budget increased the number of users by 70 percent and the numbers of encounters by 31 percent, by increasing physician productivity and decreasing administrative cost.

That same process is under way in most of these programs.

Of course, it frees up significant numbers of dollars from the administrative and poorly used productivity costs into patient care. That is where largely those increases come. The record is fairly clear on CHC's and becoming clear on migrant management. Improved management can result in significant increases that do not require additional dollars.

Senator KENNEDY. If we can, in both of these areas, I would like to get a description and analysis of what you expect to be done.

[The following material was subsequently supplied:]

INCREASED EFFICIENCIES IN COMMUNITY HEALTH CENTERS AND MIGRANT
HEALTH PROGRAM

The Bureau of Community Health Services requires all funded projects to be responsive to the health needs of the population it serves. Within that mandate projects are also required to be responsive to specific management and organizational efficiencies, where appropriate. Examples of these are:

Health Maintenance.—Program emphasis on provision of preventive, comprehensive health services to reduce the morbidity of the patients and to control costs.

Direct Health Services.—Many BCHS projects have demonstrated innovations in providing services which support the health and well-being of the people they serve.

Efficiency.—Assure that BCHS projects meet chosen indicators of productivity and program efficiency.

Specific Indicators.—Development of specific indicators of uniform performance and management for their specific purpose. The indicators are measured to give specific indication of operational efficiency and financial viability.

Senator KENNEDY. For the community mental health centers, what are you planning this year?

Dr. DICKSON. As I said before, I think the situation is much the same with respect to moneys that are available.

Senator KENNEDY. 1976 is 215 and 1977 is 232 and the Carter budget 233, is that correct?

Dr. DICKSON. Yes. Again, I think the program is being held stable through the coming year.

Senator KENNEDY. You have no new starts?

Dr. DICKSON. That is right. There are not any new starts.

Senator KENNEDY. People are going to ask me to explain why, on one hand we had the announcement by the White House of the formation of a Presidential commission on mental health, and here we have got a budget that allows for no new starts in a program that has done a first-rate job under difficult circumstances. I know the facilities in my own State are really excellent. What do I tell them? That, on the one hand, you are getting no new starts in the program, and this is the first time this has happened since the start of the program. And, on the other hand, we have a pronouncement from the White House in terms of how important mental health is. What do I tell these people?

Dr. DICKSON. I can only say to you what I said before about the general policy that was followed with respect to the budget for 1978, in terms of generally trying to make across-the-board restorations where the Ford administration had been making cutbacks, and not to expand except in a few areas in the coming year.

Senator KENNEDY. How many programs did they start last year, mental health centers?

Dr. PLAUT. Forty-seven new ones were started in 1976, Senator, and a number of centers are in the process of conversion from the previously required 5 services to 12 services. A substantial number qualify for the first time under the consultation and education program which is an indirect outreach service, as you know.

Senator KENNEDY. How many did you have the year before?

Dr. PLAUT. In 1976, there were 12 new centers started from the construction funds.

Senator KENNEDY. How many last year?

Dr. PLAUT. Forty-seven, but we anticipate that there will be an additional 34 new projects qualified and approved, but for which there will be insufficient funds to initiate them.

Senator KENNEDY. You had 34 in 1976, 34 last year, and now we are not going to have any? Tell me I am wrong.

Dr. DICKSON. I wish I could.

Mr. SOPPER. Senator, I would like to say that is true in terms of what the President has proposed as a result of the 3-week process to look at the budget. But the Secretary did say on Monday that he has not had the time to look at every item. As the appropriations process unfolds and he has more time to review some of these programs, he is sure some changes will be made. I think there is spirit and commitment on his part to not let things just stand pat.

Senator KENNEDY. That is certainly my impression in my conversations with him, where we have gone over these matters—and quite clearly President Carter has made a commitment to mental health.

Senator SCHWEIKER. What is the spirit of commitment in OMB? I would like to know that.

Senator KENNEDY. You probably have a good enough evaluation.

Dr. DICKSON. The last call I had before I came here was from the Secretary indicating that tomorrow morning there will be a meeting between the mental health people and the White House, Dr. Bourne and Dr. Bryant and myself and some representatives from the National Institute of Mental Health, discussing exactly what to do.

Senator KENNEDY. We are going to have to look into the authorization for these programs and figure out what we might expect in terms of the future and supplementals.

As for the Food and Drug Administration in fiscal 1976, it was 210 and 1977, 253, and for 1978 you propose that it goes up to 279. You are very much aware of the enormous responsibilities that the FDA has. I think in fairness to Dr. Schmidt, we just unloaded responsibility after responsibility on him, and we gave him inadequate resources to be able to carry those forward. He and others were really caught right in the middle of it. FDA is involved in some of the most important health areas including the quality of scientific research.

I know Dr. Frederickson is very much aware of it.

We added more responsibility to the FDA in terms of medical devices. We will probably add more in the cosmetic legislation. There is a whole new additional concern in terms of food additives and all its health implications. We will want FDA to fulfill its responsibility.

I am just wondering whether the budget request is consistent with these responsibilities, or whether we are going to find out 3 years from now that the new head of the FDA is going to say that the reason he was not able to do the kind of job he was asked to do was because of inadequate resources.

As a person who has attempted to fashion legislation which has given FDA some important new responsibilities and to hold them accountable in terms of performance, I do not want FDA leadership to come back and say, "You people just did not give us the resources to do this kind of job."

I would be interested if you would talk about how you think that they can fulfill their responsibility with this kind of budget.

Dr. DICKSON. I am thoroughly aware of the insistence you have had in the past year and meetings you have had on these issues. I intend to accent the things that you have mentioned here at the earliest opportunity. There is no question about the problem of demand, honest demand, on that agency versus its resources. It is a very difficult situation.

Senator KENNEDY. In the last year, we had good cooperation from Dr. Cooper. We did not have so in terms of OMB.

Senator SCHWEIKER. We never have had.

Senator KENNEDY. This is a very important area, involving the whole question of the quality of scientific research. This is going to be something that we are going to have to follow very, very closely. I know, again, from my conversations with the Secretary and the work he is doing in terms of assuring that he is going to fill the assistant secretary position with a person of high quality and competence. It is of utmost importance that we have someone in there that can speak effectively for the new administration.

Now in the area of NIH, there was \$2,300,000 in 1976 and \$2,500,000 in 1977, and you are holding it at \$2,500,000 for 1978. That probably does not include the cost of living increase, does it?

Dr. FREDRICKSON. No; that does not include the cost of living, Mr. Chairman.

Senator KENNEDY. It does not include the cost of living?

Dr. FREDRICKSON. No.

Senator KENNEDY. Would you like to speak a little bit about the budget, what this belt-tightening is going to mean in terms of the re-

search community? I think we have seen in some of these other areas where it is going to mean a holding pattern, some of the important areas of the health care system. I think all of us have an enormous respect for the NIH and the programs which it shapes and fashions.

What can we expect from what effectively will be a budget cut if we do not get a cost-of-living increase?

Dr. FREDRICKSON. Mr. Chairman, the President's fiscal year 1978 budget contains an increase of about 1.8 percent in current dollars. We estimate the rate of inflation in the area of research costs to be about 6½ percent at present. That is the deflator that we are using.

I think that this budget means that we will have to exercise great prudence in choosing the best priorities that we have. The allocations within that budget for the several institutes represent pretty close to the judgment that we passed on to the Department at the time this budget was being assembled. You will note that in the areas that we are discussing primarily today, the five areas whose reauthorizations are being considered, that the Cancer Institute's budget rises by about one-half percent between 1977 and 1978, and for the Heart, Lung, and Blood Institute, it is approximately 1 percent.

We have, in addition to that, four other items: National Research Service Awards, Medical Library Assistance, and population research, which are being considered here today for reauthorization.

Senator KENNEDY. You would not venture what you requested from OMB, would you, last year?

Dr. FREDRICKSON. Actually, by the time we got to OMB, Mr. Chairman, we had a figure which we were allowed to request. I think you see here an exercise in the direction on a preset level—

Senator SCHWEIKER. I gather that changed?

Dr. FREDRICKSON. It did change after it returned; yes.

Senator KENNEDY. Can you tell us how much it changed?

Dr. FREDRICKSON. Actually, Mr. Chairman, we were addressing a figure already supplied us by the administration prior to any submission to the OMB. That budget did change downward, somewhat, after it returned from OMB, on the order of \$40 million.

Senator KENNEDY. I just want to state for the record that I hope when you go back and talk to the Secretary about some of these matters that we raised this morning, you will tell him I was delighted to hear about his positive response to our January 21 letter on the new certificate of need regulations that appeared in the Federal Register. I think this is to be commended.

I think what we are seeing, hopefully, is a clear commitment to bring the regulations into compliance with both the requirements of 93-641 and its legislative history. I think Secretary Califano deserves a great deal of credit for giving us a prompt and satisfying response. It is a tough issue and there are a lot of pressures to bear on it.

As you bring back some of these other questions, I hope you will mention this. I am very much aware that in the establishment of a new administration and filling out positions that you have been under the gun. This is basically not the budget of the Carter administration, but the budget of the previous administration built upon and supplemented. These programs we have mentioned this morning I have talked to Secretary Califano about. He knows our interest and the interest of the committee. But I just want to give you the assurance

we are going to work very closely with you and to hopefully gain support for additional resources in these areas as the budget process moves along. Many of these programs have important implications in terms of cost and quality control. That, I know, is what the administration is concerned and interested in.

As someone who has commented on these matters time and time again, the cutbacks and stabilization of programs at minimal levels are matters which are important. These programs reach out to the people that, quite frankly, put President Carter in the White House. And these people are basically the ones that are most affected by these kinds of programs. I know he believes in these service programs deeply. I remember very well when we debated health security at the Governors' Conference, with Secretary Weinberger, and the head of the AMA in Seattle about 4 years ago. And the person who spoke in response to questions of these kinds, both on community mental health centers and neighborhood health centers, was Governor Carter.

He had understood it. Understood its implications in terms of the States. We want to make sure his concerns are reflected in his budget. Senator Schweiker.

STATEMENT OF HON. RICHARD S. SCHWEIKER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SCHWEIKER. The purpose of today's hearings is to receive testimony on two bills which extend existing authorities for health services and health research programs for 1 year. Both bills, as introduced, involve simple extension of expiring programs, with strictly technical changes in the existing law.

I have joined as a cosponsor of this legislation because I believe it is important that program continuity be maintained as Congress and the administration review proposals for substantive changes in such widely diverse programs as the National Cancer Institute and the Health Planning and Resources Development Act. There is no doubt in my mind that we are committed to health planning, cancer control and research, and other programs included in these bills, although it is possible some changes in existing programs are desirable. In the area of biomedical and behavioral research activities, for example, I look forward to participating in this subcommittee's comprehensive review of existing Federal efforts. In the meantime, however, we must meet Senate budget deadlines and I do not believe we can allow these vital disease control and research programs to lapse.

In some other instances, for example, the health planning and community mental health centers programs, more time is needed so that the existing law or changes in the original law enacted during the 94th Congress may be fully implemented and evaluated.

I commend Senator Kennedy's leadership in moving for prompt consideration of these bills. I appreciate the new administration's willingness to come before us today to express its views on this approach, and I hope we will learn of the concern felt by various interested parties as a part of today's hearing process.

Going back to the budget, as I read the budget: In both the Carter and the Ford budgets, there is zero requested for nursing, educational and institutional support, zero for optometry, educational and institu-

tional support, zero for veterinary medicine, zero for pharmacy, and so on. That is really the same pattern as under the Nixon administration. That has not changed at all in three administrations.

Where are the changes?

As I read it, the difference between the Carter budget and the Ford budget, in general, is only \$5 million, and that is in the National Institute of Child Health and Human Development. It looks like we are on a plateau.

Dr. DICKSON. I think, Senator, as I said before, there was an overall approach to the budget here, in which the intention was to try and repair the losses that occurred in general services in the Ford administration budget, and then to hold steady beyond repairing those losses in services during the coming year when we examine the entire program. That is the general umbrella under which we proceeded to generate the budget, except for some areas: children, immunization, and so forth, where we wanted to make initial signal at this time as to some feelings they had about where they would like to go.

Again, looking at the entire budget, within a period of 3 weeks, it simply was not possible to do much more than that. Many of these programs are clearly integrated with each other, and they will require further examination over the period of several months. That is the reason why there are not increases here and there, as people would like to see them.

Senator SCHWEIKER. I do not have all the figures in front of me. I bet there are not many segments of the Federal budget that do not increase at least the cost of inflation. I just bet there are not many segments or sectors or divisions in the Federal budget that really had zero population growth, so to speak, from last year to this year. I just bet that is the case.

Here we are with all of our health activities—heart, cancer, et cetera—and zero growth for inflation.

I have said this before. I criticized the Republican administration for making health the whipping boy for budget cuts because health budget is the one with the least visible constituency out there, and the one easiest to cut in terms of grassroots lobbying.

It looks like we are on the same track again. I just bet that just about every other segment of the Federal budget has had some kind of inflation rate increase. Correct me if I am wrong.

What other segment of the budget has not really grown? Why do we always single out health for this illustrious honor, and why does the health community stand for it?

Dr. DICKSON. You are asking me why in this period that the country's aspirations outdistanced its resources, and it is necessary to make judgments between defense, health, and other areas. That has not been my province, and no one has inquired of me how those distributions should be made. It is a very serious problem, clearly.

I think it is quite clear that after many years the country has finally come to the point where our aspirations have outdistanced the resources. There are choices that have to be made.

As you look back through history, mankind has probably not made better use of any money it ever had than putting it in health. There are other demands and other needs. Someone has to make a choice someplace. Everyone cannot be satisfied in a period when aspirations

outdistance resources. Someone has to make a judgment. These are passed on to the Public Health Service to do the best it can within those decisions. We are trying to do that.

Senator SCHWEIKER. Here is a position paper from HEW. It shows some of the inconsistencies that I have trouble reconciling.

This is in the booklet titled "Fiscal Year 1978 Budget Revisions," the background paper on health professions. I believe this is a document of HEW.

"The primary goal of the Carter budget for health professions in both fiscal 1977 and 1978 is to redress imbalances in the distribution of health professionals by specialty and by geographic area. This continues the shift away from earlier emphasis on increasing the overall supply of health care providers."

Now, right above this statement, if you look at the figures which show the current levels of expenditures in these areas, for health professions education, they are \$470 million for fiscal 1977, and \$470 million for fiscal 1978.

Yet on the other side of the sheet—this is on page 24—it looks like the Carter budget is \$448 million for the fiscal year we are in now, 1977. This is obviously a cut of some \$22 million. For the fiscal year 1978 that we are getting into, you are talking about a Carter budget, as I read these figures, of \$331 million, which is \$139 million cut, or a 20-percent cut.

How on earth can we accomplish these objectives, or even argue that we are standing still, when, as I read this document prepared by HEW, we are making a cutback even in this fiscal year, and a significant cutback in medical education for 1978?

Did I misinterpret the figures? Where have I gone wrong?

Dr. MARGULIES. Senator Schweiker, the reduction in the budget is associated with, as you have pointed out, a change in the legislation, Public Law 94-484, which clearly emphasizes a shift away from a quantitative approach to manpower—

Senator SCHWEIKER. The legislation did not cut the money.

Dr. MARGULIES. I am not saying that.

Senator SCHWEIKER. Go ahead.

Dr. MARGULIES. I do want to set the stage for what we have done. With that legislation there are opportunities provided for dealing with the issues of maldistribution, with a shift from high specialty to primary care, and with a general movement toward putting people in underserved areas. This can be done effectively with the budget which is available.

The key issues are the scholarship program, federally guaranteed student loan program, pay back mechanisms which are associated with national scholarship program activities, and the Graduate Medical Education National Advisory Committee's analyses, which are going to set the stage for reports to you on how specialty redistribution can be achieved.

What you are seeing is a shift away from an expansion of programs which are not tied to the targets identified in the legislation which you passed.

I would say this budget is quite faithful to purposes of Public Law 94-484.

Senator SCHWEIKER. What, in essence, are we cutting out? Obviously, if we are cutting \$22 million in this fiscal year, and \$140 million in the next fiscal year, something is suffering in medical education. Where are those cuts coming from?

Dr. MARGULIES. The major cuts are those in the nurse program, which is dropped from the present fiscal year to the next fiscal year with the argument that there is adequate support for the training of nurses at all levels. So when you drop that out, which is a separate kind of issue, which you may wish to discuss, and look at the amount which remains in Public Law 94-484, the Health Professions Education Assistance Act, the reductions are not that significant. There are programs which are dropped out. You will see changes in capitation levels. You will see in there certain kinds of special project activities which are diminished.

Quite frankly, the reason for doing that was to maintain a reasonable budget, but shift the emphasis toward redistribution, toward health service areas, and toward meeting the needs of physician shortage areas.

Senator SCHWEIKER. Of course, one side benefit of dropping that institutional support is that you are not bound by the trigger mechanism, so it enables you to cut deeper, because we did write in a trigger mechanism, tying capitation to scholarships, to ensure that the National Health Service Corps Scholarship program was funded.

Dr. MARGULIES. I do not really believe it was done for that purpose. If I may, I would like to comment on the advantages and long-term cost of the scholarship program which I personally think has not been examined thoroughly.

Senator SCHWEIKER. In your comment will you explain with a little more specificity where that \$140 million, you are cutting is actually coming from?

Dr. MARGULIES. The combination of the nurse professionals and health profession is reduced \$130 million plus. One hundred million of that is from the nursing program. The other, as you will see, affects segments of capitation, and so on. Some of the activities in public health are the main sectors which are reduced.

Senator SCHWEIKER. On what basis are you cutting \$100 million out of nursing? What is the logic, rhyme or reason for that?

Dr. MARGULIES. Based on the present output through various kinds of nurse training programs, the total number of nurses available, the areas in which they are likely to be found, and existing means of support, State, local and others, it was felt that there was not a need for continuing large Federal support. This is a position which has been maintained in the past, and I think this administration will probably continue to support that view.

What we really need is an increased emphasis of health care delivery in the primary areas of service, which this will allow us to do more effectively, than simply adding to the number of individuals being turned out of basic training programs.

Senator SCHWEIKER. There is another point I am not quite clear on: What is the rationale for knocking out the loan program?

Dr. MARGULIES. There is a change in the legislation which replaces the loan program with a special scholarship program for the disadvan-

taged. There is discontinuance of one, and replacement by another in that process, although it depends on which one of these particular items you are talking about.

Senator SCHWEIKER. Wait a minute. The Ford budget had it in. Ford put it in at a level of \$18 million. The 1976 level was \$24 million. The Ford budget, 1978, had \$18 million. The new Carter budget for 1978 has knocked it all out.

I do not see how we are getting people into the right specialties and the right geographic areas when we knock out \$24 million in loans which provide some incentive to do exactly that.

Dr. MARGULIES. The scholarship program, on the other hand, goes up \$40 million. There is a shift which is consistent with the legislation which you passed—

Senator SCHWEIKER. How many dollars? How many people will that cover? In other words, how many students will be covered for that fiscal year?

Dr. MARGULIES. In fiscal 1978, it will cover 4,000 students. There is also, as you know, a guaranteed student loan program which can add significantly to that. There is a special scholarship program for the disadvantaged. These are all being attended to in this budget.

Senator SCHWEIKER. Four thousand represents what percentage of the student group? In other words, how much of the medical student body will your proposal for National Health Service scholarships cover?

Dr. MARGULIES. I think it depends upon the extent to which it is distributed, and the amount that goes into all the scholarships, probably in the range of 25 percent. But I would have to give you some figures later on that. I am not sure. I would have to come back with some more data.

Senator SCHWEIKER. What percent? Say that again.

Dr. MARGULIES. As I say, I really do not know. I will have to come back on that.

[The following was subsequently supplied for the record:]

PROPOSED COVERAGE OF MEDICAL STUDENTS

The law authorizing the National Health Service Corps Scholarship Program requires that of sums appropriated for the scholarships, 90 percent shall be obligated for scholarships to medical, osteopathic, and dental students; and of such 90 percent, 10 percent shall be obligated for scholarships to dental students. The required distribution of the total therefore becomes: 81 percent for medicine and osteopathy, 9 percent for dentistry, and 10 percent for "other."

Assuming an average cost of \$10,000 per scholarship, the 1978 request of \$40 million would provide scholarships for 3,240 students of medicine and osteopathy, representing 5.1 percent of estimated total enrollment of such students in 1977-78. It would provide scholarships for 360 dental students, representing 1.7 percent of total enrollment.

Senator SCHWEIKER. That figure you shot out sounds rather high, I am afraid.

Dr. MARGULIES. Which group of students are you referring to? Which classification would you like covered in the response?

Senator SCHWEIKER. Basically, what do you mean by these HEW figures here, where you say the level for National Health Service scholarships will be \$40 million under Carter?

Dr. MARGULIES. If you look at the legislation, you will see that those scholarships are distributed according to specific requirements in the legislation. As you follow through those requirements, I think the percentage covered by those requirements will be higher than you have in mind.

Rather than guess at it, Senator, I would rather give you precise figures later. They are tied to a certain percentage which goes according to legislation to certain classes of students.

Senator SCHWEIKER. I am a little confused here, because as I read further, in your own explanation you say in fiscal 1978 the President has proposed a \$5 million increase in National Health Service Corps scholarships.

Now, that cannot be taking care of very many new people, with only a \$5 million increase, as I read this thing.

Dr. MARGULIES. You mean from one fiscal year to the next?

Senator SCHWEIKER. That is right. Here you are knocking out \$24 million in loans on the one hand, and only adding—again, these are your figures, and maybe I am confused in interpreting them, but you are knocking out \$24 million in medical student loans on the one hand, and only increasing the National Health Service Corps, which was the major vehicle Congress chose to meet the problem of geographic—

Dr. MARGULIES. That is right. You have also introduced in the legislation a federally guaranteed student loan program which is new, which will be initiated, which has something in the range of \$500 million potential in the first fiscal year.

Senator SCHWEIKER. My point is that we are knocking out \$24 million in student loans, and only increasing the National Health Service Corps, which I understood was the principal vehicle for alleviating maldistribution by specialties and geographic area, by \$5 million.

Dr. MARGULIES. If I may say so, I think that is not fiscally prudent, and a little reckless. If you will price out the control of the scholarship program on the pay-back basis, over outcoming years, you will see the cost of it will run between \$2½ and \$3 billion by the time you get all the pay back worked out. I am not sure the Congress had that in mind when they put the scholarship system in. If the program was to be funded at the levels authorized in the law, by 1981 there would be about 13,000 physicians potentially paying back services. The costs for that do not even take into account the business of placing, managing and supervising what they do.

I think it would be a good idea to look over the cost of this scholarship program very, very carefully in terms of the total cost over the next decade, and this is only for Public Law 484. If this is followed by further scholarship pay-back mechanisms, the cost will be extremely high. I personally do not object to it on budgetary basis; I do not think that was ever discussed when the bill was passed.

Senator SCHWEIKER. This committee held a great series of hearings on this whole issue. Both Senator Kennedy and I, and Paul Rogers and Dr. Carter in the House, all zeroed in on what would be the most effective and best route to go to solve the specialty and geographic maldistribution problems, and this scholarship program was going to be our principal vehicle.

Now, if you say our principal vehicle ends up with only a \$5 million increase, you are circumventing the thrust and intent of what our committee and the Congress decided to do.

While we can honestly differ on the effects of this, it really is contrary to the new bill we passed in terms of where the emphasis should be, and what we should be doing. You may honestly differ with us, but we did pass a law. We put a triggering mechanism in just to protect us from what is happening.

Obviously it did not work, because you got around it.

It looks like we are going to hit heads on this thing. We have not yet analyzed all the details and come down on it, but my preliminary thinking has got to be that your proposals are contrary to what this committee decided, what the House committee decided, and what the Conference Committee decided.

We have been legislating this thing for 5 years, fighting it through first with the Nixon administration, and then we had the renewal in the Ford administration. If we are going to battle again on it, what kind of health professions policy are we going to have?

You have a right to your opinion. We did legislate, and we did come to a conclusion. This has been a 5-year process. I have been on the committee 8 years, and for 5 years we have been battling this issue.

Now we come up through all the battling, vetoing from the Nixon administration, and rewriting the bill, and we are still on the wrong target, unless I am missing something here.

Dr. DICKSON. I think it might be helpful at this point, if we could, to submit for the record for you a careful profession by profession analysis of the impact of the 1978 budget.

Senator SCHWEIKER. That would be helpful, I agree. That would be very helpful.

[The following material was subsequently supplied for the record:]

IMPACT OF PRESIDENT'S 1978 BUDGET

The President's fiscal year 1978 budget of \$330.7 million for health professions education is directed toward providing available high quality health care to all Americans. Support is targeted toward alleviating the specialty maldistribution of health professionals by increasing the supply of primary care physicians and auxiliary personnel; redressing the problem of geographic maldistribution through scholarships tied to service commitments and programs to regionalize health professions education in medically underserved areas; assuring opportunities for the disadvantaged to pursue health careers; and increasing productivity and containing costs through more efficient use of personnel. Through the Public Health, Allied Health, and Nursing programs, emphasis is placed on the maintenance of health and on improving the efficiency and competence of health care personnel.

Capitation

Capitation grants provide a base of Federal financial support to health professions schools to assist them in meeting the costs of their educational programs in return for efforts to meet identified national health manpower needs. These include the maintenance or expansion of training capacity, increased emphasis on training for the delivery of primary care, training in medically underserved areas, and altering specialty and geographic distribution patterns.

The request of \$114.5 million in fiscal year 1978 will support 186 schools in the disciplines represented below:

	<u>Enrollment</u>		<u>Average amount per student</u>
Medicine			
Allopathic	59,388	X	\$1,350
Osteopathic	3,898	X	1,350
Dentistry	<u>21,470</u>	X	1,350
	84,756		

The average amounts per student compare with average amounts of \$1,100-\$1,200 proposed for fiscal year 1977.

National Health Service Corps Scholarships

The NHS Scholarship program will substantially influence the distribution of physicians practicing in rural or inner-city shortage areas by requiring one year of service in return for each year of scholarship support received. A minimum of two-years service is required.

Tuition and fees are paid directly to the school and the student receives 12 monthly stipends of \$400 per month. Eighty-one percent of the awards must go to students of medicine and osteopathy; 9% to students of dentistry; and 10% may go to other health professionals designated by the Secretary as in short supply in the National Health Service Corps.

The budget request of \$40 million for fiscal year 1978 will provide support for approximately 4,000 participants as follows:

	<u>Total</u>	<u>New Awards</u>	<u>Continuations</u>
Medicine	3,240	1,860	1,380
Dentistry	360	360	-
Nursing	52	- 1/	52
Other	348	320	28
Total	4,000	2,540	1,460

1/ In 1978, all nursing personnel included under "other" category.

The number of new awards to medical students in 1978 would be almost 500 more than the number proposed for 1977.

Assuming that appropriations for NHSC Scholarships continue at the level of \$40 million in fiscal years 1979 and 1980 (and then are phased out), and making certain other assumptions as to award distribution and deferral patterns, it is estimated that the following man-years of obligated service of physicians, dentists and others would be available:

<u>Year (July-June)</u>	<u>Physician man-years</u>	<u>Dentist man-years</u>	<u>Nurses & other man-years</u>
1979-80	1,477	69	350
1980-81	2,197	19	400
1981-82	2,414	172	400
1982-83	2,319	350	150
1983-84	1,963	361	-
1984-85	1,940	198	-
1985-86	2,225	180	-
1986-87	2,589	18	-

Federally Insured Loans

The Health Professions Educational Assistance Act of 1976 authorizes a new program of insured loans for health professions students (medicine, osteopathy,

dentistry, veterinary medicine, optometry, pharmacy (after third year of training), podiatry, and public health), effective in fiscal year 1978. Up to \$500 million in loans may be approved under this program in fiscal year 1978. Except for pharmacy students (who may borrow up to \$7,500 a year), these loans are allowed up to \$10,000 a year, at an annual rate of interest not to exceed 10 percent. It is estimated that a total of about 25,000 health professions students will be aided under this program in fiscal year 1978.

Loan Repayments

This program serves as an additional mechanism for attracting health professionals to medically underserved areas by providing for service agreements in exchange for repayment of up to 85% of educational loans incurred by health professions students. Individuals with degrees from accredited schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry and veterinary medicine, who obtained direct health professions student loans, are eligible to enter into an agreement with the Secretary for repayment of a part of these loans for practice in a shortage area.

For the minimum period of two years of service in a shortage area, 60 percent of the outstanding principal will be repaid (plus interest as it falls due). For a third year of service, an additional 25 percent of the principal will be repaid (plus interest as it falls due).

Three hundred health professionals practicing in shortage areas would have loans repaid under the 1978 request of \$1,500,000.

Exceptional Need Scholarships

This program is intended to encourage persons with limited resources to enter a career in the seven health professions (MOD, VOPP) and thereby assure that such education is accessible, not only to the wealthy, but also to students from low-income or disadvantaged backgrounds.

These scholarships assist full-time students with exceptional financial need in their first year of post-baccalaureate study at a health professions school. Scholarship recipients will receive a stipend of \$400 a month for living expenses, plus tuition and other reasonable educational expenses without incurring a service obligation.

The 1978 request of \$5,000,000 would support 500 financially needy students.

Dental Education - TEAM Grants

The program of Training in Expanded Auxiliary Management provides support to dental schools for the development and implementation of didactic and clinical training experiences which prepare dental students to organize and manage multiple-auxiliary dental practices, including the utilization of dental extenders. TEAM trained dentists operate at the patients chair utilizing dentistry assistants while traditionally trained dentists do not delegate direct patient care tasks to others. This training will

enable graduates to improve the efficiency of dental practice and the increased productivity resulting from greater efficiency should make more dental services available to more people, and be a significant factor in cost-containment.

¹⁹⁷⁶The request of \$2,100,000 would support 12 TEAM programs for approximately 800 students.

TEAM Projects	<u>1977</u>	<u>1978</u>
Number of projects.....	27	12
Students in training projects.....	1,725	800

Nurse Practitioner Programs

This activity provides support to programs which train nurse practitioners. The overall impact is improved accessibility, availability, and quality health care, especially in medically underserved areas.

Both shortage and the maldistribution of primary care health professionals are addressed by this program since nurse practitioners provide primary care in community and ambulatory care settings.

Presently there are about 8,000 nurse practitioners. The ¹⁹⁷⁸request of \$9,000,000 would support 45 nursing programs which have approximately 590 students in training as nurse practitioners.

Nursing Special Projects

The Special Project program is directed at improving the nursing education process and the product. This program aims to improve access to quality health care, to strengthen the nursing workforce's competencies, and to assure nursing opportunities for the disadvantaged.

¹⁹⁷⁸The request of \$6,000,000 would support 65 projects in the aforementioned targeted areas.

Nursing Scholarships

The Nursing Scholarship program provides scholarships up to \$2,000 per academic year to assist students having exceptional financial need so that they might undertake a course of study leading to a diploma in nursing, an associate degree in nursing, a bachelor's degree in nursing or its equivalent, or a graduate degree in nursing. Funds are allocated according to a legislative formula to participating schools of nursing education which in turn make scholarship awards to those in need.

The 1978 request of \$9,000,000 would provide scholarships averaging \$1,000 to 9,000 nursing students at 1,350 schools.

Grants to Graduate Programs in Health Administration

A number of current problems in the health delivery system, including high costs, inadequate access and inefficiency have been attributed in part to the lack of effective planning and management. Recognizing the need for increased numbers of appropriately trained managers in all segments of the health system, this new program of grants for graduate programs in Health Administration will support the expansion and improvement of graduate programs in health administration, hospital administration and health planning.

Under the ¹⁹⁷⁵ request of \$3,000,000, an estimated 30 public or non-profit private educational entities, including schools of social work, would receive grant awards.

Special Projects: Public Health and Health Administration

The 1978 request of \$5,000,000 would support approximately 100 projects training about 7,000 students in the following high priority areas: Biostatistics and epidemiology; health administration, planning, and policy analysis; environmental and occupational health, and dietetics and nutrition.

Allied Health Special Projects

This allied health program helps assure the availability of qualified health professionals through its credentialing and continuing education efforts. It influences the efficiency of health care services through role definition and career development projects. The program contributes to improved geographic distribution through regional systems of coordination and management.

The law stipulates that of the amounts appropriated for special project grants and contracts, 50% is to be reserved for awards to training centers for allied health professions. Priority would be given to programs training allied health professionals in specialties crucial to the support of primary care practitioners and in specialties with critical manpower shortages.

¹⁹⁷⁶
A The request of \$8,000,000 would support an estimated 150 projects.

Family Medicine Residencies and Training

This program supports development of family medicine faculty and family medicine training programs so that more family medicine practitioners will enter the health care delivery system where they are needed. It also supports efforts to increase the portion of training occurring in an ambulatory environment instead of in-patient hospital settings to assure that family medicine training occurs in a community setting.

The program is directed at making comprehensive personal health care available and accessible to medically underserved areas, an effort which must be considered a key part of a national goal of quality health care for all Americans. An adequate supply of such comprehensive personal health care practitioners is essential for any national health care program since such practitioners can and should handle the vast majority of patient complaints and illnesses. It will help to stabilize and reverse the significant downward trend in the number of family physicians which has occurred in the last 30 years and help assure the continued availability of needed family care to many communities.

A combination of allopathic residencies, osteopathic internships, faculty development and predoctoral training are supported under the family medicine residencies and training program.

The 1978 request of \$40,500,000 would support 146 residency projects training 2,850 residents (including 1,260 first-year residents); 30 faculty development projects training 300 faculty; and 60 preceptor training projects.

General Dentistry Residency Training Program

The General Dentistry Residency program will support the planning, development and implementation of didactic and clinical experiences that enable dental students to acquire the advanced skills and competencies that characterize primary care general dentistry.

¹⁹⁷⁸
The request of \$4,500,000 would support 20 grants, providing training and experience for approximately 200 students and faculty.

Primary Care Residencies

By promoting the training of primary care doctors in fields of general internal medicine and general pediatrics, this program will directly address the specialty maldistribution problem. The program also may help alleviate the geographic maldistribution problem since primary care practitioners tend to distribute themselves in more equitable proportion to the population.

The 1978 request of \$15,000,000 would support an estimated 96 residency projects training 675 residents.

Physician Assistants

This program supports the planning, development, operation, or maintenance of physician assistant training programs and the training of faculty to serve in such P.A. programs. The educational programs supported by these grants must have an orientation in the curriculum and a deployment mechanism which encourages the graduates to work in Health Manpower Shortage Areas.

The Physician's Assistants graduating from Federally funded programs directly impact on the primary care shortages recognized by Congress. Research has shown that primary care physicians' practices can be augmented by 40% to 70% by the introduction of appropriately trained Physician's assistants. Physician assistants deliver those primary care services for which they have been trained to function at the same competency as the physician, including: complete physical examination; analyses of patient complaints; performing attendant examinations; ordering laboratory tests; recording medical data and outlining treatment regimes within physician specified parameters. Research also demonstrates that 44% of P.A.'s are located in non-metropolitan areas, while only 14% of non-federal physicians are located in the same areas. Thus, we expect the P.A. programs to impact on the geographic maldistribution of health service problems.

1978
 The request of \$9,100,000 would help sustain 40 programs training 2,700 physician assistants and 6 faculty development projects supporting 60 faculty students.

Dental Extenders

The purpose of the Dental Extender program is to upgrade the training of dental hygienists and dental assistants to qualify them to assume expanded functions under the supervision of the dentist as members of the dental care team. The degree of task responsibility allowed dental extenders varies from state to state. Duties can include administering certain types of anesthesia, applying cavity liners and bases and placing and removing periodontal dressings. The use of dental auxiliaries increases the amount of services a dentist is able to provide, and potentially extends the mix of primary dental services. This contributes to cost-containment, alleviation of health manpower shortages, and broader accessibility to health care.

The 1978 request of \$2,000,000 would support approximately 24 programs, benefitting an estimated 1,200 students and faculty.

	<u>1977</u>	<u>1978</u>
Number of Projects.....	24	24
Number of Students and Faculty Trained.	1,200	1,200

Area Health Education Centers

The AHEC program is especially designed to alleviate the geographic maldistribution of health manpower and, to a lesser extent, specialty maldistribution. By supporting projects linking schools of medicine or osteopathy, and other health institutions to rural and urban communities, practitioners in training may develop commitments to serving in such underserved areas. Continuing education is provided to practicing health professions and basic training is afforded to students.

The 1978 request of \$15,500,000 would support 16 centers serving 18 states and 325 counties. These centers would train 9000 health professions students and 800 medical and dental residents. They would provide an estimated 62,500 hours of continuing education to rural health practitioners.

Disadvantaged Assistance

This program is one of the few training programs exclusively for individuals from socioeconomic backgrounds who are educationally or financially disadvantaged, and who are interested in pursuing a health career.

The types of programs supported are motivation, recruitment, admissions, retention and placement of these students. Funds are awarded directly to public, nonprofit private health or educational entities not to individuals. A limited stipend, however, is allowed for students participating in these programs.

The 1978 request of \$8,000,000 would support 100 projects benefitting 9,000 students.

Transfers from Foreign Medical Schools

This program supports grants to schools of medicine and osteopathy to plan, develop and operate programs to assist U.S. citizens enrolled in foreign medical schools before October 12, 1976 in transferring to U.S. medical or osteopathic schools with advanced standing. A major objective of this program is to identify the deficiencies that exist in the medical education of the transferring U.S. foreign medical students and to develop materials and methodologies for correcting these deficiencies. Eventually, such students may be integrated into the U.S. health workforce as highly qualified practitioners.

The 1978 request of \$2,000,000 would support 14 projects benefiting 600 students.

Graduate Medical Education National Advisory Committee

This Committee provides the Secretary of HEW with a resource group to address the problem of physician specialty maldistribution through the analysis of specialty requirements, the examination of the characteristics and outputs of the current specialty education system, and analysis of the effects which patterns of reimbursement and support for specialty education have upon the numbers and types of physician specialists being trained.

The request of \$1,000,000 would allow the Committee to examine issues, review analyses, and advise on data requirements and research needed to permit the CMENAC to fulfill its task of proposing national goals and recommending Federal policies, strategies and plans to achieve the established goals. It would also fund three analytic contracts required to support the Committee's mission and charter functions.

Health Professions Start-Up Assistance

This program provides grants to new MOD, VOPP and public health schools so that they may begin instruction earlier or substantially increase their enrollments over what would otherwise be possible.

The \$1,000,000 requested for 1978 will meet prior year commitments to seven schools in six states.

Financial Distress

This program provides financial assistance to health professions schools to meet costs of operation if in dire financial distress, to meet pressing accreditation requirements, or to carry out operational, managerial or financial reforms in response to a cost analysis study. A school may, in return for financial distress assistance, be required to reform its operation.

Financial Distress grants are intended to provide interim assistance to schools in serious financial straits. The amount of the grant to a school is limited to 75 percent of the financial distress grant to that school in the preceding year.

An estimated five schools would receive funds under the 1978 request of \$2,000,000.

Manpower Supply and Distribution Reports

These funds will provide a Congressionally mandated comprehensive program of studies on supply, requirements, and distribution by specialty and geographic location of health professionals.

The request of \$2,000,000 would support a program to generate the statistics and develop the analyses needed to design effective health manpower legislation, develop policy, and plan, develop and evaluate programs.

Health Teaching Facilities: Interest Subsidies

The Federal Government will continue to support construction for health professions education through loan guarantees for private non-profit schools. The Government also has the authority to guarantee the full amount of any losses in case of loan defaults.

The Interest Subsidies program provides assistance to eligible health professions schools or affiliated hospitals and out-patient clinics which did not receive construction grant support.

In 1978, \$2,000,000 is needed to pay the 3% interest subsidies on prior guaranteed loans of \$75 million for health professions teaching facilities awarded in 1972. Payment of these subsidies is a continuing commitment during the life of the 30 year loans. This assistance program provided expansion of training facilities at five institutions with an increase of 92 first year enrollment places, 369 new teaching inpatient beds and the replacement of 1,156 obsolete teaching beds.

Program Support

The Bureau of Health Manpower is responsible for the development, implementation, and operation of programs authorized under the newly enacted Health Professions Education Assistance Act of 1976, P.L. 94-484 and the Nurse Training Act of 1975, P.L. 94-63.

The 1978 request of \$23,020,000 and 668 positions is needed to carry out new initiatives directed in the health manpower legislation and also to provide for the orderly completion of activities supported in previous years.

Senator SCHWEIKER. I think what we also ought to have for the record is where we are cutting back, the impact that is going to have, and whether what you are adding really offsets the impact of your cutbacks.

I just have basic trouble with the fact that we wrote a new law, defined a new direction, a new thrust, and here in fiscal 1978, instead of your current level of \$470 million for medical education, we are down to \$331 million. Granted, a big chunk of that is nursing. I acknowledge that fact.

I wonder whether a \$5 million increase in fiscal year 1978 scholarship money—\$5 million for the whole thing, directed toward a whole new law, a law which you say you are not excited about—really does anywhere near what the committee and the Congress had in mind.

Dr. MARGULIES. Senator, I am sorry if I misled you in thinking I am not excited about it. I think this is one of the most remarkable, potentially effective pieces of legislation in a long time.

Senator SCHWEIKER. Well, then let's fund it.

Dr. MARGULIES. I am trying to describe the budgetary restrictions that were based on that funding process. I would like to have you look at the alternative choices, federally guaranteed student loan program and scholarships. I think you put them in deliberately. I think they provide alternatives, and are useful, and that we ought to employ them effectively.

Senator SCHWEIKER. Correct me if I am wrong, but in the guaranteed loan program that you are talking about, isn't one of the big features and options of this program the ability of students to buy out of it? Given that feature, the fact that you can buy out of any service obligation, emphasis on this loan program completely circumvents what we are trying to do, which was to channel people into needed medical specialties and into health manpower shortage areas throughout the country, without an option for them to buy out and not serve. If you buy out, you completely make an end run around the whole thrust of what we are trying to do, unless I am missing the point.

Dr. MARGULIES. There are two thoughts on that.

Senator SCHWEIKER. There sure are.

Dr. MARGULIES. As a matter of fact, you took very good account of that in the bill you wrote. If you look at the amounts they have to pay back, they are not slight; \$50,000 is not something that someone is going to pay back rather readily.

The Secretary has the choice of using payback mechanism in shortage areas, which he can utilize in the way the bill was written. I do not say that is a guarantee that mandatory process is, but it is an alternative which may prove quite effective.

Senator SCHWEIKER. With the buy-out concept, if you are well off and well to do, you are in great shape, but the people who are not well off end up on the other side of the coin. Right away you are differentiating in a way this committee was very concerned about, giving some people with more money the right to buy out and therefore not perform any needed service.

It looks to me as if you mean to make this vehicle, which in fact we did set up as an alternative but not as the main piece of action, the main thing. You mean to emphasize the program with the buy back

feature, and I think that is very disconcerting. I think we have to get all these figures on the record.

I think it would be very helpful if you would submit them for us in great detail, and break them down, so we can analyze them.

I would like to come back to mental health for a minute or two. Under the provisions of the 1975 law, centers providing children's services will lose funding if they cannot convert to full-fledged community mental health centers by the end of 1977.

Of course, some of these centers are in areas that are not served by community mental health centers and may not be able to support full-fledged centers now. Some people feel they ought to be allowed to provide their specialized children's services. I know what the law says, and what I am really seeking is an opinion, as to whether you have addressed yourself to this issue and formulated a position on it yet.

Dr. PLAUT. If I may respond to that—that is an issue dealt with in one paragraph of Dr. Dickson's opening statement. It has to do specifically with the question of whether or not a children's services grantee must provide all services required of a CMHC by the third year of funding after enactment of Public Law 94-63, pending substantive reconsideration next year.

The current situation, unless there is some change in the legislation, is that the 2-year requirement for having providing all 12 center services would prevent these children's projects from being funded during fiscal 1978.

I believe the paragraph in Dr. Dickson's opening statement indicates a willingness on the part of the Department and the administration to work with the committee to insure that the 1-year extension has that technical change in it, so these programs can be funded during this hold-harmless year.

Senator SCHWEIKER. It is further my understanding that some centers that want to convert to full service centers, as required by the 1975 amendments, have had conversion grants approved, but they have not been able to convert because conversion grant funding has not been available.

For this reason, many are concerned about the need to extend the 2-year grant limitation. Is your position on this the same as on the other question, the question of children's services centers? What is the administration's position?

Dr. PLAUT. It is correct that community mental health centers that are offering only the services required under the old act cannot continue to receive funds under the old act for a third year following enactment of Public Law 94-63. Unless they are able to receive a conversion grant during the third year, or some other assistance, some centers could not receive additional funding under the terms of Public Law 94-63.

Senator SCHWEIKER. Will you be recommending more money for conversion?

Dr. PLAUT. I believe there was an interchange between the chairman and Dr. Dickson on this issue, just as you came in, indicating that while the original proposal does not include this, the Secretary has not had an opportunity himself to go over all these matters in detail, and it is possible that might be modified when it is reviewed.

Senator SCHWEIKER. I do not know who would like to answer this question.

When can we expect to see an Assistant Secretary for Health on the job? Does anybody care to tackle that?

Dr. DICKSON. I think we would all like to know the answer to that.

Senator SCHWEIKER. I just thought I would ask.

In this case, no news is bad news instead of good news.

The Mental Health Association has prepared a statement of its position on the proposed extension of the community mental health centers program we are considering in this legislation. The association has made recommendations on suggested authorization levels for community mental health centers, some changes it would like to see in the present bill, and some observations on changes in the program we might want to contemplate in future legislation. The association has requested that this background material detailing its views be inserted in the written hearing record, and I ask unanimous consent that this be done. Also any other pertinent material supplied for the record.

[The following was subsequently received for the record:]

The Mental Health Association
1800 North Kent Street
Arlington, Virginia 22209

MHA RECOMMENDATIONS FOR THE BUDGET OF THE NATIONAL INSTITUTE OF MENTAL HEALTH FY 78

NIMH	APPROPRIATED FY 77	MHA RECOMMENDATION FY 78	NUMBER OF GRANTS 1978
RESEARCH	\$101.900	\$117	
TRAINING	86.600	*	
CMHCs			
Initial Operations	26.500	56.4	100
Planning and Development	1.	6.9	150
Consultation and Education	8.	7.8	100
Conversion	20.	25.3	100
Facilities Conversion			
Financial Distress (CMHC Subtotals)	7. <u>\$62.500</u>	3.9 <u>\$100.300</u>	<u>25</u>
Continuations under new law	<u>99.249</u>	180.699	
Continuations under old law	<u>98.592</u>	52.247	
RAPE PREVENTION	5. ¹⁹⁹³	**	
NIMH MANAGEMENT AND INFORMATION (including Central and regional offices)	<u>28.502</u>	<u>29.664</u>	
TOTALS	*** 482.343	*** 479.910	

* The MHA has not taken a position on mental health manpower training, but will make a recommendation after the NIMH Task Force completes its study of this area and issues its report.

** The MHA has not taken a position on the Rape Prevention Appropriation.

*** It is important to note that the FY 1978 total recommended by the MHA does not include an amount for training or rape control. The FY 1977 total appropriated for NIMH does include those two amounts, which came to \$91.6 million. Therefore, comparison of FY 77 and FY 78 totals given here should be treated with caution, because the data do not reflect totally identical program areas.

February 11, 1977

RECOMMENDATIONS OF THE MENTAL HEALTH ASSOCIATION REGARDING
AUTHORIZATION LEVELS FOR CMHCS IN FISCAL YEAR 1978
FOR CMHC RENEWAL LEGISLATION AND APPROPRIATIONS

The Association recommends \$100,300,000 in authorizations for new community mental health services in FY 78 (attachment #1). We are recommending that CMHC continuation costs be funded at the "such sums as needed" level, to permit the federal government to meet its continuing funding obligation to CMHCs in succeeding grant years. Following is a breakdown of our recommendations:

INITIATION GRANTS

The Association is placing particular emphasis on the need for an authorization of \$56.4 million for Initial Operations, which would fund 100 new Community Mental Health Centers (CMHCs) (See attachment A).

There has been a sharp reduction in funding for new Community Mental Health Centers since 1972. Following is a review of the recent history of Federal support to start new CMHCs.

FISCAL YEAR	FUNDS TO START NEW CMHCS	FUNDS FOR NEW SERVICES IN EXISTING CMHCS	CONSTRUCTION FUNDS	FUNDS FOR NEW CHILDREN'S SERVICES
1972	45.2	(Millions)	14.	10.
1973	40.5		18.4	11.7
1974	29.7		13.9	11.7
1975				
1976	24.	24.*		
1977	26.5	28.*		

(* - includes funds to convert from 5 to 12 services, and consultation and education money)

In 1972, there was \$45.1 million to start new CMHCs and that amount had decreased to \$26.5 million by 1977. If an inflation factor is added, the differential is even more startling.

It is true that as of 1975, the Federal government started to put some funds into the development of new services in existing CMHCs, in addition to providing support to start new centers. Important as funds for new services in existing centers are, they do not help that 60 percent of the nation that still has not received its first dollar in CMHC start-up funds.

There is a considerable accumulation from previous years of approved but unfunded Community Mental Health Centers grants. Currently, there are 38 communities awaiting initiation grants to start new centers, and many more will be added to that list shortly. In addition, there are 139 other grants that have not been funded, in areas related to Consultation and Education, Conversion grants, etc. The total needed to fund all of these grants, and the start-up grants, is \$51.2 million. We want to underscore again that all of these grants are a back log from previous years. During FY 78, an equal number of grant requests is anticipated. The need is there. It is just a question of getting the additional funds.

It is also important to note that the Federal funds represent only about 35 percent of the total dollars that are being spent on CMHC services. The other largest part of the funding dollar comes from state government (30 percent), followed by local government (11 percent).

Congress has established a goal of complete national coverage of 1500 Community Mental Health Centers by 1980. Presently, there are 649 Federally funded centers. Although the Association has concluded that it will not be possible to achieve the 1980 target, it is crucial that Congress support a very substantial increase in the FY 78 funding for new centers, if the nation is to make even modest progress toward the goal of national coverage.

PLANNING AND DEVELOPMENT

The Association is recommending \$6.9 million which would provide 150 Planning and Development grants. Recognizing the strong support from the Administration for moving the CMHC program forward and anticipating continued strong support from Congress, the Association is recommending funding for 150 new Planning and Development Grants. A number of communities have held back in recent years in planning for new CMHCs because of the previous Administration's opposition to funding Centers. There are currently 40 approved but unfunded planning grants, and it is expected that the momentum of the receipt of planning grants probably will accelerate later in the fiscal year. Funding for 150 new Planning and Development grants would provide adequate support to meet the expected new impetus coming from communities throughout the country.

CONSULTATION AND EDUCATION (C & E)

The Association is recommending \$7.8 million for FY 78, which would provide for 100 new C & E grants.

Centers, by providing C & E services, reach out into the community. They consult at the local level with individuals and groups, including clergy, police, schools and courts, who are the first to come in contact with people suffering from emotional problems. This results in early case-finding, an important part of preventive mental health services. It also allows for early intervention in life crises, which can reduce the incidence of mental illness. This service is truly on the cutting edge of Community Mental Health Center care.

CONVERSION

The Mental Health Association is recommending \$25.3 million, which would provide for 100 conversion grants. Funding of conversion grants for CMHCs has been seriously short in both FY 76 and FY 77. As a result, many Community Mental Health Centers that wanted to convert from 5 to the newly mandated 12 services, have been unable to do so. This is in the face of the fact that such conversion was mandated by the CMHC Act passed in 1975. \$25.3 million would be sufficient to meet the need in FY 78, assuming that centers will be given two years after receipt of the conversion grant to provide these 12 mandated services.

FINANCIAL DISTRESS

The Mental Health Association is recommending \$3.9 million, which would provide for 25 Financial Distress grants. The Association has had mixed feelings regarding their support of the financial distress program. To provide much in the way of support to the communities that have already received eight years of federal grant support, while two-thirds of the nation goes without any federal start-up funds for CMHCs, is questionable practice. We support distress grants only where the need is well-documented, and the CMHC has carried out a well-planned effort to seek other funds.

2/11/77
Mental Health Association,
National Headquarters
1800 N. Kent, Suite 200
Arlington, Va. 22209

CONTINUED SUPPORT FOR CHILDREN'S SERVICES UNDER THE CMHC ACT

Nineteen Children's Services (part F of the CMHC Act of 1975) are in catchment areas not served by Centers. Current law states that unless they convert to become full fledged CMHCs, they will lose Federal funding at the end of FY 77. Many of these nineteen are special services that do not easily lend themselves to providing an adequate base to become a CMHC. They should be "grandfathered" so that they can complete their recommended periods of support without becoming a CMHC.

CMHC CONVERSION GRANTS

The 1975 CMHC Act required that all Centers convert from five to twelve services within two years. However, appropriations have been inadequate to permit all CMHCs to convert to the twelve mandated services.

Centers qualifying for and unable to obtain Federal assistance for conversion should not lose all Federal assistance because of failure to meet the requirements of the 1975 Act. Such Centers should have two years after receipt of a Conversion Grant to meet Section 201 of the CMHC Act. In addition, at least one more year's authorization is required, and possibly two years.

FEDERAL MATCHING FUNDS FOR STATE WIDE COMPREHENSIVE
COMMUNITY MENTAL HEALTH PLANNING PROJECTS

The President ^{has just established} ~~is expected momentarily to establish~~ a President's Commission on Mental Health, which will study and make recommendations regarding major unmet mental health needs in the nation. A similar study has not been conducted since the Joint Commission on Mental Illness on Health in 1961.

In follow-up to the 1961 Joint Commission Report, Federal matching funds were provided to states to carry out statewide comprehensive community mental health planning projects. Those planning projects resulted in many changes in the care and treatment of the mentally ill, including the enactment of Community Mental Health Service Acts in a number of states.

The Joint Commission Report and the state mental health planning that followed were complementary. Both were needed to achieve change. The Joint Commission detailed mental health problems on a national level, but the state planning was essential if the states were to discover and take action on their own mental health needs.

In recent years, there have been major changes in the delivery of mental health services. But it is not clear that adequate services are being delivered. Indeed, there are indications of major gaps, such as failure to provide adequate assistance to patients leaving state mental hospitals.

There are many other questions and problem areas that should be addressed through a new statewide planning effort. Therefore, the Mental Health Association is recommending that in 1978, legislation be enacted that provides for Federal matching funds to states to engage in statewide comprehensive community mental health planning projects. It may be appropriate for such projects to be funded as a part of legislation providing for long term extension of the CMHC Act.

Specifically, the purpose of the planning effort would be to encourage the states to:

- 1) Consider the advantages of developing an integrated mental health delivery system, bringing together the state mental hospitals and community mental health services. This might include having all patients who are admitted to state mental hospitals enter through the Community Mental Health care system. It might also include financial incentives to community mental health care contained in "single stream" funding. That is, it could provide funds to the Community Mental Health systems, which in turn could fund state mental hospital care, similar to the California system. It might include taking steps to develop a system which provides for continuity of care, including emphasis on the provision of community support systems for persons leaving state mental hos-

pitals and other mental health facilities.

- 2) Begin planning for the advent of national health insurance and its impact on state funding of mental health services.
- 3) Study and make recommendations concerning the development of a continuing mental health planning capacity within the state mental health authority.
- 4) Consider how much of a state mental health authority's efforts should continue to be focused on the delivery of services, as opposed to becoming principally an authority for planning, financing, program review, etc., of mental health services.
- 5) Examine the state mental health code in relationship to new model mental health codes now available.
- 6) Plan for more adequate utilization of Title XVI (Supplemental Security Income) and Title XX (Social Services) funds under the Social Security Act.
- 7) Review the Medicaid policy in relationship to funding of mental health services.
- 8) Consider mental health research needs and possible state involvement in funding more research.
- 9) Study the need for developing an ongoing mental health manpower training capacity at the state level.

February 17, 1977

CONSIDERATION OF PERMITTING COMMUNITIES TO START COMMUNITY MENTAL
HEALTH CENTERS WITH FEWER THAN TWELVE SERVICES, AND A LONGER
TIME PERIOD TO ACHIEVE THE TWELVE MANDATED SERVICES

The Community Mental Health Centers Act, as amended in 1975, mandated that all new CMHCs provide twelve services, instead of just five, as required under the old legislation. It also mandated centers currently receiving Federal funds to develop the twelve services within two years.

The increased funding needed to start new CMHCs providing the full twelve services, and the increased money needed to convert existing centers to twelve services, have made it more difficult for those communities that have no Federal CMHC start-up money to obtain such funding. Presently, 649 communities out of 1500 have received Federal funds to start new CMHCs.

In 1977, \$26.5 million went to start new centers, while \$28 million went to provide new services in existing centers.

The Mental Health Association recommends that this problem be studied in depth, with a view toward spreading the Federal dollar to more communities that have received no Federal funds. This might mean cutting back on the number of services required to start new CMHCs, and permitting a longer period until centers would have to provide the full spectrum of twelve services.

February 17, 1977

BRINGING THE CMHC ACT AND THE HEALTH PLANNING ACT
INTO CONFORMITY

Changes are needed in the CMHC Act and the National Health Planning and Resources Development Act to bring several provisions in the one act into conformity with the other.

- 1) The CMHC Act should require that its catchment areas be changed so that none lies in more than one Health Service Area.
- 2) The composition and definition of the governing board memberships should be changed in the Health Planning Act to be consistent with the CMHC Act.
- 3) The CMHC Act and the Health Planning Act should be modified to require that provisions related to CMHC planning mandate their integration into the Health Systems Agency and state plans.

February 17, 1977

John H. Vetne
303 S. Illinois St.
Arlington, Va. 22204

April 4, 1977

Hon. Edward M. Kennedy, Chairman
Subcommittee on Health and Scientific Research
Rm. 431, Russell Senate Office Building
Washington, D.C. 20510

Re: S - 755, Health Services, Hemophilia and
Health Planning and Development Extension
Act of 1977. Amendments relating to
medical student transfers.

Dear Mr. Chairman:

I write this in anticipation of -- and in opposition to -- "technical" amendments to S-755. I respectfully request, further, that these comments be made a part of the hearing record on the bill.

Section 7(i)(3) of the House Bill (H.R. 4976) contains a proposed amendment postponing the effective date of medical student transfer provisions of the Public Health Service Act (§ 771(b)(3)(A))^{1/} which would substantially and adversely affect thousands of American students studying in foreign medical schools, including approximately 2,500 American students at Guadalajara (Universidad Autonoma de Guadalajara).

In the six months that have passed since the Act was approved, the Department of H.E.W., disregarding the express congressional mandate that the transfer provisions are to become effective the Fall Semester of this year,^{2/} has failed to issue even proposed rules or to actively solicit public comment. It is recognized that drafting regulations may require complex considerations, however, H.E.W. could clearly publish proposed, broadly defined guidelines and receive the benefit of objective public comment, with a view to implementing regulations flexible enough to meet specific problems that may come up.

H.E.W. laid the groundwork for its foot-dragging shortly after the Act was approved by the President. In November 1976, the Department issued the following statement: "It is possible ... that the provision could be amended before it takes effect." In December H.E.W. published this statement: "Pending clarification of requirements, it appears that a student identified by the Secretary as eligible would NOT be ASSURED of a position in a U.S. medical school, at least not in any given year." (underscoring supplied)

^{1/} Enacted as part of the "Health Professions Educational Assistance Act of 1976, P.L. 94-484; 90 Stat. 2243, Approved, October 12, 1976.

^{2/} According to the terms of the Act, § (3)(A), the Fall 1977 Semester is "the school year beginning immediately before the fiscal year" starting October 1977.

Thus, in arrogant disregard of the statutory time-frame, the Department of H.E.W., in ostrich-like fashion, has avoided its responsibility rather than acting upon it.

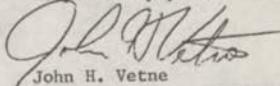
In a very brief exchange during House hearings (Tr., Vol. I, pp. 62 - 64), the issue was all but ignored. Rep. Rogers indicated to Dr. Margulies (Dep. Administrator, Health Resources Administration, H.E.W.), that amendments would be made to accommodate H.E.W.'s problem.

I urge you, and the members of the Health Subcommittee, when this comes up, that H.E.W.'s bureaucratic delinquency not be condoned by legislative amendment, but rather that H.E.W. witnesses be required to explain their inaction, and further, that the committee go on record by emphasizing executive branch responsibilities to carry out existing law.

My brother, and thousands like him who have a record of academic excellence and a burning desire to practice medicine, but who have found a limited and restrictive domestic medical school market, are anxious to participate in the well-conceived transfer plan. Their present frustrations with H.E.W. are complicated by National Board of Medical Examiners' action, within weeks after the law was enacted, restricting access to the examination for students studying abroad.

Your efforts, and that of the committee, are greatly appreciated.

Respectfully yours,



John H. Vetne

cc. Sen. Pell
 Sen. Nelson
 Sen. Hathaway
 Sen. Schweiker
 Sen. Javits
 Sen. Chaffee
 Dr. Margulies, HEW
 Kathy Henderson, Health Subcommittee

AMERICAN FEDERATION OF LABOR AND CONGRESS
OF INDUSTRIAL ORGANIZATIONS,
Washington, D.C., February 28, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Health and Sciences Subcommittee, Human Resources Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The AFL-CIO strongly supports S. 754 and S. 755. These bills would extend present programs for biomedical research and associated programs; and health services and health planning for one year.

We concur with what we believe to be the majority sentiment of the Senate that these health programs, the authority for which would expire in 1977 without congressional action, should be extended for one year in order that the administration be given time to develop their plans for improvements and establish their priorities.

We are, therefore, opposed to any substantive amendments to these Public Health Service programs at this time.

Sincerely yours,

ANDREW J. BIEMILLER,
Director, Department of Legislation.

TESTIMONY BY R. LEE CLARK, M.D., PRESIDENT, AMERICAN CANCER SOCIETY, WITH REGARD TO RE-EXTENSION OF THE NATIONAL CANCER ACT OF 1971 (PUBLIC LAW 92-218) AS EXTENDED (PUBLIC LAW 93-352)

Mr. Chairman, I want to thank you for inviting the American Cancer Society to testify before the Subcommittee on Health and the Environment on the subject of extension of the National Cancer Act.

This is a brief presentation in view of the subcommittee's decision to extend the law for 1 year at this time and to investigate longer term extension later this year.

The Society is in favor of the extension of the National Cancer Law. We further submit in this statement a few comments in justification of that extension, anticipating a more extensive justification for your continued support of the National Cancer program when hearings are reconvened some months from now.

The Society's suggestions for modest changes in the law I will detail shortly, but first I would like to put into the record an interesting few facts on cancer mortality.

The Metropolitan Life Insurance Co. has the most up-to-date large-scale tally of cancer deaths. In 1970 cancer mortality among the company's standard ordinary policy holders was 3 percent below that for 1975. Data are adjusted by the company so that the trend is not warped by the year-to-year difference in ages of the persons covered.

Next month the company will publish their data, attached to this testimony in appendix A, showing that deaths from every type of cancer they measured were percentage points below 1975, with death from Hodgkins disease 17 percent below 1975.

I'll mention other signs of truly significant progress in a moment.

Section 408 of the National Cancer Act concerns cancer centers (see appendix B). Establishment of centers under section 408 has been done with core grants. Beyond core grants, center investigators work under basic and clinical research grants. The law authorizes training grants and support for demonstrations by centers of diagnosis and treatment methods deemed likely for effective use in the general population.

Under the present statute, core grants are for 3 years, but may be renewed for 3-year periods.

The American Cancer Society suggests that the law be changed to 5 years, instead of 3. Much of the work done under core grants is organizing, sometimes organizing that reaches out into the community, involving institutions with which the center has not before jointly worked. This, and other new duties of the centers, require long lead times. Just about the time the work gets under way, a new grant application must be written.

This is wasteful of scarce time. The people who must participate in grant writing are the people who do the work under the grant for the most part. A good grant application takes months of careful work and involves great detailed attention to complex application requirements.

An interval of five years for these grants would save money as well as provide a better period for truly reliable evaluation of the center's progress.

This would be in line with legislation you passed with regard to similar grants under the National Heart and Lung Act.

The center grants authorized by Sec. 408(b) are restricted to \$5 million per year per center. This limitation is suitable as originally conceived, but in operation has dwindled both by center's rising overhead costs, over which the National Cancer Institute has no control since they are set in government-wide negotiations, and through inflation.

The American Cancer Society supports the \$5 million restriction with the modification that it be exclusive of indirect costs and that an adjustment equal to the percentage rise in the Consumers' Price Index since the National Cancer Act of 1971 be allowed whenever such a grant is made.

The act should be amended to permit the distribution of chemical carcinogens and animals to investigators who are not NCI contractors or grantees. The HEW general counsel has ruled against this practice, but cooperation by the National Cancer Institute with the Occupational Safety and Health Administration and others requires this, because these items are often not commercially available.

In accord with the Intergovernmental Personnel Exchange Act, we recommend that reimbursement for travel and two-way moving expenses be paid for expert consultants providing limited tenure work for the National Cancer Institute. These experts have provided crucial help when the Institute would otherwise have had to contract out or delay activities because of employment ceilings imposed, not by the Congress, but by the Office of Management and Budget. These experts are working, in fact, at a savings to the U.S. Government because they do not share in the full range of usual employee fringes, including the very important one of retirement pay. They are much more subject to National Cancer Program planning and supervision from the National Cancer Institute program leaders than would be the same persons working for an outside contractor.

In addition to providing these emoluments for these experts, an additional 100 such positions could be utilized economically by the institute, and the American Cancer Society recommends that the law provide for them.

We recommend for fiscal year 1978 an authorization of \$104 million for cancer control work and an authorization of \$1,196 million for cancer research to make a total of \$1,300 million for fiscal 1978's authorization. We intend to present proposals for later years at your hearings on extension later this year.

There has been comment that your Subcommittee is considering a cost-of-living increase of 10 percent on authorizations enacted in the current round of short-term health law extensions. This would work a hardship on the National Cancer Institute staff and retard progress under the National Cancer Law and provide only \$97.3 million for cancer control instead of what we request. We hope the reported 10 percent figure is incorrect. Thus where we request \$104 million for cancer control the 10 percent figure would produce a short-fall of \$6.7 million. For research, the 10 percent would authorize \$1,082.4 million instead of the requested \$1,196 million, a short-fall of \$113.6 million.

In cancer control there will be practically no new activities initiated in fiscal 1977 because of lack of funds. In research, the National Cancer Plan's proposed NCI Federal lead agency role has been severely curtailed by failure of authorizations and appropriations to provide adequate support for statutory responsibilities under this, and other, acts including the Toxic Substances Act.

Congressional largesse vis-a-vis the National Cancer Institute has been grossly exaggerated as measured against the Institute's innovative responsibilities. There is no possible way to maintain the Institute's traditional high quality of administration and surveillance of grant and contract work if fewer site visits must be made, if the workload of interim and final research reports review is doubled or tripled where staff increases have been fractional.

Community based activities are seen as essential to the practical development of workable models for upgrading the therapeutic treatment that the vast majority of cancer patients receive—only 15 percent of them are treated at comprehensive cancer centers—a large amount of staff and consultant time is required.

Since the passage of the original National Cancer Law, research on lung cancer, bone cancer and leukemia has expanded, and that expansion has paid off

in new therapy approaches for thousands of patients with cancer. In other areas such as prostate cancer and colon-rectal cancer, however, clinical research is far too limited in light of the fact that yearly there are 19,300 deaths from prostate cancer and 49,000 deaths due to colon-rectal cancer.

For the first time in several decades prostate cancer therapy has begun to show advances in useful and productive life extension, but research is still limited far below the nation's capacity for investigation. There is urgent need for a larger proportion of today's patient flow to be subjected to research protocol and studied by epidemiologists, surgeons, chemotherapists and radiologists influenced by the sophisticated knowledge flow emanating from the National Cancer Institute. This cannot be done without more money.

This Subcommittee enacted the last National Cancer Law extension in 1974. Consumers' Price Index for 1974 was 147.7 (Statistical Abstract, 1975 edition, p. 422). The Consumers' Price Index for December 1976 (U.S. Dept. of Labor press release) was 174.3, or 18 percent above the 1974 figure.

The American Cancer Society is requesting an authorization no larger, in percent, than the increase in the Consumers' Price Index.

We are in sympathy with this subcommittee's moves in recent years to bring authorizations down to more realistic levels. We commend the Subcommittee for eliminating the fiction that caused great misunderstanding among citizens. But that work has now been done. The authorizations are now so close to pare-to-the-bone budgets that there is little leeway for the interchange among budgeters and appropriators, which is essential to completion of the appropriation process. It is still impossible for the agency or the citizen to ask for a dollar and get a dollar from an appropriations committee, no matter the impressive strength of justification. The figures herein requested by the American Cancer Society are highly realistic and should be enacted to protect the momentum of the National Cancer Program.

There are more than 1,500,000 Americans alive today who have been cured of cancer—and free of the disease at least 5 years after diagnosis and treatment.

Each of you on this subcommittee very likely knows someone who has had cancer and is back in a normal life schedule. Several are on the Hill.

And if you go to your local doctor in Washington, D.C., you will possibly be asked to take a "routine" CEA test. It's given in many cities now, but was only a research idea when the National Cancer Plan commenced. The question of "markers," of which the CEA test is one, was highlighted in the report by the Panel of Consultants to the Senate in 1970. The Carcino-embryonic Antigen (CEA) test was then one of the beckoning research possibilities the National Cancer Plan was designed to exploit. It has now become an important part of the diagnostic as well as the prognostic workup for colon-rectal cancer.

Another test, long possible with available science before the enactment of the National Cancer Law, has now become routine, the Hemocult test, as it is called by the test kit manufacturer, SmithKline Corp. This is a test which identifies blood that is in the feces but which in small quantities is invisible to the naked eye. SmithKline reports that the test is frequently used in 4,500 of the nation's 7,000 hospitals, routinely in the larger ones. It is used in 15,000 to 25,000 physicians' offices. The American Cancer Society has developed strong community education and implementation programs whereby large numbers of persons are screened with the Hemocult test.

There is little question that this simple, extremely valuable test, which in fact can be administered by the test subject, himself, was marketed partly because of the impetus given cancer work by your legislation. A test subject just sends an ordinary mailing envelope to a laboratory where a special kit he used is analyzed and results returned by mail. A product, in part, of the atmosphere created by your legislation, it did not cost the American people any federal outlay.

Maybe the Subcommittee considers that sort of advance non-specific as regards the law. The American Cancer Society believes the general "can do" attitude these days about cancer is an extremely important result of your legislation.

A great many claims can be made for truly significant progress against the various cancers. Eleven are curable that were not curable ten years ago, if diagnosed in time, however most of those are relatively minor in incidence. Under the National Cancer Plan advances are accruing against the major cancers such as breast, lung, bowel, bladder, prostate, and pancreas. The Society will present extensive data on this at the next National Cancer Law hearings.

For the present, some mid-1976 figures should be of interest as examples:

1. In disseminated breast cancer, chemotherapy with combination drugs has tripled the median survival time. Single drug chemotherapy under regimens in use when the National Cancer Plan went into effect resulted in a median survival time of 8 months after diagnosis. That survival is increased to 15 months for 44 patients fortunate enough to enroll in one of the best multidrug clinical trials, and in over 22 months for 45 patients, many still alive and leading normal lives, after enrolling in a clinical trial on immunotherapy plus combination chemotherapy.

Incidentally, immunotherapy is scientifically esoteric, but clinical action is so simple that spouses of cancer patients are being taught in some instances at M.D. Anderson Hospital to give the patients treatment at home. (The hospital is administered by American Cancer Society President B. Lee Clark, M.O.)

2. In osteogenic sarcoma, an ongoing study at the Sidney Farber Cancer Center has produced 80 percent disease-free patient survival after two years. The historical survival rate was 20 to 25 percent, by contrast, showing another magnificent advance.

At future hearings on the National Cancer Act we will present details of the progress and accomplishments including advances in the treatment of human cancers which have been made under the National Cancer Program since its inception in 1971.

APPENDIX A

CANCER MORTALITY REPORT STANDARD ORDINARY POLICYHOLDERS, METROPOLITAN LIFE INSURANCE CO. 1976 COMPARED WITH 1975

Cause of death	Death rate per 100,000 in 1976 ¹	1976 death rate as percent of that in 1975 ¹
Cancer—all forms.....	152.4	97
Digestive system.....	39.8	95
Respiratory system.....	41.5	99
Lung.....	49.7	99
Breast.....	10.6	97
Genital organs.....	14.7	99
Hodgkins disease.....	1.2	83
Leukemia.....	6.2	95
All other cancers.....	41.8	99

¹ Death rates for 1975 are adjusted to correspond to the age and sex distribution of the standard ordinary policyholders in 1976.

"NATIONAL CANCER RESEARCH AND DEMONSTRATION CENTERS

"SEC. 408. (a) The Director of the National Cancer Institute is authorized to provide for the establishment of fifteen new centers for clinical research, training, and demonstration of advanced diagnostic and treatment methods relating to cancer. Such centers may be supported under subsection (b) or under any other applicable provision of law.

"(b) The Director of the National Cancer Institute, under policies established by the Director of the National Institutes of Health and after consultation with the National Cancer Advisory Board, is authorized to enter into cooperative agreements with public or private nonprofit agencies or institutions to pay all or part of the cost of planning, establishing, or strengthening, and providing basic operating support for existing or new centers (including, but not limited to, centers established under subsection (a)) for clinical research, training and demonstration of advanced diagnostic and treatment methods relating to cancer. Federal payments under this subsection in support of such cooperative agreements may be used for (1) construction (notwithstanding any limitation under section 405), (2) staffing and other basic operating costs, including such patient care costs as are required for research, (3) training (including training for allied health professions personnel), and (4) demonstration purposes; but support under this subsection (other than support for construction) shall not exceed \$5,000,000 per year per center. Support of a center under this section may be for a period of not to exceed three years and may be extended by the Director of the National Cancer Institute for additional periods of not more than three years each, after review of the operations of such center by an appropriate scientific review group established by the Director of the National Cancer Institute.

AMERICAN COLLEGE OF CARDIOLOGY,
Bethesda, Md., February 23, 1977.

HON. EDWARD M. KENNEDY, *Committee on Human Resources, Senate Subcommittee on Health and Scientific Research, Dirksen Senate Office Building, Washington, D.C.*

DEAR SENATOR KENNEDY: Pursuant to the request of the staff of your Subcommittee, the American College of Cardiology is taking this opportunity to submit testimony pertaining to the extension of the legal operating authorities of programs of the National Heart, Lung, and Blood Institute and the National Research Service Awards Program. If I can provide you with further details regarding our recommendations, please let me know.

Sincerely,

CHARLES FISCH, M.D., F.A.C.C.,
President.

Enclosure.

STATEMENT OF DR. CHARLES FISCH, DISTINGUISHED PROFESSOR OF MEDICINE, AND DIRECTOR, KRANNERT INSTITUTE OF CARDIOLOGY, INDIANA UNIVERSITY SCHOOL OF MEDICINE, PRESIDENT, AMERICAN COLLEGE OF CARDIOLOGY

Mr. Chairman and members of the subcommittee: I would like to thank you for inviting the American College of Cardiology to submit its views on legislation pending before you to extend the operating authority of the National Heart, Lung, and Blood Institute. For the record, my name is Dr. Charles Fisch and I am Distinguished Professor of Medicine and Director, Krannert Institute of Cardiology, Indiana University School of Medicine. I am also President of the American College of Cardiology. It is in this last capacity that I submit this testimony to you. As you may know, the College is a professional medical specialty society of more than 7,000 physicians and scientists who specialize in cardiovascular and other closely related disorders.

May I preface my statement by saying that the College supports fully the activities of the NHLBI. In Dr. Robert Levy, the Institute has a dedicated leader, an eminent scholar respected in the scientific communities, and a capable and imaginative administrator. The Institute has clearly forged ahead in meeting the statutory mandates of implementing the National Programs to combat heart, lung, and blood disease.

May we also take this opportunity to express our appreciation for your having taken this early initiative in introducing "The Health Services Research, Health Statistics, Medical Libraries, Biomedical Research, and Research Training Extension Act of 1977".

The effort that you, Mr. Chairman, and the other Members of this Subcommittee make to assure that this legislation moves quickly through the Senate and eventually is signed into law is evidence of your commitments to cooperate with the new Administration and to assure that the Institute functions smoothly prior to the time that you consider legislation to revise substantially its programs and mandates.

Therefore, the College agrees that a 1 year extension of the Institute's operating authorities is entirely appropriate under the current circumstances.

S. 754 authorized "such sums as may be necessary" for research and prevention, education and control programs. We believe the Subcommittee should specify more precisely authorization levels sufficient to meet at least the existing commitments and mandates of the Institute. In your Report that accompanied S. 988 last year, you praised the Institute for its research contributions to the understanding of arteriosclerosis, hypertension, coronary heart disease, peripheral vascular diseases, arrhythmias, heart failure and shock, and congenital and rheumatic heart diseases, more importantly, you noted these cardiovascular problems as high priority items in the National Program in the years to come.

Yet, despite the great support of the Congress and these efforts by the Institute, cardiovascular disease continues to be the primary health problem in the United States. Diseases of the heart, lungs, blood and blood vessels, collectively cause more than one half of all deaths each year in the United States. Public Law 94-278, which extended the operating authorities of the Institute through fiscal year 1977, provided for the implementation of the 1972 mandate regarding the establishment of thirty hearty, lung, and blood research and development centers, only three are operational. The National Heart, Lung, and Blood Ad-

visory Council has recommended that \$50 million be allocated this year for these centers; however, given fiscal year 1977 budget constraints, only \$5.8 million will be so spent. Without an authorization and appropriation at substantially increased levels, there will be no further expansion of these important centers for applied research.

This year, the Division of Heart and Vascular Diseases of the Institute has announced that it will request contract proposals for important studies in non-invasive methodology for detection of arteriosclerosis, anti-arrhythmic drug therapy, and others. The opportunity to develop important research programs in heart, lung, blood, and blood vessel disease are at hand, but the ability to do so far exceeds the resources which have been made available for the implementation of the National Program. Therefore, we recommend that S. 754 be amended to include an overall authorization of \$490 million—\$450 million for research and \$40 million for prevention, education and control programs.

The College must also respectfully request a higher fiscal year 1978 authorization for the National Research Service Awards Program. We are pleased that P.L. 94-278 provided for the resumption of federal support for pre-doctoral as well as post-doctoral biomedical research training. The American College of Cardiology believes that the outlook with regard to research training programs is bleak. In fact, considerable instability has been a dominant characteristic of research training programs in the past several years. Support of research training in cardiovascular disease has actually decreased by more than 30 percent during the past 6 years. For fiscal year 1977, the Institute received 17 percent or about \$17 million from the total NRSA appropriation of \$100 million. It has been estimated that some 2,000 researchers and educators are needed this year and a greater number next year, just to keep Institute extramural programs at their present level.

In order to insure that the needed pool of scientific talent will materialize in the years to come, the American College of Cardiology recommends that S. 754 be amended to provide for fiscal year 1978 authorization of \$130 million. This would allow the Institute to support about 1300 full-time equivalent traineeships from NRSA funds, provided this section is fully funded by the Congress.

Finally, there is one more very important reason for setting specific and reasonable authorization levels for research and prevention, education and control, and training programs. Recent experience has shown that authorizations often are interpreted as exaggerated ceilings by appropriations. In fiscal year other words, actual appropriations fall far short of authorizations. In fiscal year 1973, about \$400 million was authorized for the National Heart, Blood Vessel, Blood and Lung Programs; only \$280 million was appropriated. In fiscal year 1974, about \$460 million was authorized and only \$284 million was appropriated. In fiscal year 1975, there existed a \$200 million gap between the two figures. While authorization levels should provide guidelines for Institute appropriations, room should be allowed for new initiatives in promising program areas as well as for continued funding of the present programs at current inflationary rates. We believe that the adoption of the College's recommended authorization levels will insure that your mandate that the important national programs continue through 1978 will not be frustrated by the realities of the appropriations process.

Finally, may I reiterate our appreciation for your efforts to insure that this vital Institute function effectively through 1978. We understand that later in the 95th Congress, you will consider legislation to revise substantively the National Heart, Lung, and Blood Institute's policies, programs and mandates. At that time, we hope that we will be afforded the opportunity to submit details pertaining to the following recommendations:

- (1) That the Institute and its programs be extended and authorization levels designated for a longer—perhaps 5 year—period;
- (2) That support be increased for the establishment of the new research and demonstration centers;
- (3) That the role of the National Heart, Lung and Blood Advisory Council be expanded, and;
- (4) That, consistent with our testimony before this Subcommittee last year, the salary of the Director of the National Heart, Lung and Blood Institute, as well as the salaries of other top executives at NIH, be substantially increased.

Mr. Chairman and distinguished members of this subcommittee, on behalf of the American College of Cardiology, I wish to express our deepest gratitude for your having invited us to submit our views on this extremely important subject.

Thank you.

RAYMOND D. COTTON,
Washington, D.C., March 4, 1977.

Hon. EDWARD M. KENNEDY,
Committee on Human Resources, Senate Health Subcommittee on Health and Scientific Research, Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR KENNEDY: On behalf of the American College of Chest Physicians, I have been requested to transmit the enclosed official ACCP Statement regarding S. 754 for inclusion in the hearing record.

Thank you for your cooperation in this matter.

Sincerely,

RAYMOND D. COTTON.

Enclosure.

STATEMENT OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS, DR. JOSEPH ROSS,
CHAIRMAN

Mr. Chairman and members of the subcommittee: My name is Dr. Joseph C. Ross, and I am professor and chairman, Department of Medicine, Medical University of South Carolina. I am also the President-elect of the American College of Chest Physicians. It is my pleasure to represent this professional medical specialty society which is composed of more than 10,000 heart and lung medical specialists.

I would like to take this opportunity to express our gratitude for your having afforded us the opportunity to submit our views on legislation to extend the legal operating authorities of the National Heart, Lung and Blood Institute and the National Research Service Awards Program. We appreciate this early effort on your part in introducing S. 754. We hope that the momentum created by the introduction of this bill will insure its passage by the Congress at the earliest possible moment.

This should assure that the Institute continues to function smoothly prior to the time that the operating authorities, mandates, programs, and policies of NHLBI are substantively revised.

The College, therefore, fully supports your proposal that the operating authorities of the Institute be extended for 1 year, through fiscal year 1978.

We are concerned, however, that authorization levels which the Subcommittee decides upon for research and prevention, education, and control programs be sufficient to meet existing commitments. The causes of many lung diseases remain largely unknown. Due to the consideration time lag between the increased incidence of these diseases and the establishment six years ago of a major research program to study them, the College believes that stringent financial limitations should not be placed on the Institute as an obstacle to reaching the goals of the program.

Thus, despite the great support of the Congress and the efforts of Dr. Levy and the Institute, cardiopulmonary disease continues to be a major health problem in the United States. NHLBI's Division of Lung Diseases intends to fund important research projects in lung cell biology, pulmonary vascular disease, chronic bronchitis and emphysema, pediatric pulmonary disease, and respiratory failure. The Division of Heart and Vascular Diseases will fund critical projects in hypertension, cerebrovascular disease, cardiovascular disease, arrhythmias, and congenital and rheumatic heart disease. And while we are pleased with the efforts of the Pulmonary Diseases National Research and Demonstration Center at the University of Vermont, it is distressing to note that this is the only pulmonary center thus far established, although authority exists for the establishment of ten such lung centers. Without a substantially increased authorization and appropriations, there can be no further expansion of these important centers for applied research.

The opportunity to develop these crucial research and prevention, education and control programs in cardiopulmonary disease is at hand, but the ability to do so far exceeds the resources that have been made available for the implementation of the National Program. Therefore, we recommend that S. 734 be amended to provide for an authorization of \$490 million for the National Heart, Lung, and Blood Institute—\$450 million for research and \$40 million for pre-

vention, education, and control programs. The College feels that, in light of the extension of Section 419B of the act which includes the 15 percent reservation of sums appropriated for NHLBI for lung disease, the Institute can make significant progress in combatting cardiopulmonary disease.

With regard to the extension of the National Research Service Awards Program, we would like to reiterate our strong support for both pre-doctoral and post-doctoral training. Yet, the National Heart, Lung and Blood Advisory Council has estimated a need for 2,000 researchers to maintain Institute programs at existing levels. The College recommends an NRSA Program authorization of \$103 million, an amount, which if appropriated, would yield about 1,300 full-time equivalent traineeships from NRSA funds.

Mr. Chairman and distinguished members of this subcommittee, on behalf of the more than 10,000 members of the American College of Chest Physicians who specialize in treating diseases of the heart and lungs, I wish to express our deepest appreciation for your having invited us to present our views on the legislation pending before your Subcommittee. Moreover, we hope that we will be afforded an opportunity to appear before you to present our views later in the year when you consider legislation to revise substantively the National Heart, Lung, and Blood Institute's policies, programs and mandates. In the spirit of mutual cooperation and support, it is our hope that you will continue to call upon us for advice and consultation whenever you think we can be helpful to you and this subcommittee.

Thank you again.

Respectfully submitted.

JOSEPH C. ROSS, M.D., FCCP,
President-elect,
American College of Chest Physicians.

AMERICAN DENTAL ASSOCIATION,
Washington, D.C., February 24, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health, Committee on Human Resources,
Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR KENNEDY: I am writing to express the views of the American Dental Association concerning the numerous expiring Public Health Service Act programs which are the subject of legislation to provide one year extensions. I request that this letter be made a part of the hearings on this legislation.

We are sympathetic with the problems which are faced in organizing a new administration and with the difficulties which would be present if the new administration were required to respond to formal amendments to these numerous programs or to propose its own amendments. Accordingly, we support the efforts of your Committee to extend these programs without change for one year.

While accepting the necessity for this procedure, we must point out that the dental profession has some very strong concerns with the current National Health Planning and Resources Development Act. We will, therefore, be most anxious to participate in formal amendments to that Act at the earliest possible date.

We thank you for your consideration of our views.

Sincerely,

WILLIAM E. ALLEN, D.D.S.,
Chairman, Council on Legislation.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association, representing some 6,500 member institutions, including most of the nation's hospitals, as well as extended and long-term care institutions, mental health facilities, hospital schools of nursing, and over 24,000 personal members. We appreciate this opportunity to present the views of the Association on S. 754 and S. 755, which extend certain expiring authorities under the Public Health Service Act, and the Community Mental Health Centers Act.

We concur with the Subcommittee's support for a simple one-year extension of these programs, and we understand that the Subcommittee intends to postpone consideration of substantive amendments until a later date. However, we would like to take this opportunity to make preliminary comments on substantive changes in certain of these programs that are of particular concern to hospitals.

EXTENSION OF THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT,
PUBLIC LAW 93-641

The AHA has supported and encouraged the development of sound health planning. Despite our concerns with some provisions of the legislation, we supported enactment of Public Law 93-641 in 1974. Since that time hospitals have participated actively and constructively in the implementation of the program. It is our belief that a sound health planning process is necessary to the development of a national health policy.

We understand that the Subcommittee intends to recommend a one-year extension of P.L. 93-641, recognizing that such an action would permit the new Administration time to develop its position and recommendations. Moreover, additional time and experience with the program will provide all interested parties further insights to the strengths and weaknesses of this Act. We, therefore, support a simple one-year extension of Titles XV and XVI of the Public Health Service Act.

While we agree with the one-year extension approach, there are two important issues which we wish to bring to the Subcommittee's attention. First, while a simple extension of this Act indicates no substantive changes in the program, we strongly recommend that appropriations for this activity be considered not in the light of a relatively stable program, but rather in terms of a new program which is in a critical stage of development. We urge the Subcommittee in its recommendations to the Budget Committee and to the Appropriations Committee to call for funding levels which will provide the necessary resources for the sound development of this program across the country.

Second, our Association, in its participation in efforts toward implementation of this program, has identified a series of amendments we believe should be made in the existing statute. While we recognize that such recommendations will not be acted upon in a simple extension, we are providing a brief summary of these amendments. We intend a more detailed presentation when the Subcommittee subsequently schedules hearings on substantive changes to the Act.

I. Provider Representation on HSA Governing Boards

The composition requirements of Section 1512(b) (3) (C) for the governing bodies of HSAs, their subarea councils, and advisory councils restrict membership to providers who reside in the health service area. This precludes the participation and input of providers who supply services in the area, but do not reside there. We propose amendments to Section 1512(b) (3) (C) that would require governing bodies of HSAs to include at least one representative of the hospitals located in the health service area and permit governing board membership to providers of health services in the area regardless of the location of their residence.

II. Provider Representation on the National Council on Health Planning and Development and the Statewide Health Coordinating Councils

The underlying philosophy of the statute is that health care policy is to be developed through a coalition of representatives of various consumer and provider interests. We believe that the statute has failed to ensure the adequate representation of provider interests at the national and state levels of the planning structure.

We recommend that Section 1503 be amended to require that provider membership on the National Council on Health Planning and Development include at least one representative from each of the direct provider categories identified in Section 1512(b) (3) (C) (ii).

We also recommend that the statute be amended to require that the provider members of Statewide Health Coordinating Councils (SHCCs), as defined by Section 1524(b) (1) (C), include representatives of each of the five provider categories listed in Section 1512(b) (3) (C) (ii).

III. Definition of "Indirect Provider"

The definition of "indirect provider" in Section 1531(3) (B) goes to an extreme to assure that persons who are directly tied to the interests of a specific health

institution or to the provision of health services do not serve as "consumer" representatives. Some persons who are, in fact, nonproviders with only coincidental or indirect ties to the health system and who should qualify as "consumers" are instead included in the category of "indirect providers."

We recommend that "indirect provider" not include members of the immediate family of an indirect provider or any individual who receives less than one-quarter of his gross income from a health care interest or activity.

IV. Conflicts of Interest

The Health Systems Agency (HSA) can be a nonprofit corporation, a public regional planning council, or a single unit of general local government. There is a potential conflict of interest when an agency of local government that is also a major provider or major purchaser of health services becomes an HSA. It is not unusual for large urban counties to own and operate general and special hospitals, nursing homes, outpatient clinics and the like. It is clear that Congress went to great pains to establish ground rules for the HSAs to assure that they would not be dominated by provider interests. Therefore, it would be inconsistent to permit a local government agency that is also a provider or purchaser of services to become an HSA.

We support an amendment that precludes those governmental agencies which are major purchasers or major providers of health care from being designated as HSAs.

V. Private Contributions

We fully appreciate the advisability of limiting the amount of funds or contributions in kind which an HSA can accept from an agency that has a vested interest in an HSA's actions. However, Section 1512(b)(5) so severely limits the sources of private contributions, that an HSA is precluded from accepting funds or contributions from some appropriate contributors. We propose that the HSA's sources of nonfederal support be broadened so that the statute would permit HSAs to accept contributions from health insurers.

VI. Phase-In of HSA Functions

The functions of the HSAs are delineated in Section 1513 of the statute. The problem here is that these functions are required regardless of capability. We feel that HEW should evaluate each applicant HSA's proposed work program according to the agency's level of expertise and financing. Therefore, we support an amendment that permits HSA functions to be phased in according to expertise and availability of funds.

VII. Certification of Need Laws

The principal regulatory tool assigned to the state government by P.L. 93-641 is certification of need (CON). It is the process whereby the state grants permission to health care providers to change their scope of services or to make significant capital improvements. No institution or service should be excluded from the certification of need process because of its ownership, including a facility or service operated by a governmental or quasi-governmental agency or unit.

Therefore, we recommend that the definition of "new institutional health service" in Section 1531(5) be broadened to include all facilities and programs, irrespective of ownership. We recognize that exemption should be made for the private offices of health practitioners to the extent that those offices do not include highly specialized equipment typically found in institutional settings.

VIII. Appropriateness Review

Periodic review of institutional services for appropriateness in Sections 1513(g) and 1523(a)(6) requires that HSAs and state agencies individually review each service and facility within the area or state. The magnitude of the burden can only be appreciated when one considers that there are over 7,000 hospitals which provide a broad range of different services and over 22,000 nursing homes, all of which would require review. We believe that such a requirement only adds an impossible burden on an already overworked process. Therefore, we recommend its deletion from the statute.

IX. Federal Health Grants—Review and Approval

The statute provides that the HSA will "review and approve or disapprove" certain federal grants to and contracts with local public and private health enti-

ties under Section 1513(e). The ambiguous wording suggests that the federal government has delegated to HSAs final decision-making authority over federal health grants in the local area. Of course, a local HSA's approval or disapproval of an application to a federal agency for a grant does not constitute final federal action. The Secretary of HEW can choose to commit federal funds in a manner inconsistent with the HSA's recommendation. Therefore, we recommend that this section be amended so that the function is more accurately identified as review and recommendation by the HSA.

Like the HSA, the State Health Coordinating Council or SHCC is a planning agency, and its function in the "review and approval" process is advisory only. The statute should also be clarified in this regard. Further, where the HEW Secretary or state agency makes a decision regarding a grant or contract contrary to the recommendation of the HSA, we recommend that the federal or state agencies provide a written explanation to the applicant as well as the HSA.

X. Area Health Development Fund

We disagree with the assignment to HSAs of the direct developmental assistance functions in Section 1513(c)(3). This section authorizes HSAs, through grants and contracts, to assist in the development of programs deemed necessary to achieve the goals contained in the HSA-developed plans. We are in agreement that a developmental assistance function is necessary, and should be supported by federal funds. We believe that the developmental program activities should be the responsibility of a state level agency. HSA planning functions should be limited to review and comment on developmental proposals in light of established plans. To provide HSA planners the authority and resources to implement their own plans would, we feel, detract from the principal function of the planning agency—planning.

Therefore, we recommend an amendment that would convert the Area Health Development Fund to the State Health Services Development Fund to be administered by the designated state agency.

XI. Uniform Accounting and Reporting

Section 1533(d) of the bill calls for the establishment of uniform systems for cost accounting, rate calculation, classification and cost reporting. The Association has supported the establishment and implementation of uniform billing systems, uniform cost reporting, uniform rates for all purchasers and a uniform classification system reporting as necessary to equitable comparative systems of reimbursement.

However, we must emphasize that although uniform accounting may appear useful in theory, a mandated system which lacks flexibility when applied to individual institutions cannot be implemented without impairing management and accounting innovation. The importance of a flexible accounting numbering system—a requisite for the wide diversity, scope and complexities of health care institutions—and adherence to generally accepted accounting principles cannot be overemphasized. Therefore, we believe that the uniform systems proposed under this provision should not extend to uniform accounting.

Uniform reporting, pricing and classification can be, and are, acceptable concepts, since they need not affect internal accounting systems and management prerogatives in obtaining their desired results. The necessary requisite to uniform reporting need only be an adequate method of reconciliation for the conversion of internal accounting information into a uniform reporting system. This does necessitate uniform accounting.

The American Hospital Association believes, however, that this section of the law is no longer valid since the requirements established by this section were to be complied with on or before January 1976. We, therefore, recommend that Section 1533(d) be deleted in its entirety.

XII. Facility Modernization and Construction Assistance

While hospitals have provided and continue to provide services to individuals unable to pay for care, the accountability for providing evidence of meeting the assurance requirements for a reasonable volume of uncompensated services in Section 1604(b)(1)(J)(ii) should be limited to the existing 20-year period for recovery of assistance funds under Title VI of the Public Health Service Act. Further, the enforcement activities of the assurance requirements should be carried out by the state agency.

COMMUNITY MENTAL HEALTH CENTERS

Title II of S. 755 provides authorizations for FY 1978 grants to community mental health centers (CMHCs) to assist in planning, initial operation, conversion to expanded services, provision of consultation and education services, as well as to assist centers in financial distress and to fund rape prevention and control programs.

The American Hospital Association strongly supports continuation of the CMHC program. Centers funded under the Community Mental Health Centers Act have had a major impact on the quality of mental health care in the United States and have increased the availability of such care. The program has been a principal force in the growth of comprehensive community-based treatment of the mentally ill, and also constitutes a positive effort toward prevention of mental illness and disability.

The AHA has long been committed to improvements in the delivery of mental health care, and the participation of hospitals in the CMHC program is significant. Of the 547 currently operational community mental health centers, approximately 80 are based in private, nonprofit hospitals. The latest HEW estimate is that the catchment areas of hospital-based CMHCs serve approximately 12 million persons.

While supporting a simple one-year extension of the Act, the AHA would like to identify an issue that is critical to the continuation of hospital participation in the Community Mental Health Centers program. The 1975 amendments to the Community Mental Health Centers Act, embodied in P.L. 94-63, incorporated a provision in Section 201 requiring that each CMHC establish an independent governing board, with specific membership requirements and possessing autonomous budgetary, operational and policymaking authority. The effect of implementing this provision in a hospital-based CMHC would be to establish two governing bodies within the hospital, with competing authorities over some of the institution's functions. Such an anomaly would occur because in a hospital setting the CMHC becomes an integral part of the institution's comprehensive program of services. Historically, however, the hospital's governing board has responsibility for *all* the operations and policies of the institution. The requirement imposed by Section 201(c) that a hospital-based CMHC must have a separate governing board introduces a requirement which is intolerable from a management point of view and presents a serious deterrent to hospital sponsorship of such centers.

Such interference with a hospital board's authority over the institution would place the board members in legal jeopardy. Board members would continue to be liable for all aspects of the hospital's operation, yet would not be in control of all policymaking. Thus, an autonomous board for a hospital-based community mental health center could well make a decision resulting in liability for the hospital board as well. From a legal perspective, therefore, as well as from a management point of view, Section 201(c) is unacceptable to hospitals.

The purpose of Section 201(c) could be accomplished in a hospital-based CMHC by the development of a CMHC advisory committee, made up of individuals from the center catchment area as described in Section 201. Such an advisory committee could report to the hospital governing board, which is responsible to the community for all functions of the hospital. In this way, individuals directly affected by the operation of a CMHC could have a voice in the center's functioning, and the hospital governing board could continue to exercise authority commensurate with its legal responsibility for the center's activities.

Our discussions with participating hospitals indicate that unless hospital-based CMHCs continue to come under the sole authority of the hospital governing board, many hospitals presently involved will withdraw from the Community Mental Health Centers program, and other institutions will be discouraged from sponsoring CMHCs. This would be unfortunate, and would impair the ability of many CMHCs to provide the comprehensive services called for in the Act. Moreover, we believe that all qualified providers should become involved in this program to assist in developing a nationwide system of community mental health centers.

It is our understanding that enactment of S. 755 as it is presently drafted will postpone the effective date of Section 201(c) for one year. If this interpretation is valid, then we urge the Committee to include the fact in its report on the bill. On the other hand, if this interpretation is incorrect, we urge that the existing

postponement be extended. Extension of this time limit would prevent disruption of services at hospital-based CMHCs prior to a full examination of this issue by the Congress during consideration of substantive changes later this year. The AHA looks forward to a future hearing by the Subcommittee on this program at which this issue can be addressed more comprehensively.

Recommendation: That the Committee include in its legislative history on S. 755 a specific acknowledgement that the postponement of implementation of Section 201(c) of the Community Mental Health Centers Act is to be continued for one year, consistent with the extension of the Act for that period.

MIGRANT HEALTH

Migrant and seasonal farm workers and their families currently comprise a population group of approximately three million individuals in the United States. A number of factors adversely affect the ability of migrants to use existing health care programs effectively; therefore, the migrant health programs meet a special need for this segment of the population.

In fiscal year 1977 approximately one-half million migrants and seasonal farm workers and their families will be served in 125 projects supported by this program. Of these migrants, nearly 100,000 will be served in 33 new Primary Health Care Centers. Continued federal support of migrant health services programs is essential because state and local health programs and services often are not accessible to migrants.

Recommendation: The American Hospital Association supports and encourages extension of the authority for migrant health services programs.

COMMUNITY HEALTH CENTERS

The Community Health Centers (CHC) program supports ambulatory care projects to provide services to medically underserved populations in both urban and rural areas. Services provided through Community Health Centers emphasize preventive and comprehensive care, as well as family-centered, multidisciplinary approaches to health care services, including outreach and transportation.

In fiscal year 1976, the CHC program served an estimated 2.1 million persons. Although large, this total represents only 4.1 percent of the estimated number of people nationally who reside in medically underserved areas. In fiscal year 1977, the program is supporting 164 ongoing Community Health Centers and Primary Health Care Centers which provide a range of preventive, curative, and rehabilitative ambulatory services and arrange for in-patient services for nearly 3.9 million persons, or about 6 percent of the total estimated population of medically underserved areas. Because this program is among the efforts to address a difficult and complex problem of service delivery, it should be continued.

Recommendation: The American Hospital Association endorses extension of this program.

MATERNAL AND CHILD HEALTH

The Maternal and Child Health program enables each state to extend and improve services promoting the health of mothers and children and to reduce infant mortality and morbidity. In addition to providing services, standards of care are developed, facilities are licensed, clinical research findings are implemented, and health professionals are trained. The program also develops and improves services for locating, diagnosing and treating children who are crippled or suffering from conditions which lead to crippling, and for providing these children with medical and rehabilitative care. Although much has been accomplished, much remains to be done, and the program should be continued.

Recommendation: The AHA urges extension of this program.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

The primary activity of the National Center for Health Services Research is to support and conduct a program of research which will contribute to improvements in the way health services are produced, organized, distributed and financed.

The National Center has established sound working relationships with providers of health care services and researchers based in universities. The American Hospital Association and the National Center jointly sponsored a Symposium on

the American Hospital in the 1980's this past December in an effort designed to anticipate and define public policy issues of the future. Initiatives of this sort afford an opportunity for representatives of government, providers, and researchers to share and discuss research findings and assess needs for future research efforts.

Recommendation: The American Hospital Association strongly supports the extension of the authority for the National Center for Health Services Research.

NATIONAL CENTER FOR HEALTH STATISTICS

The National Center for Health Statistics has played an important role within the federal government by gathering data related to the health field. The Center seeks and reports information on health status and trends; availability and utilization of health manpower, facilities, and services; demographic characteristics of the population; character and quality of the environment as it relates to health; and knowledge, practices, and attitudes toward health and health care. The center thus produces data needed on a continuing, periodic, or ad hoc basis for the broad assessment of the health status of the population and the planning, management, and evaluation of the delivery of health services.

Recommendation: The AHA supports continuation of authority for the Center.

MEDICAL LIBRARIES

The American Hospital Association supported the initial Medical Library Assistance Act of 1965 and its extension by the Health Services Research, Health Statistics and Medical Libraries Act of 1974 and is pleased to continue that support at this time. The National Library of Medicine (NLM), which administers this program, continues to be one of the world's most important research libraries and contributes to a strong system throughout the country.

In fiscal year 1977 the NLM is expanding efforts directed at establishing cooperative, resource sharing library consortia among the nation's health care institutions. Support, data gathering and planning operations are currently underway for 50 such consortia projects. The Regional Medical Library Program continues to grow in terms of the number of services provided, for example, document delivery services funded by the NLM are expected to exceed 450,000 during the current fiscal year. Improved library and communications services also are important to the success of educational programs for physicians, hospital administrators, nurses and other allied health personnel. The NLM is attempting to meet these needs through improved library resources and improved communications technology.

Recommendation: AHA supports the extension of the legislative authority for medical libraries.

Mr. Chairman, we appreciate this opportunity to present our views on this legislation.

AMERICAN LIBRARY ASSOCIATION,
Washington, D.C., March 10, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health, Human Resources Committee, U.S. Senate,
Washington, D.C.

DEAR SENATOR KENNEDY: This letter is submitted on behalf of the American Library Association, a nonprofit educational organization of some 35,000 members dedicated to the improvement of library service in the United States. We strongly support extension of the Medical Library Assistance Act (MLAA), which is part of your bill S. 754, the "Health Services Research, Health Statistics, Medical Libraries, Biomedical Research and Research Training Extension Act of 1977." We request that this letter be made part of the hearing record on the bill.

Length of authorization. We are pleased that your Subcommittee is acting promptly on extension of the medical library program, so that funding will not be disrupted for lack of compliance with the May 15 deadline imposed by the congressional budget procedures. Ordinarily we would urge you to enact a three to five-year extension of this important library program, but we understand that the one-year extension you propose this year is primarily to allow the new Administration time to make its own recommendations for substantive changes next year.

We hope you will include in the legislation the same contingent one additional year extension authority that you did in the 1974 extension of the Medical

Library Assistance Act (PL 93-353). A provision such as this would assure medical libraries throughout the country of at least minimal continuity. Such contingent one-year extension authority is provided to all education programs, through the General Education Provisions Act, and we have found it to be most helpful to the states and localities. We are very pleased to see this approach incorporated in the Medical Library Assistance Act, and hope you will continue it in the 1977 amendments. It is all the more important when the program is only being extended for a single year.

In-depth hearings. This new copyright law enacted last year (PL 94-553) takes effect January 1, 1978. This law is expected to have substantial impact upon hospital and other health science libraries throughout the country. In the light of this new law, we believe it is imperative that your Subcommittee conduct in-depth hearings on medical library service during the 95th Congress.

We believe that not only the National Library of Medicine should be invited to testify, as has been the custom in recent extensions of the Medical Library Assistance Act, but that you invite also representatives from medical libraries, both large and small, regional and local, to present their views on library and information service in the health science field. Our Association's membership includes among its constituent divisions the Health and Rehabilitative Library Services Division, and we would welcome an opportunity to testify at such hearings.

The 1965 enactment of the Medical Library Assistance Act was a milestone in the field of medical library and information service. The 1976 enactment of the copyright revision act may well prove to be another. The impact of the copyright law on medical libraries must be carefully monitored. We may well find that the Medical Library Assistance Act requires strengthening to assist small hospital libraries. Your Subcommittee, with jurisdiction over the Medical Library Assistance Act, seems to us to be the logical place for this oversight function. We stand ready to be of whatever assistance we can.

Importance of Medical Library Assistance Act. One of the most important achievements of the MLAA has been the development of the Regional Medical Library network. Backed up by the National Library of Medicine, the eleven regional medical libraries provide community hospitals with access to the literature of the whole system through resource sharing and document delivery service.

In addition, community hospitals have been assisted in acquiring the basic resources for a health library through the Improvement Grant Program under the act. In this way many small community hospitals have either established libraries where none existed, or have improved minimal resources.

This highly successful program has become the base for another program of self-help and development—hospital library consortium grants which provide seeding funding and then matching funding aimed at broadening the utilization of shared resources. The consortium grant program is just getting underway and deserves to be expanded. It will encourage better service and wider availability of biomedical information and research resources by supporting groups of libraries in institutions such as hospitals, mental health centers, research institutes, clinics, community colleges, public libraries, and others who serve health personnel in sharing resources and planning for improved services.

Through a demonstration project funded from the MLAA, in many teaching hospitals and medical centers, librarians are now serving on the health care team as information specialists. Taking information to the point where it is needed, at the patient's bedside, is a part of the philosophy of information delivery and knowledge utilization that has been the hallmark of the programs supported through the legislation.

Medical Library Assistance Act projects have served as successful models, as pilot projects, and as seed money. Libraries begun with federal funds have continued after the federal project ended; innovative projects have been duplicated elsewhere; cooperative efforts have spread; specialists receiving training have gone on to train others.

Much remains to be done, however. There are new developments in medicine daily, and the literature continues to multiply rapidly. In the health sciences it is extremely important that all practitioners keep well-informed. The high quality of health care depends heavily on continued life-long learning on the part of our providers of health care and a more informed patient population. The health library's role is a vital one, providing the channel through which

new knowledge flows to those with the responsibility and obligation to apply that knowledge to the betterment of us all.

Conclusion. In conclusion, we strongly support extension of the Medical Library Assistance Act. If there is only a one-year simple extension to allow the Carter Administration time to develop its own recommendations, we believe it should include as well an additional year's contingent extension, as was done in the 1974 amendments. Finally, we strongly urge you to hold in-depth hearings on medical libraries in connection with next year's extension bill. We believe such hearings are imperative at this time.

Thank you very much for this opportunity to present our views on the Medical Library Assistance Act. We request that this letter be made part of the hearing record on S. 754.

Sincerely,

EILEEN D. COOKE,
Director, ALA Washington Office.

AMERICAN LUNG ASSOCIATION,
New York, N.Y., February 25, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health and Scientific Research, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is a statement of the American Lung Association, setting forth the views of our organization relative to the one-year extension of authorization for the National Heart, Lung and Blood Institute. We would appreciate the attention of your Subcommittee to the views expressed therein and hope that this statement will be made a part of the record of your consideration of this important legislation.

Very truly yours,

WILLIAM ROBERTS,
Managing Director (Acting).

Enclosure.

STATEMENT OF THE AMERICAN LUNG ASSOCIATION TO THE SENATE COMMITTEE ON HUMAN RESOURCES SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH IN SUPPORT OF AUTHORIZATION FOR THE NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, FEBRUARY 23, 1977

The American Lung Association wishes to record its support for extending the authority of the National Heart, Lung and Blood Institute.

We realize that the circumstances of a new Administration which is faced with complex health policy decisions make it advisable to consider only a one-year extension of authority. However, it is our hope that next year the Institute can at least obtain a three-year authorization; only with adequate lead time can it effectively plan a viable ongoing research program.

NHLBI, through its Division of Lung Diseases, is the major Federal agency conducting and supporting research in the broad range of lung diseases which affect Americans, including chronic bronchitis, emphysema, asthma respiratory disease of the newborn and environmental and occupational lung disease. For that reason, our organization, including its medical section, the American Thoracic Society, works closely with and supports the Institute so that its lung disease program can have maximum impact on the control and prevention of these important causes of premature disability, early mortality and chronic adverse influence on the quality of life.

The American Thoracic Society has more than 7,000 members. Among these there are leading pulmonary disease specialists in both academic and clinical settings. ATS members contribute to the work of lung associations especially in the development of medical standards for the diagnosis and treatment of respiratory disease patients, the population with which lung associations throughout the country are concerned. These medical scientists are aware of the tremendous gaps in our knowledge about pulmonary diseases and are committed to increase that knowledge. For that reason, the relationship of the ALA and ATS with the Institute is very close and our organization can attest to the financial problems the Institute faces.

The Division of Pulmonary Diseases in NHLBI was not established until 1970; it is only now developing the momentum which enables it to influence the diagnosis, prevention, and treatment of the lung diseases prevalent in our population. DLD has made striking progress during its brief tenure, but because the establishment of the lung program in NHLBI was so long overdue, it is essential that this program continue to be fully financed during this necessary growth or "catch-up" period. In order to accomplish that, we urge that the ceiling for 1978 for the Institute be increased to \$490 million, which would allow for an important increment in DLD funding. In 1977, the Institute received an appropriation of \$397 million, which was close to its authorized ceiling. A FY78 appropriation which is linked to the present ceiling would have a disastrous effect on this vital area of biomedical research.

The Institute must not only meet its obligations to fund research in diseases which represent leading causes of death, but it must also carry out specific Congressional mandates in those disease fields which have been added since 1970. Meeting these augmented responsibilities in a climate of continuing inflation, the Institute could do very little to support promising new areas of research under the current authorization ceiling.

In the field of pulmonary disease alone, there are several areas which could have been productively pursued this year but were not because funds were not available. For instance, three worthwhile Specialized Centers of Research grant proposals with good priority ratings, totalling \$3 million, could not be funded. There is only one pulmonary National Research and Demonstration Center. There are important programs relating not only to adult and pediatric lung diseases but to broad areas such as structure and function of the lung where new initiatives should be actively pursued. Such work leads to understanding of the mechanisms by which disease processes develop, knowledge which is then translated into the effective care of patients.

The specific causes of many lung diseases remain largely unknown. Because of the considerable time lag between the dramatic rise in these diseases and the creation in 1970 of a major research program to study them, there should be no financial hindrance placed in the way of that research program. Emphysema and other chronic obstructive lung diseases are today the fifth cause of death from disease and are significant causes of disability. The Social Security Administration estimates that benefits for workers retired prematurely because of these conditions cost the country at least half a billion dollars annually. Each year our industrial technology becomes more complex and pervasive; adverse environmental influences make it imperative that research in respiratory disease not be held at the status quo.

With its increased responsibilities, the NHLBI has not received an increased proportion of NIH resources. As opposed to the National Cancer Institute whose proportion of the total has doubled, the percent for NHLBI has stayed at the 16-17 percent level since 1970. We believe that it is incumbent on Congress to increase the money authorization for NHLBI by a significant amount if it is to be realistic about the Institute's ability to handle its mission. Heart, lung, and blood disorders represent an enormous research field. Heart disease alone accounts for almost 40 percent of all deaths in this country. In our opinion a ceiling of \$490 million is commensurate with the size of the disease problems NHLBI is handling, and we hope that this Committee will recommend at least this amount to Congress.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., March 7, 1977.

Hon. EDWARD KENNEDY,
Chairman, Subcommittee on Health and Scientific Research, Committee on Human Resources, Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR KENNEDY: The American Medical Association submits the attached statement pertaining to a one-year extension of certain provisions of the Public Health Service Act and of the Community Mental Health Centers Act, presently under consideration by the Subcommittee.

The AMA urges that the Subcommittee reauthorize certain of these programs at appropriate levels. Although we believe that several provisions of these Acts should be amended, it is our understanding that the Subcommittee is now considering only a one-year extension of the expiring provisions, and that consideration of substantive revisions of these programs will be deferred to later in this Congress.

Therefore, we will reserve any specific suggestions for change to these programs for the later consideration by the Subcommittee.

We request that this statement be made part of the Subcommittee's record on this subject.

Sincerely,

JAMES H. SAMMONS, M.D.

Enclosure.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION; RE: EXTENSION OF EXPIRING HEALTH LEGISLATION, SUBMITTED TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH, COMMITTEE ON HUMAN RESOURCES, U.S. SENATE

MARCH 7, 1977.

The Subcommittee on Health of the Committee on Human Resources is presently considering a one-year extension of many health programs contained in the Public Health Service Act and the Community Mental Health Centers Act.

The Public Health Service Act is a major vehicle for much of the Federal funding of health programs throughout the country. The Act authorizes a variety of general grant programs with wide latitude for the direction of the programs to be taken by the recipient. Programs expiring this year include those directed toward providing certain health services (such as community health centers, migrant health and others) and also includes programs in basic and applied research, data collection and other health activities.

Also under consideration by the Subcommittee is extension of the Community Mental Health Centers Act which provides funds for the development and operation of such centers.

We have reviewed the programs to be extended, many of which we have supported from their inception. While we remain supportive of most of these activities and urge that you favorably consider a one-year extension of them as we discuss below, we have also indicated those which we believe should not be continued. Although we believe that substantive changes should be made to certain of the programs for which we recommend continuation, it is our understanding that such changes will not be considered by Congress until later this year. We would be happy to work with the Subcommittee at that time in developing certain needed substantive changes and will reserve our comments and detailed suggestions until that time.

We urge the Subcommittee to evaluate each program as if a "sunset" law were in effect and to terminate those which are no longer productive.

Our comments on the programs being considered for a one-year extension by the Subcommittee follow.

COMMENTS

A. Public Health Service Act

(1) Health Statistics and Health Services Research

General recognition is made of the importance of adequate statistics and health services research in developing and providing proper health care.

To this end, provisions of the PHS Act empower the Secretary of HEW to carry out health services research and to develop and compile health statistics. Two agencies, the National Center for Health Services Research and the National Center for Health Statistics, are created under these sections. Also funded are grants to set up research centers around the country.

The AMA has supported these activities in the past, and, although we have certain reservations about program specifics, such as the need for two agencies to perform related tasks and the numbers of research centers to be established, we support the one year extension of these programs.

(2) Comprehensive Public Health Services

This is a block grant program for the states and allows each state wide latitude in selecting how the money will be distributed. Frequently, these grants supply the sole Federal support for many activities of the state public health services. Funding is also provided for certain state mental health services.

This provision of the PHS Act also provides additional funding for establishing and maintaining state programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.

The AMA has also supported this block grant program since the program's inception in 1966. The provisions of the law have served to ameliorate many of the difficulties that characterized the system of categorical grants which existed prior to the enactment of this program. These block grants to states have permitted each state to meet its particular needs by establishing its own priorities.

We support the one year extension of this program.

(3) *Migrant Health*

The health care problems of migrant workers and their families are acute and proper delivery of the means to meet these needs often requires active Federal participation. The provisions which are considered for extension authorize the Secretary to provide grants to public and non-profit private entities for projects to plan, develop and operate migrant health centers. These centers are to provide primary and supplemental health services to migratory and seasonal agricultural workers and their families. Also authorized are contracts with states for the implementation and enforcement of acceptable environmental health standards in migrant labor camps.

Over the years, the AMA has consistently supported Federal efforts to expand the availability of health services to migrant workers, pointing out, however, that the development of a federally supported program utilizing voluntary health insurance would be the most appropriate means of providing health care to migrant workers. One of the concerns over the present program provisions that has been expressed is an undue reliance on migrant health centers as the method of providing services. Such stationary centers may in fact be too inflexible to cope with the needs of a migratory population. Appropriate changes should perhaps be considered at a later date.

However, we believe that the program has helped to meet essential health needs of the migrant worker that might otherwise go unmet. Therefore, we urge the one year continuation at this time.

(4) *Community Health Centers*

Many sections of this country can be considered "medically underserved areas." Multiple and imaginative responses are appropriate in encouraging and stimulating the provision of proper health services for these areas.

One legislative response to this situation was the creation of community health centers (formerly called neighborhood health centers). Community health centers are defined in the PHS Act as entities providing primary and supplemental health services and referral to, and information about, other available health services and facilities for persons living in medically underserved areas.

The provisions of the PHS Act provide for grants to plan, develop and operate such centers.

However, available evidence does not indicate that these centers are panacea for underserved areas. In fact in some cases, they are the least cost-effective method of health care delivery. The AMA recognizes that, in certain cases, the community health center may be an appropriate means of delivering needed health care. Nevertheless we believe that the evidence of the program emphasizes that recognition should be given to alternate means of providing health services that are equally effective. The community health center should be viewed as only one possible alternative in appropriate circumstances.

Therefore, while we do believe that a one year extension of this program would be appropriate in order to provide continuity of services, we recommend that the community health centers concept be carefully studied during the period of any extension with a view to the development of alternative forms of health care delivery in shortage areas.

(5) *Medical Libraries*

The importance of proper medical library services to research, patient care and medical education cannot be overstated. The Congress has recognized the importance of such facilities and has responded with the present grant program.

The medical library grants provide assistance to individuals for training as medical librarians and to institutions to support such educational programs. Also provided are grants to establish, to expand, and to improve medical libraries at schools, hospitals and other institutions.

The AMA supported the Medical Library Assistance Act when it was originally enacted in 1965 and since then has urged continuation and expansion of this program. We support the one year extension of this program.

(6) *National Institutes of Health and National Research Service Awards*

It is through the National Institutes of Health that much of the Federal money for basic and applied medical research comes. The contributions by NIH to the quality of health care in the country are many, and its activities should receive a full measure of Congressional support.

To be reviewed this year are the programs of the National Cancer Institute and the National Heart, Lung and Blood Institute. Also to be reviewed is funding for the National Research Service Awards.

The AMA has endorsed an increased national effort to seek the causes of, and cures for, cancer. We continue to support these activities and urge funding levels as high as possible consistent with adequate funding for other medical research activities.

The AMA also supported expansion of activities under the National Heart and Lung Institute. The Association urged, however, that the research and demonstration centers established under these provisions not function primarily as general patient care facilities but rather as the research centers that they were intended to be. We also supported extension of the National Research Service Awards but we have been concerned over the service payback provisions which would require mandatory service in areas not related to the purposes of this program.

We urge that these programs in support of needed medical research be continued for another year. However, we still believe that the payback provisions of the National Research Service Awards should be appropriately amended as soon as possible.

(7) *Family Planning*

Aside from a change in birth rates or population growth statistics, one of the benefits of the family planning program is to be found in the lowering of infant mortality and morbidity figures. The knowledge which women have gained in understanding family planning principles and options results in healthier mothers and infants.

Expiring this year are funds for family planning services including grants for the establishment and operation of voluntary family planning programs and training grants for personnel to carry out these programs.

The primary source of birth control information has been, and will continue to be, the personal physician. However, the program funded under these provisions also serves for many people as an appropriate and useful source of reliable information and counseling. If the progress which has been made is to be carried forward, these programs must continue to receive necessary financial support.

The AMA supports the one year extension of this activity.

(8) *Sudden Infant Death Syndrome*

These provisions authorize programs to develop and to disseminate public information and professional educational materials relating to sudden infant death syndrome. Also authorized is the provision of information and counseling to families affected by sudden infant death syndrome.

The AMA supports the one year extension of this important activity.

(9) *Hemophilia Program*

This program provides funding for grants for establishing comprehensive hemophilia treatment centers and blood separation centers.

The AMA believes that the inclusion of these provisions in the PHS Act is unnecessary. We believe that private and other public programs have adequately cared for those persons with hemophilia and can continue to provide quality care. The number of patients involved does not, in our view, justify a special Federal program. We believe that increased support for basic research could be a more productive use of Federal funds and could in fact benefit many other people.

(10) *National Health Planning and Health Resources Development*

P.L. 93-641 provides for a system of national health planning (Title XV) and for funding of health care resources development and construction (Title XVI).

The AMA opposes the Health Planning and Resources Development Act and is currently involved in a lawsuit challenging the constitutionality of the pro-

visions of that Act. P.L. 93-641 should not be extended (but an appropriate program of assistance for resource development should be formulated in lieu of Title XVI in order to provide for necessary Federal assistance as in the former Hill-Burton program).

B. Community Mental Health Centers Act

This Act provides grants for the planning and initial operation of community mental health centers. Also included are grants to establish consultation and education services with community entities involved with mental health services. Other programs are conversion grants designed to assist existing community mental health centers meet new federal program requirements, grants to centers in financial distress, assistance for the construction of needed community mental health facilities, and funding for rape prevention and control activities.

The Association has in the past given its overall support to this legislation. However, we are concerned that the cost of delivery of mental health services through these centers may, in some instances, be excessive. Services provided by the private sector would cost less than many of the services provided by the Centers.

Although we support extension of this Act for an additional year, we urge that the whole concept be thoroughly studied and evaluated during that extension period, with a view toward consideration of desirable modifications.

C. Conclusion

In conclusion, we reiterate our support for a one-year extension of the following health programs expiring this year: health statistics and health services research, comprehensive public health services, migrant health services, medical library support, National Cancer Institute, National Heart, Lung and Blood Institute, National Research Service Awards, family planning programs, Sudden Infant Death Syndrome programs, and community mental health centers.

Certain substantive changes are warranted and we again would be pleased to offer our assistance in development of changes when the subcommittee considers the programs in greater detail.

AMERICAN NURSES' ASSOCIATION—STATEMENT ON EXTENSIONS OF HEALTH PROGRAMS AS PROVIDED BY S. 754, S. 755

The American Nurses' Association, the professional organization of registered nurses, with 52 state constituents and 200,000 members, supports the one year extension of the health programs provided by S. 754, the Health Services Research, Health Statistics, Medical Libraries, Biomedical Research and Research Training Extension Act of 1977 and S. 755, the Health Services, Hemophilia and Health Planning and Development Extension Act of 1977. Although we do have concerns about several features of the above, we feel continued funding of the services under the legislated programs is deserved until a thorough evaluation can be made at a future date.

We speak first to Health Services programs, of which, many of the provisions are in the early stages of implementation. Changes or termination of them could seriously jeopardize the health of those persons receiving program services who otherwise are unable to afford the necessary health care. The need for continuing federal assistance for the programs operating under the Act is especially obvious now that millions of workers are unemployed.

Among the many programs established by the Act, some are just getting a head-start. To cite one: Interim regulations relating to Hemophilia treatment Centers were published in the Federal Register, September 13, 1976. Final regulations are several months away. The services rendered and the data collected by the many programs are essential to assure a total health care system. We believe it essential that these programs be continued pending any proposals for changes by the new Administration.

ANA has lent its support to the legislation since it was first introduced, especially the community health centers, migrant health centers and community mental health centers programs.

COMMUNITY HEALTH SERVICES

The concept of community health services located in a facility that is accessible to residents of a circumscribed geographic area has long been endorsed by the Association. Services provided in such facilities make primary care available to people in neighborhoods where low income levels and poor transportation services make it difficult or impossible for them to seek health care in distant locations. At this time there are 157 of these centers serving approximately 1.5 million people, many of whom would otherwise not receive health care.

MIGRANT HEALTH CENTERS

One of the most needed programs of the Health Services Act is that for support of Migrant Health Centers. The plight of the migrant worker has had dramatic emphasis during this winter. Not only the severe cold of the East but also the drought in areas of the West have damaged potential crop yield and caused a drop in the migrant employment. They will have increased difficulty in acquiring the necessities of food and shelter. Health care will be a low priority, especially preventive care. Therefore, the services provided by the migrant health centers are especially important. These include both acute and preventive care. Supplemental services may also be provided as appropriate to assure adequate support of the primary health care. With migrant health centers in strategic locations along the migrant worker's geographic path, health care will be available. We strongly support the continuation of these services to the migrant workers and their families.

COMMUNITY MENTAL HEALTH CENTERS

The American Nurses' Association urges the Congress to renew the Community Mental Health Centers Act by providing adequate funding authorization to sustain the CMHC programs beyond the expiration date of July 29, 1977. We believe that Community Mental Health Centers have had a substantial impact upon the quantity and quality of mental health care. Accessibility to mental health services has remarkably improved in those areas where Centers are comprehensive and operation.

Although a total of 603 community mental health centers have been initiated with federal assistance through fiscal year 1975, there continues to be a shortage of quality community-based mental health services in many areas of the country. We believe it is imperative that this innovative mode of mental health service delivery be allowed to flourish by increasing CMHC operating centers. Only, in this way will the original intent of the 1963 legislation be realized.

Though we have no suggestions for changes in the law at this time, we do have several questions regarding administration and direction of the program, which we would like to call to the attention of the (sub) committee.

The first related specifically to the role and utilization of the nurse in Community Mental Health Centers. Psychiatric nurses have demonstrated expertise in: crisis intervention, staffing 24-hour emergency phone services, providing quality care in the therapeutic milieu of inpatient and partial care units, functioning effectively in outpatient services such as Aftercare Clinics, delivering, with specialized preparation, group, family and individual psychotherapy, making home visits, working directly with the client in his home environment, and in providing follow-up care to patients discharged from Community Mental Health Centers. However, there seems to be an obvious discrimination against employment of Registered Nurses in the various components, other than inpatient care, of Community Mental Health Centers. Registered nurses are repeatedly underutilized in outpatient, daycare, consultation and education, alcohol and drug components not because they don't choose employment in these areas, but because they aren't seriously considered for employment. Nurse administrators have had limited opportunity to prove their value to CMHC program operations as program directors and senior staff. We believe this is unfortunate and would like to see some changes occur in the staffing of such Centers.

The ADAMHA Forward Plan fiscal year 1978-82 highlights the need to include community mental health centers as "providers of service" under Part B of Medicare. Our Association favors this direction because we believe that Community Mental Health Centers must be given every opportunity to be financially self-sufficient if they are to survive and continue to be viable providers of quality mental health services. We fully realize that such a direction requires

amending Section 1861(u) of the Social Security Act, but we trust Congress will consider such a need in conjunction with the CMHC legislation. Lack of certified provider status for CMHC's has encouraged the costly, dehumanizing institutionalization of many patients.

We would also like to see a movement toward delineation of and reimbursement for nursing services in the CMHC care delivery system. Many psychiatric nurses are exceptionally well credentialed through R.N. Licensure, graduate degree and professional certification to deliver high quality mental health services. As providers of service they should be allowed to bill for third party funds. These funds could be dispersed to the qualified nurse provider or indirectly through mutual employee-employer arrangements.

A third area of concern relates to maldistribution. Are Community Mental Health Centers giving high priority to underserved areas and areas of extreme need? Current legislation does speak indirectly, to the issue, but we believe that the matter of maldistribution should be addressed more explicitly, and program planners, directors, and federal monitors held increasingly accountable in this regard. Perhaps, current reimbursement restrictions demand that Centers operate closer to more affluent, organized health care settings.

The ANA 1976 House of Delegates passes a resolution on establishing Community alternatives to mental hospitalization. The resolution reaffirmed the Association's support of federal legislation designed to assure the high quality of community alternative to hospitalization in public institutions for mentally ill and mentally retarded persons. It further clarified the role of the professional nurse in this regard by resolving:

"that professional nurses take the initiative in providing effective linkages between community based mental health and mental retardation services and those services provided by large public institutions, and

that nurses utilize and increase their skills in community education to facilitate the physical and social integration of mentally disabled persons into the community."

Deinstitutionalization is a meaningless term without high quality community alternatives. Too often patients do go from backwards to back alleys and too often, too, community institutionalization in custodial nursing homes or social isolation in single room occupancy situations replace state hospital confinement. We believe there should be greater emphasis on aftercare services, transitional half-way house services, sheltered workshops, and renewed efforts at community reintegration of persons discharged from mental institutions. This may mean pursuing rezoning legislation at the local level, establishing a social and community support system, and providing job counseling, training and placement. We sincerely hope CMHC's will see this as an integral part of their commitment to the communities they serve.

The National Center for the Prevention and Control of Rape is authorized to carry out and support research, services, and education. We are very pleased to see this Center operational and request continuing Congressional support so that services of the Center can be expanded to include training personnel to deal with rape victims, their families, and offenders. This is viewed as a most needed and worthwhile endeavor by our constituency.

The Committee on Mental Health and Illness of the Elderly, which grew out of this legislative mandate, is to be commended for its initial efforts. We would like to see Congressional support continued for this committee, which has undertaken the rather unique task of promoting mental well being in the special age group of the elderly. This has been a long neglected area.

HEALTH PLANNING PROGRAMS

We also support extension of the health planning law. As nurses we are well aware of the lack of coordinated comprehensive health planning and the resultant waste and duplication in allocation of health resources and services in some areas while still other areas of our country and some segments of our population remain underserved or without services. For that reason, we strongly endorse the objective of the National Health Planning and Resources Development Act of 1974, that is, to facilitate the development of recommendations for a national health policy that would contribute to the goal of adequate and accessible health services for all Americans, and ask it be extended for one more year.

However, we do have some observations we would like to bring to your attention. The complexity of the law has been a deterrent to its early implementation. Statewide Health Coordinating Councils (SHCC), an important organizational structure in administering the Act and having certain specified responsibilities for review and approval of applications for special health funds under other acts, are still being formed.

The National Council on Health Planning and Development, charged with the responsibility of advising, consulting and making recommendations on national guidelines, and the implementation of the Act has held *one* meeting. Only five members were present. Seven had not yet been appointed by the Secretary at the time of that meeting. No official business could be transacted because there was no quorum. National guidelines and a health planning policy are necessary for the Health Systems Agencies (HSA) to develop their health systems plan and annual implementation plans (AID). In turn, HSPs are needed by the SHCCs for incorporation into a state health plan. These are just a few of the incompleting mandates of P.L. 93-641.

Although at this time we do not recommend amendments to the Act, we feel we must express another major concern. It is the lack of a registered nurse as a member of the Council. There are approximately 1,350,000 registered nurses in the United States and 961,000 of them are in the active work force. We know that nurses represent the largest group of health professionals (407 per 100,000 population); that nurses are providing health services in all settings; and that nurses provide continuity in the provision of health care. By not having a nurse representative on the Council, a precedent is set for ignoring the importance of obtaining nurse representation on the SHCCs and governing boards of HSAs. Latest figures show only 165 nurses on HSA Boards or to put it another way, nurses make up only 7 percent of the provider group of all HSA governing boards. (The number of dentists is 136 (6 percent) and the number of physicians is 643 (27 percent)—despite the nurse-doctor ratio of 3:1). We feel nurse contribution is essential for setting priorities for a national health policy and developing guidelines to assist with planning for health care and the distribution of resources.

Just last month, certificate of need regulations implementing section 1523(a) (4) (A) were finalized. We strongly believe that some Health Services should not have been excluded from the regulations and we have sent a letter to Secretary Califano expressing this opinion. We feel this is an unfortunate direction for DHEW to follow since inclusion of Home Health Services was seen as a device to assist in the coordination and appropriate expansion of home health services. (Recent rumor that the nursing home industry is preparing to move into home health services underscores this concern.) In the absence of a mechanism for monitoring and avoiding the proliferation of the home health services, we feel there may well be duplication of services thereby increasing health care costs. Our recommendation to the Secretary was to amend the final regulation to include home health services under the certificate of need requirements.

When we reviewed the HEW draft of the proposed goals and standards, we noted the omission of home health services. Home health services, provided, coordinated and supervised by registered professional nurses, can give the preventive, restorative, and health maintenance services that save the cost of hospitalization or institutionalization. We feel this omission in the proposed goals and standards does not fulfill the intent of the law to build into the system alternate services other than hospitalization and sick care.

We also noted an absence of goals related to national health priorities enunciated in the law dealing with utilization of nurse practitioners and clinicians and the education of the public in health care and use of health services. This can be corrected, but again, we would point to the need for nurse involvement at all levels in order to accomplish the intent of these priorities.

As a final recommendation we urge this year's extension as a means to stabilize the funding of this massive health planning effort. It is crucial that the present employees of HSAs can be assured of paid employment to enable the HSA to carry on the projects already underway. It is unfair to jeopardize the progress already made or to undermine the intent of P.L. 93-641 by delaying in any way the momentum that is just now having an effect. Implementation of P.L. 93-641 has just gotten started. Let us wait one more year for an indepth review of its promises—kept or unkept!

BIOMEDICAL AND BEHAVIORAL RESEARCH PROGRAM

We also endorse extension of provisions for support of biomedical and behavioral research. The significant increases in the cost of health care and the rising expectations of the public for health care services have placed immense pressure on all health professionals to provide improved, yet economical, health care and to reduce or prevent health related problems.

The great majority of those who provide health care in this country are nurses. Nursing can be effective only if adequate research is carried out to provide increased knowledge and sound data on which to base clinical nursing practice.

Nurse researchers are engaged in investigations designed to identify better methods of care, such as strategies for reducing the complications and costs of hospitalization; facilitation of home-based care and self-care in chronic illness; improving the outlook of high risk groups such as premature infants and the elderly; and reducing the disabilities, discomforts, and costs of coronary- and cerebral-vascular problems. Such research includes studies focused on pain alleviation, care of burned patients, home care during dialysis or parenteral nutrition, and management of dying patients.

Through the system of federally funded scholarships and training for researchers, current personnel needs generally have been met in many biological and behavioral fields. This is not true in nursing, where a major barrier to research development is the small number of adequately prepared research personnel. In 1973 there were 1,106 nurses who had earned doctorates in the United States, which represents approximately 0.2 percent of all employed registered nurses in this country. Since 1972 approximately 100 additional nurses have received doctorates each year.

Support for nursing research and research training for nurses from the major institutes of N.I.H. has been minimal. N.I.H. priorities have most been oriented to the cure of disease and have less often been directed toward improvement of preventive methods or toward improvement in the quality of care of the ill, which are the types of problems nurse researchers investigate.

In recent years approximately half of all nurses earning doctorates received some federal assistance during their doctoral studies. Funds have been provided through the Health Resources Administration, U.S. Public Health Service, Division of Nursing.

The need for additional numbers of nurses with doctoral-level preparation is evident when the personnel resources of schools of nursing are compared with those in the biomedical and behavioral fields. Whereas the ratio of graduate and undergraduate students per biomedical and behavioral Ph. D. scientist employed in academic settings ranged from approximately 20.1 to 40.1 between 1960 and 1972 (see Figure 32, page 45, 1976 Report, Personnel Needs and Training for Biomedical and Behavioral Research), in 1974 the ratio of full-time graduate and undergraduate students per full-time nurse faculty holding a doctorate was 158.1.

Just as support for predoctoral training was essential during the last quarter-century to supplying research personnel in the basic biomedical and behavioral fields, there is a critical need to increase the availability of doctoral preparation for nurses in a variety of substantive areas.

Thank you for the opportunity to submit this statement for the record.

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.,

March 8, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health, Committee on Human Resources, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The American Occupational Therapy Association wishes to record its support for the extension of several important health planning programs and activities, including those mandated under the "National Health Planning and Resources Development Act of 1974" (P.L. 93-641), as proposed in S. 755.

The attached statement has been prepared to inform the Subcommittee of our support for S. 755 as well as to elucidate some of the problem areas in the implementation of Public Law 93-641 which have come to the attention of occupational therapy practitioners.

The Association requests that this statement be made part of the hearing record, and we offer our assistance to the Subcommittee as may be necessary in the future.

Sincerely,

JAMES J. GARIBALDI,
Executive Director.

Attachment.

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION ON S. 755*

Mr. Chairman and members of the subcommittee: The American Occupational Therapy Association is pleased to submit this statement on the extension of health planning and other programs as mandated by S. 755.

For 60 years this Association has represented independent health professionals who specialize in alleviating the suffering and increasing the independence and productivity of the aged, the physically or mentally disabled, and the economically or culturally disadvantaged.

Occupational therapy practitioners are trained in curricula involving developmental psychology, anatomy, neurophysiology, and the social sciences. This training is followed by field work experience in areas such as psychiatry, rehabilitation, developmental disabilities, and gerontology.

Occupational therapists are among the few non-physician mental health professionals who are trained in the medical and biological sciences. They provide services in general and psychiatric hospitals, nursing homes and tuberculosis sanatoria, community health and mental retardation centers, rehabilitation agencies and home health settings, and public and private school systems.

The Association has actively encouraged its membership to participate in local health planning programs and activities since the enactment of P.L. 93-641, and it currently has fifty occupational therapy health planning coordinators throughout the United States. The Association and the 23,000 members which it represents therefore have a direct interest in the legislation extending authorizations for health planning agencies and their concomitant activities.

It is our understanding that the subcommittee intends to recommend a one-year extension of Public Law 93-641. The Association supports this action in light of several factors. First, there has been insufficient time for Congress to evaluate the effectiveness of recently designated Health Systems Agencies (HSAs), Statewide Health Coordinating Council (SHCCs), and State Health Planning and Development Agencies (SHPDAs). Second, the National Council on Health Planning and Development, mandated to advise the Secretary of Health, Education, and Welfare on health planning activities, has yet to meet as a committee with its full complement of members as designated in the Act. Third, the new administration needs further time to develop its own positions and recommendations on Public Law 93-641.

The Association, in conjunction with its support of a simple one-year extension of titles XV and XVI of the Public Health Service Act, urges the Subcommittee to recommend to the Budget and Appropriations committees funding levels that will insure the development of a strong health planning program throughout the United States.

We are aware that comprehensive amendments of Public Law 93-641 will not be addressed in the one-year extension of health programs. However, the Association and its members would like to point out several problem areas in the implementation of Public Law 93-641 which we believe will require amendments to this statute in the months to come. These areas have been discerned through occupational therapists' involvement in various health planning activities throughout the country.

The Association strongly urges that the five categories of providers [as defined in section 1512(b)(3)(C)(ii)] composing the membership of HSA governing bodies be made mutually exclusive. If health professionals are specifically mentioned in one of the categories of providers, they should not be allowed to represent one of the other four categories. For example, occupational therapists in several states have remarked that health professionals from category I including "physicians," "dentists," and "nurses," are being selected to serve on HSA governing boards as representatives of category V, the allied health professions." The agencies in question had received applications for HSA board membership

*A statement submitted to the Subcommittee on Health of the Committee on Human Resources, U.S. Senate, Washington, D.C., March 1977.

from qualified allied health professionals, such as occupational therapists. In spite of their manifest interest and qualifications, their place on the board was filled by non-allied-health personnel.

The Association is aware that a number of health professions fall under the rubric of "allied health," and we are not advocating that these professionals be specifically enumerated in Public Law 93-641. However, the Association does strongly assert that the health professionals that comprise this category of providers do have substantial contributions to make to the health planning process, particularly in the areas of preventive health and in the provision of alternate forms of health care. Therefore we assert that the "allied health professions" category should not be obscured by the other four categories of providers, and that providers specifically mentioned in categories I-IV should not be placed on HSA governing boards as representatives of category V.

In light of the Association's concern that allied health professionals be adequately represented on health planning bodies, we also recommend that section 1503 of Public Law 93-641, designating the National Council on Health Planning and Development, be amended to include categories of health providers as designated in section 512(b)(3)(C)(ii).

Occupational therapists have also noted a problem with the representation of allied health professionals on SHCCs. Section 1524(b)(1)(C) of Public Law 93-641 requires that "Not less than one-third of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 1531(3))." However, there is no provision that SHCC members who are providers of health care be representative of the five categories of health providers (as described in section 1512(b)(3)(C)(ii)). In order that all categories of providers, including allied health professionals, be represented on SHCCs in the same manner that they are on HSAs, the Association recommends that section 1524(b)(1)(C) be amended by adding the following sentence at the end of this section: "Providers of health care who are members of a SHCC shall be representative of the five categories of health providers (as described in section 1512(b)(3)(C)(ii))."

Association members have also commented on problems resulting from the percentage of SHCC members appointed by a state governor who are not HSA representatives, as compared to those members who are HSA representatives. As defined in section 1524(b)(1)(B)(i), at most, 40 percent of the total membership of the SHCC must be non-HSA representatives. The remaining 60 percent must be HSA representatives. This gives HSA representatives a majority voice in reviewing the decisions and recommendations made by the HSAs. The Association believes that this situation could result in a conflict of interest or in a failure of the "checks and balances" function which the SHCCs are supposed to perform. We therefore recommend that these percentages be reversed so that 60 percent of the SHCC members do not represent the HSAs and 40 percent do represent the HSAs. The requirement of consumer majorities on the SHCCs should be maintained.

The Association appreciates this opportunity to record our support for this legislation and submit suggestions for future amendments to Public Law 93-641. We stand ready to offer assistance to the subcommittee as may be necessary regarding this and other health legislation.

STATEMENT BY THE AMERICAN PSYCHIATRIC ASSOCIATION ON S. 755, THE HEALTH SERVICES EXTENSION ACT, PRESENTED TO THE SUBCOMMITTEE ON HEALTH, HUMAN RESOURCES COMMITTEE, U.S. SENATE, MARCH 4, 1977

The American Psychiatric Association, which represents twenty-three thousand and psychiatrists in the United States, wishes to express its support for the enactment of S. 755 with respect to the extension of Public Law 94-63, title III, the 1975 amendments to the Community Mental Health Centers Act.

This association believes that a simple one-year extension is indicated at this time in order to authorize the continuation of the present law, and at the same time enable the careful examination and evaluation of the CMHC program by the new Administration.

We have been traditionally supportive of the CMHC movement and its goal to build a viable network of Community Mental Health Centers consisting of 1,500 centers to serve the Nation.

While advocating this movement, we have also made it known that as physicians and providers of psychiatric services, we view CMHCs as an important

element in a pluralistic spectrum of mental health service delivery. We do not believe that any one form of delivery, including CMHCs, should be favored in public policy at this time over any other.

The "Legislative Guideline" that is presently employed by the APA in regard to the mental health care delivery system in the United States is as follows:

The APA espouses a pluralistic health care delivery system, as being (a) the most likely to encourage growth, progress, and continuing evaluation with the field of clinical medicine and (b) the best able to provide the patient freedom of choice as to locus and modality of care. The APA therefore shuns any plan that would favor one health care delivery system over any other except in those instances where one can be shown to be dependably superior to another in providing patients with care of high quality.

We believe that it is important to provide adequate federal funding for "new starts" so that the CMHC national network will be completed. If federal funding is not provided, we will find areas within this country which will not be served by CMHCs leaving an inequitable patchwork pattern of CMHC service availability around the nation—a development certainly not anticipated by the architects of the law. It is important that every catchment area be adequately served by CMHCs, especially at this time when many state mental hospitals are being phased out, leaving few if any community alternatives to treatment.

Also, we must assure that all population groups, including children, the elderly, and poor, will be able to receive quality treatment in CMHCs as prescribed by the 1975 amendments.

We now find that many mentally and emotionally ill persons are falling into the cracks following their release from mental institutions, where there are no adequate provisions for follow-up services through community facilities, including CMHCs. Former patients often find themselves worse off following de-institutionalization. This should not be the case, or de-institutionalization may become synonymous with no treatment in some areas. CMHCs should have adequate funding to permit the treatment of all classes and income levels, and to provide the necessary follow-through that is essential for released patients. If the latter is not provided we will be only fooling ourselves with statistics illustrating drastically reduced institutional populations, since many of these patients will eventually be readmitted.

We concurred with the Council of Community Mental Health Centers in rejecting the administration's rationale in 1975, during which time the new amendments were passed, that the program had proven to be so successful that continued further federal funding was not necessary. There are many areas, especially poverty areas where centers are most needed, that cannot raise sufficient funds through their communities to initiate CMHCs.

The American Psychiatric Association strongly supports this extension, and believes that these centers should be adequately funded to permit forward planning and encourage quality care.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES,
March 4, 1977.

HON EDWARD M. KENNEDY,
Chairman, Subcommittee on Health and Scientific Research, Committee on Human Resources, U.S. Senate, Washington, D.C.

DEAR SENATOR KENNEDY: The Association of American Medical Colleges is pleased to submit the attached statement for the record concerning S. 754 and S. 755. We appreciate the opportunity to make our opinions known to you and the members of your subcommittee.

Sincerely,

JOHN A. D. COOPER, M.D.

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON LEGISLATION TO EXTEND FOR ONE YEAR THE AUTHORIZATION FOR EXPIRING HEALTH PROGRAMS¹

Mr. Chairman and members of the subcommittee: The Association of American Medical Colleges (AAMC), formed in 1876 to work for reforms in medical

¹ Submitted by John A. D. Cooper, M.D., president, Association of American Medical Colleges, to the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee, March 4, 1977.

colleges, has broadened its activities over the years, so that today it represents the whole complex of individuals, organizations and institutions charged with the undergraduate and graduate education of physicians. It serves as a national voice for all of the 116 operational U.S. medical schools and their students, more than 400 of the major teaching hospitals, and 60 learned academic societies whose members are engaged in medical education, biomedical research and the delivery of health care. Through its members, the concerns of the Association range far beyond medical education itself and include the total health and well-being of the American people.

The subcommittee is considering S. 754 and S. 755, bills that would extend for one year the authorizations for a number of health programs. At the outset the Association would like to emphasize its support of the one-year renewal of expiring health-related legislation, provided that the extension incorporates appropriate fiscal authorization changes and appropriate perfecting technical amendments. This action will provide the Congress with the time to conduct comprehensive reviews of the nation's biomedical and behavioral research program and the National Health Planning program. We agree with the Congress that such reviews would be useful in evaluating current priorities and determining the most productive future course for these programs. The extension will also give the new Administration an opportunity to formulate its own program proposals and priorities.

The main focus of this statement is on five sets of expiring authorities of prime concern to the Association and the research community. These are: the National Research Service Award Act; the National Health Planning and Resources Development Act; the National Cancer Act; the authority for the National Heart, Lung and Blood Institute; and the medical library assistance program.

In anticipation of the expiration of this legislation, extensive discussion has taken place in the biomedical research and academic communities concerning the course of action these communities hope the Congress will take in 1977 in renewing and revising these programs. The Association is prepared to testify on its views on the more long-range directions that should be taken by these expiring programs and submit substantive amendments on each of them during oversight hearings that this subcommittee and its House counterpart have already indicated will be held during 1977 on federal support of biomedical and behavioral research, the mission and accomplishments of the National Institutes of Health, and the National Health Planning Act.

While consideration of long-range changes can be put off for a year, it is imperative that this subcommittee insure the vitality of these biomedical research programs during the intervening 1978 fiscal year. The Association supports increased authorization levels for these programs in order to provide the necessary leeway under which the Appropriations Committee can act to preserve effective programs that should not be required to wait an additional year to make up for inflationary pressures.

Section 472 of the Public Health Service Act provides for the National Research Service Awards program. This specific program was first enacted in the National Research Service Award Act of 1974 and was revised and extended for one year by Public Law 94-278, the Health Research and Health Services Amendments of 1976. This program provides funds under both NIH and ADAMHA for individuals to be trained for careers in biomedical and behavioral research. Awards may be tendered directly to individuals or to public or nonprofit private institutions to support selected individuals. Unless renewed, funding authority to support the National Research Service Awards expires September 30, 1977.

The Association has several comments for the subcommittee's consideration on the extension of the National Research Service Awards Act. These comments are grounded in our firm belief that a strong, viable program of research training is absolutely essential to produce the numbers of skilled biomedical scientists needed to carry out the nation's future agenda for research in the biomedical sciences. Without these programs to capture for biomedical science a reasonable fraction of the nation's most creative young people each year, our scientific efforts and advances will be seriously thwarted.

With respect to the level of authorization for research training for FY 1978, we believe, as does the National Research Council of the National Academy of Sciences, that the present overall level of research training support should be continued. The NIH and ADAMHA together will expend only \$150.5 million in fiscal year 1977. We support the National Research Council's recommendation that at least \$165.2 million in authorization is needed to maintain an adequate

level in fiscal year 1978. Most importantly, institutions and young scientists need stability and continuity in federal support for research training. Without this commitment, it will become increasingly difficult for research to compete with the more lucrative clinical fields in attracting top flight scientific minds.

Apart from this important concern about adequate authorization levels, the Association is still seriously concerned about the attempts made by the previous Administration to thwart the awarding of institutional grants for research training. The language of section 472(d) of the Act states that not less than 25 per centum of the sums appropriated for the National Research Service Awards shall be made available for individual fellowships. Because there is no ceiling on this percentage, efforts were made to make virtually all awards to individual fellows, rather than to institutions. This would have enable the Administration to achieve its long-sought desire to completely terminate institutional training awards. The prevention of such an eventuality was one of the primary reasons that the research training legislation was originally introduced.

The Association views the support of institutional research training grants as essential to the maintenance of the necessary quality and quantity of the nation's biomedical and behavioral research manpower. It believes that the Congress, in passing this legislation originally, intended that institutional awards be granted by the Secretary and that they be used vigorously both to maintain the high quality of existing research training environments and to develop, when justified, new training capacities not yet in existence.

A sound national training program requires an appropriately balanced mix of individual and institutional awards. Institutional awardees, selected in national competition, receive funds to support both trainee stipends and the educational environment—faculty, equipment, supplies, etc.—for training. The individual trainees, almost entirely without a "track-record" in research, are chosen by the grantee institution, which is in an excellent position to assess the applicant's merit and potential for a productive research career. The institutional award thus provides stable continuing and dependable support for a program of training in an institution, and thereby fosters high quality activity. Individual fellowship awards, made by a national selection committee on the basis of academic record and letters of recommendation, provide stipends directly to fellows during a period of training under identified mentors, often in institutions that have no appropriate institutional training grants or formally organized training programs. It is our view that the institutional award should be the mainstay of the national research training effort with the direct fellowships being used to provide special opportunities or to capitalize on special circumstances that complement the institutional grant program.

Research training awards are a particularly important part of the biomedical research training of physician scientists. The Association is particularly concerned that adequate numbers receive high quality research training in the immediate future. If this does not occur, the vital step of the transfer of research-proven ideas to clinical practice will be seriously impaired. Uncertainties and cut-backs in research training in the clinical sciences will inevitably lead to the rapid deterioration of complex clinical research training programs in our nation's academic medical centers. Physicians, as contrasted with Ph. D.'s, do not receive significant research experience in their predoctoral education programs and thus the exposure of these M.D.'s to research methods is largely dependent upon postdoctoral training programs. The institutional variety have been particularly productive. For these reasons the AAMC hopes that this subcommittee will look carefully at the research training program later this year when it considers a further renewal.

In order to preserve the mix of pre and post doctoral, individual and institutional awards, with the Association believes is essential to maintain a high quality national program for developing research manpower and in order to prevent any continuing efforts to circumvent the intent of the Congress that both institutional and individual awards be made, the Association urges this subcommittee to adopt a technical amendment or Report language reasserting the original Congressional intent that there be a balance of awards.

As previously mentioned, the Association supports a one year renewal of the Health Planning Act while the Congress conducts a thorough evaluation of this statute. When hearings are held during this next year, we hope that the Congress will carefully consider amending the law to include a provision requiring representation from academic medical centers on the executive committee (if any) of all local health systems agencies. Such a requirement would provide academic

medical centers the opportunity to fully participate in and contribute to the establishment of policies which could have a direct and important impact upon their operations. These centers constitute major resources for health care in all HSAs in which they are located and the communities should be assured of access to the insight, knowledge and experience which they encompass. Further, the AAMC urges that the law be amended to exempt research administered under NIH grants and contracts from Health Systems Agencies review and approval. Obviously, consideration of these changes in the law, and other substantive changes that are likely to be proposed, should not be undertaken hastily. A one year renewal of the Health Planning Act will provide the time necessary for a competent review of the entire statute unfettered by time pressures and constraints. The Association hopes to have the opportunity to testify further on the Planning Law at that time.

The cancer programs that are scheduled for renewal emanate primarily from the National Cancer Act of 1971, revised and extended by the National Cancer Act Amendments of 1974. There are two specific authorities in the Cancer Acts which will expire on September 30, 1977 unless renewed. The first is the Cancer Control Program (section 409 of the Public Health Service Act) which authorizes programs for diagnosis, prevention, and treatment of cancer in cooperation with State and other health agencies. The second expiring authority (contained in section 410C) provides funds for all other cancer programs, the majority of which involve cancer research. The AAMC endorses the renewal of these authorities with appropriate adjustments in the authorization levels.

The authority for the National Heart, Lung, and Blood Institute also expires on September 30, 1977. These provisions were most recently revised and extended by the Health Research and Health Services Amendments of 1976, which placed new responsibilities within the Institute by upgrading efforts with regard to blood vessel and blood diseases. Similar to the Cancer Act, there are two authorities expiring this year. The first is authorization for cooperative programs in the diagnosis, prevention, and treatment (including the provision of emergency medical services) of heart, blood vessel, lung, and blood diseases (section 414). The second expiring authority (section 419B) provides funding authority for all other National Heart, Lung, and Blood Institute programs including research. As with the Cancer Act, the Association supports the one year renewal of these Heart, Lung, and Blood authorities with the needed adjustments in the level of authorizations.

We also noted that the authority for medical library assistance programs expires on September 30, 1977. Since 1965 Congress has recognized the vital role that information services play in the advancement of knowledge in the health sciences. The need for federal assistance in this area remains a genuine priority as the massive expansion of biomedical knowledge is unabated and continues to outstrip available private resources for information services.

The Association of American Medical Colleges would appreciate your favorable consideration of our recommendations concerning renewal of these programs. As always, the Association's staff is available to assist the subcommittee in any way in which we can be helpful.

WHEATLEY & MILLER,
Washington, D.C.

DEAR MR. WENGER: Pursuant to our telephone conversation of Wednesday, February 23, 1977, I am enclosing three copies of a statement of the Candlelighters for your record on the authorization extension act.

We are circulating a questionnaire to our parents groups throughout the country on the status/impact of the 1971 and 1974 act upon them and will furnish you with a copy for your consideration in shaping the acts which will supersede the present National Cancer Act, as soon as it becomes available.

Very truly yours,

GRACE POWERS MONACO,
National Liaison Chairperson, Candlelighters.

STATEMENT OF THE CANDLELIGHTERS BEFORE THE SUBCOMMITTEE ON HEALTH AND SCIENCE OF THE SENATE SUBCOMMITTEE ON HUMAN RESOURCES

Mr. Chairman and members of the committee: My name is Grace Powers Monaco. I am representing "Candlelighters", a national organization of families with children affected by cancer. We wish to bring to your attention those areas

in which federal funding authorized under the National Cancer Act of 1971 as amended in 1974 has had the most noticeable impact on our children's lives. We direct your attention during these hearings on a one year extension of the National Cancer Act (HR 3539) to those programs we feel merit your further attention either through program re-approval, clarification or emphasis.

This statement is the product of the Metropolitan Washington Candlelighters based upon information received from parents groups in 37 states. I am accompanied by Mrs. Beverly McGaughy, co-founder of the Metropolitan Washington area Candlelighters and its Legislative Chairperson.

Let me first extend on behalf of all of us our deep gratitude and appreciation to you, Mr. Chairman, and the members of this Committee for your continuing efforts on behalf of all persons afflicted by cancer. Your unflagging interest in cancer research and the translation of this research into tangible programs for detection, treatment and rehabilitation of cancer victims throughout the country has widened the benefits of the whole cancer effort. We know that the lives of our children have been, and are continually being extended, and in some cases preserved, through the cancer research efforts which this Committee has supported through the National Cancer Institute.

Nutrition. The testimony of Candlelighters before this Committee in 1974 which motivated the Committee to explore the role of appropriate nutrition in the treatment and rehabilitation of cancer patients and the relationship between nutrition and cancer stemmed not only from a dearth of programs in these crucial areas at NCI but also in large part from the fragmentary treatment of the few programs that did exist at NCI and the dispersal of those programs in many divisions with no one accountable for assessing the status of those programs and making this information generally available to all those who might benefit from it.

As set forth below, those problems still persist and motivate Candlelighters to strongly support that this program be given a line item designation for its appropriation. We realize that the final decision on this is up to the Appropriations Committee but we feel that a recommendation to them from this Committee would carry great weight.

We have two reasons for requesting this line item designation. One is the continuing dispersion of nutrition funds at the NCI. Although the official 1977 designation under nutrition is about \$7 million, the actual budget for the Diet and Nutrition program administered by Dr. Gio Gori is \$3.5 million. Although we have made several inquiries as to the exact use of the other \$3½ million, we have not been able to get a precise list of just where the money is going or exactly what it is funding. We do know that there is still not overall coordination and authority for all diet and nutrition related activities funded by NCI. We also know that there is considerable internal disagreement over nutrition dollars that has resulted in a suggestion by the NCI administration that the current program be disbursed among the various other programs of the Institute. This suggestion would be in direct conflict with this Committee's 1974 mandate and a real loss to the citizens of this country.

Time and again the American medical community has shown itself to be disinterested in and hostile to the nutritional concerns of the people it serves. These current problems at NCI are just another example of this basic antipathy. This Committee has taken the lead in this area of awakening physician interest in nutrition and a line item designation would continue its strong steps in that direction.

Concerning dollars for the nutrition program, we would suggest a 15 percent increase over the current 7.6 million figure as a bare bones minimum.

In response to your mandate on data collection and dissemination, the Diet and Nutrition program has conducted state of the art conferences which have resulted in a clearly formulated approach to the overall problem. Also, the program is almost ready to publish separate handbooks dealing with nutrition as it affects the adult and pediatric cancer patient. Work is proceeding apace on research into diet, nutrition and prevention, but the real news right now concerns using nutritional therapy as a fourth form of cancer therapy along with surgery, radiation and chemotherapy. We feel that this is an area of particular promise with some very exciting preliminary studies which need to be followed up as quickly as possible.

Cancer Control. The Cancer Control and Rehabilitation Division was incorporated into the cancer program authorizing legislation in 1971 in order to provide

for a real need recognized by this Committee and Congress—to bridge the gap between research and the application of that research in the practice of medicine and public health programs. The seed money provided by control for demonstration of research results is working to bridge this gap.

Some examples are the beginning of a communication network (Controlline) through the comprehensive centers developed with the assistance and involvement of local agencies, public and private, concerned with cancer, most prominent in this effort the American Cancer Society. Through these systems another link has been forged to close the gap in providing each U.S. citizen access to what is known about cancer.

Community-based cancer control programs are in the planning and implementation stages. These programs will demonstrate to communities, particularly those which do not lie within the ambit of a cancer center, how they can assess their needs in the cancer control area and provide for them, utilizing the best information and results available to them from Federal research efforts. This program is another move toward the fulfillment of the concern of this Committee that all segments of the population have access to the results of federally-funded research and programs.

One very important effect of the control program has been its function as a catalyst to bring together all aspects of the public and private agencies dealing with cancer and encouraging them to work together so that input from the total community will be received in assessing the cancer control needs of each population involved and developing the ways to meet those needs through cooperative efforts decreasing fragmentation and costly duplication of cancer programs.

The control program has demonstrated acute common sense in its approach to programming for cancer control. It has acted upon the Congress' concern with spiraling costs of hospital based care and it has initiated a series of projects to determine, for example, whether at home rehabilitation and continuing care programs, day hospitals can work and be cost effective. It has realized that the federal treasury is not a bottomless pit and has taken steps to begin the development of guidelines that will enable those receiving demonstration funds to achieve financial self-support during the phasing out of federal funds thus providing some certainty that these demonstration programs will be continued after withdrawal of federal support. It has also initiated a program by which a merit review of projects in progress is conducted at stated intervals. If the review indicates that the program is not or cannot perform its obligations under its scope of work, the programs are being terminated and the moneys recycled to other areas of promise—it is dedicated to the best and most far reaching use of the moneys committed to its care.

Carcinogens. We are pleased with the increased attention being devoted by the NCI to cancer prevention, since the role of carcinogenic agents in the food we eat, and otherwise in our environment is clearly becoming more and more recognized as highly significant. We urge this Committee to give this major portion of its research effort even greater emphasis, and request that Congress provide carcinogenesis research with strong backing.

We also applaud the recent enactment of the Toxic Substances Control Act, giving the Environmental Protection Agency increased power to control the manufacture and distribution of cancer-causing and other hazardous materials and to warn the public of their hazards. We hope this law will be used as an effective means of getting at the difficult problem of reducing the harmful impact of carcinogenic agents once they are identified. We urge all of you to support vigorous implementation of the new Act. A strong regulatory effort to this type can prevent horrors like the current one of Kepone, nitrosamines, polyvinyl chloride and the seemingly endless list of chemical abominations assailing the American public in their newspaper each morning and on the television news at night.

NCI has performed a major service in assembling and publishing very detailed survey reports on the geographic distribution of cancer. Some of the most publicized portions of these reports have shown spectacularly high levels of cancer incidence in areas of chemical pollution, such as the heavily industrialized Northeast. Other areas show abnormally high incidence rates that indicate a relationship of cancer to diet.

With the release of this data, some of the localized causes of cancer became more apparent, and thereby avoidable. Evidence is increasing that major gains in the future fight against cancer lie in prevention. If a chemical plant is releasing quantities of asbestos into the air or drinking water, this can be prevented. If our children and infants are being swathed with talcum, we should not tolerate

a trace of asbestos in that talcum. If Red Dye No. 2 is carcinogenic, we can eliminate it from our food. And as we continue to identify carcinogenic agents in the air we breathe and the food we eat, we can eliminate them or minimize our contact with them.

Reducing our exposure to carcinogenic agents is easier to implement when we can clearly identify the agent and when we know that it is carcinogenic. However, there are many potentially carcinogenic foodstuffs and environmental pollutants for which our knowledge of their effects on our bodies is not sufficiently known.

Despite the growing public emphasis being placed on this subject, there is still considerable unwarranted reluctance to give it the nations full and adequate dedication and resources. For too long we have relied on wishful thinking that those substances which have so far been pinpointed as cancer-causing constitute about all of the carcinogenic agents in the environment. The repeated discoveries that certain chemicals contribute to cancer, though they had not previously been so identified, should prove the fallacy of our wishful thinking.

Knowledge of how our body reacts to the many chemicals to which we are exposed must be decreased significantly so that our health can be protected. The problem is vast, each year new knowledge is fathered and with that a realization of how much remains to be grasped. As just one example, it was not so long ago that it was believed that most of the major metabolic pathways of our bodies were well understood, and now we find vastly greater unknowns than we imagined. This complexity of metabolic pathways is highlighted in two recent Scientific American articles on the liver. This organ, the liver, is a metabolic center of vastly greater complexity than we imagined just a short time ago. Relative to how the body treats ingested pollutants, the liver performs the major house-keeping function. It produces the enzymes to break down foreign substances and provide a first line of defense against them. We know that the liver has enzyme systems that digest the many foods we eat—it has enzyme systems that attack waste products within the body to prepare them for disposal, and it has enzyme systems that break down trace poisons that we have eaten or that have entered our body through the lungs in order to prepare such poisons for ultimate disposal. In performing these functions, which poisons get through these defenses? Which get through and lead to cancers? At what levels of exposure? And the most ironic question of all: which non-carcinogenic substances does the liver turn into effective carcinogens as it attempts to treat them for disposal? We must take steps to answer these and other questions for the liver and for all of the body's cancer-related biochemistry. To prepare for this, now is the time to begin a new emphasis on the scientific studies that are to be the basis of a broader future understanding of the biochemistry of our bodies. This is particularly important for those biochemistries that are most active in metabolizing ingested pollutants, trace elements of heavy metals such as lead and arsenic.

We urge this Committee to insure that NCI and other government agencies are sufficiently funded and staffed to do the research necessary to identify carcinogenic substances and to deal with them and to take steps to eliminate or control these materials as well as warn people about their danger. We have learned that this is not always the case. Congress must further maintain an over-view that will guarantee that these agencies live up to the expectations of the public and the mandate of legislation dealing with research into and regulation of cancer-causing substances.

We applaud the establishment of a Clearinghouse on Environmental Carcinogen within NCI as a step in the right direction in this new emphasis on the carcinogen problem. We have fallen victims to cancer in our families, it is important that everything be done to prevent others from sharing in our experience.

Dissemination of information. One of the problems this Committee focused on in the 1971 Act and the 74 amendments thereto is dissemination of information to the public and the front line physician. We have mentioned several areas previously in this testimony which address efforts of NCI programming to fulfill this need. A large gap still remains.

Much of the information dissemination function has been accomplished with the addition of the Cancer Control Program and various data banks and public information sections of the NCI, for example Controline, Clearinghouse for Public Information. However, there still remains a large gap in the area of disseminating new treatment methods to all practicing physicians and medical students. The Cancer Control program is funding various retraining programs as demonstration projects at locales throughout the country. This is a good first step.

However, we have learned that there is no way to require area doctors to attend these or any other retraining programs and there is no standardized mechanism whereby medical schools incorporate these new methods into their curriculum. Instead, it is a pretty hit or miss proposition dependent on the whim or conscience of the individual doctor and the availability of federal funded retraining programs and in the case of medical schools, the decisions of the department chairmen and faculties.

As consumers, Candlelighters feel that there should be a more regularized system for dealing with the retaining of existing doctors and the updating of training for new ones. With respect to medical schools, we believe that the federal government doles sufficient funds to exert some leverage on their rapid incorporation of the newest treatment methods in the curricula of all the medical schools in the country. Concerning retraining of older doctors, we feel that some means must be devised to make sure that all doctors are required to upgrade their training on a regular basis at their own expense.

Candlelighters plans to undertake a questionnaire process in the months ahead to assess the areas which parents of children with cancer consider the most crucial in new initiatives, redirection of old initiatives and will make the results of this survey available to this Committee in its oversight process leading up to the legislation relating to cancer in 1978. In addition to the subjects noted in this testimony, we will be exploring the problem of portability of insurance, the mechanisms of catastrophic health care coverage or mandating of uniform coverage standards on the private or non-profit insurance sector to avoid the bankruptcy of working families on top of the other strains attributable to an experience with childhood cancer; the application of the best cancer treatment techniques in the area of childhood cancer at medical centers and particularly at the comprehensive cancer centers which hold themselves out to be all things to cancer patients.

We thank you for the opportunity to express our concerns to you and thank you for all you have done for us and for our children.

CITIZENS FOR THE TREATMENT OF HIGH BLOOD PRESSURE, INC.,
Washington, D.C., February 23, 1977.

Mr. ROBERT WENGER,
*Professional Staff Member, Senate Human Resources Committee, Dirksen Senate
Office Building, Washington, D.C.*

DEAR BOB: At the suggestion of Stan Jones, I tried to get in touch with you in relation to testimony on S. 754, the Health Services Act, introduced by Senator Kennedy on February 22. I did talk to Stewart Shapiro, and he informed me that the record was open for five days for additional statements.

I am therefore enclosing the statement of Doctor Joseph Wilber, President of the Georgia Heart Association. I would like to call your attention to one technical change in the language of the old bill (Public Law 94-63) which state and county health officers agree is necessary to clear up some confusion about the right to treat. The suggested new language appears on page two.

I have already talked to Congressman Paul Rogers, Chairman of the House Health Subcommittee, and to Steve Lawton, Professional Counsel of that Committee, and they agree that a technical change is needed in the new bills (H.R. 3598 and S. 754).

If you have any questions on this, I would be very glad to answer them and look forward to an opportunity to meet you personally.

Cordially,

MIKE GORMAN.

Enclosure.

RENEWAL OF HIGH BLOOD PRESSURE FORMULA GRANTS TO STATES

TESTIMONY BY JOSEPH WILBER, M.D., DIRECTOR OF ADULT HEALTH SERVICES,
GEORGIA, PRESIDENT, GEORGIA HEART ASSOCIATION

Mr. Chairman and members of the committee: The 1975 Health Services Act (Public Law 94-63) authorized \$15 million in fiscal 1976, and \$15 million in fiscal 1977, empowering the Secretary of Health, Education and Welfare to make grants to state health agencies for the purpose of establishing and main-

taining programs for the screening, detection, diagnosis, and control of high blood pressure.

Due to delay in appropriations in fiscal 1976 because of an Administration veto of the Health Services Act, the formula grant program received only \$3,750,000 in fiscal 1976. For the current year, fiscal 1977, \$9 million was appropriated. The Ford administration recommended \$9 million for the program in fiscal 1978, the exact same amount as in the previous year.

Mr. Chairman, there is just one important change in language which I feel is absolutely crucial to the success of the high blood pressure program. We must insist that treatment be included in the formula grants to the states program. We know that this was the intent of the Congress, but we want it spelled out in clear terms.

In the four-paragraph regulation on high blood pressure released after a six-months delay, there was reference to prevention, detection, diagnosis and "referral for treatment." This "referral for treatment" language, developed by some obscure lawyer in the Office of Regulations of HEW during the Ford Administration, has been greeted with either mystification or derision by state and county health officers. They point out that to detect a hypertensive but then not have the ability to treat him because of lack of funds is a patent absurdity.

On February 11-12, the state and county health officers met with officials of both the National Heart Institute and the 314(d) formula program to straighten this matter out before Congressional hearings were held. The general consensus of those present was that the formula grants to the states and localities should be used "for the screening, detection, diagnosis, prevention and ambulatory care for the management of high blood pressure." This language has been submitted to the House Health Subcommittee by myself on behalf of the Southeastern Regional Council on High Blood Pressure and the New England Council for High Blood Pressure, whose President is Doctor John Karefa-Smart, of Roxbury, Massachusetts.

The greatest benefit to be gained by treatment of early hypertensives is in the field of prevention. This is the first preventive program being launched against a major chronic disease. It keeps people out of hospitals, because 99 percent of its victims can be treated on an ambulatory basis. For example, chronic kidney failure requiring kidney dialysis costs \$20,000 a year for each patient hospitalized. In our experience in Georgia, we have found that anywhere from 25 to 50 percent of those suffering from end-stage kidney failure could have been treated successfully if their high blood pressure had been detected and treated earlier. The facts of high blood pressure treatment are these:

(1) In a great number of people with hypertension, drug therapy is not necessary. In the report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure, reprinted in the *Journal of the American Medical Association* January 17, 1977, it is pointed out that in a large percentage of the patients with a 90-105 diastolic range (90 is considered normal) treatment should start with non-drug therapy. This treatment includes reduced salt intake, weight control, no smoking, etc. It is obviously very reasonable.

(2) Patients with diastolic pressure of 105 or more should receive drug therapy. The annual costs of the medications:

(a) For generic name prescriptions, \$70 a year. This comes to about \$6 a month. Very importantly, public programs engage in bulk buying of generic drugs because of the savings achieved.

(b) Trade name prescriptions, \$131 per year.

(3) A rough estimate of state high blood pressure control program directors early this year indicates that about 15 to 20 percent of their total programs goes into total treatment costs. The rest is for screening, detection, diagnosis and prevention. According to Doctor Robert Levy, Director of the Heart Institute, we still have about ten million Americans who are either not aware that they have hypertension or are on no therapy at all for one reason or another. It is also important to note that creation of public awareness is a long-term problem—in other words, you can detect and motivate only a certain number of people each year. This is obviously a cost limitation factor.

(4) Even using the most conservative estimates of benefits and the most liberal estimates of treatment costs, the National Heart Institute estimates that the average benefit-to-cost ratio of hypertension control is \$1.24 for every dollar spent. In other words, treatment returns 25 percent more than it costs.

I have been in the field of hypertension for more than 20 years, and I have worked among many of the poor folk in the rural areas of Georgia. Some of my

patients cannot pay the small amount of money for drugs to control their disease. I have been very fortunate in the fact that President Carter, as Chief Executive of my state, started the first ten hypertension treatment clinics for those who had no physicians or could not afford the drugs.

In 1974, then Governor Carter recognized high blood pressure as a major public health problem and he also recognized that stroke (the third leading cause of death) was the most preventable of all the major killers and cripples by control of high blood pressure. As a result Georgia was the first State to appropriate public funds (\$500,000) to begin community programs to detect and treat high blood pressure. The South Carolina and Mississippi legislatures have followed suit and also have begun public health efforts to control high blood pressure. With the passage of the 1975 Health Services Act all of the states have begun programs and for the first time there is national recognition that this is a common public health problem where results will be seen in terms of reduced deaths and disability immediately if the majority of the people with hypertension can be detected, educated and treated. It would be a tremendous step backward not to increase the funds available to the states at this time when programs are just getting underway in a majority of the states.

The theme of the Third National Conference on High Blood Pressure Control will be "long-term maintenance of therapy." We have chosen this theme because we know that hypertension drugs must be taken over a lifetime, just as the diabetic takes insulin. We have a large drop-out rate among those we detect as hypertensive, and we attribute a great deal of this to two factors: lack of motivation to go to the doctor when you have no symptoms, and the constant fear that it will cost a great deal of money, a fear which is totally unjustified.

In other words, Mr. Chairman, we are just beginning to do the job. We are reasonably confident that additional state legislatures, depending upon their financial condition, will vote additional monies for the treatment of those who are unable to afford treatment, but we need help in conquering the national problem which affects 23 million of our citizens.

The allotments to the states are based upon population and financial needs. They are woefully inadequate; only two states—California and New York—receive more than \$500,000, and most states receive less than \$100,000. The National Center for Health Statistics has reported that there are a minimum of 23 million hypertensives in the United States; only 30 percent of these are both aware of the disease and are receiving adequate therapy. The other 70 percent comprise 29 percent who do not know that they have the disease; 23 percent who have been detected but have received no treatment, and 19 percent who have been detected but are receiving inadequate therapy for a variety of reasons.

Why are detection and treatment so important in this disease which has no manifest symptoms?

First of all, because health officials of the Department of Health, Education, and Welfare have on numerous occasions in recent years categorically stated that, undetected and untreated, high blood pressure is responsible for at least 200,000 deaths each year. It can, and frequently does, lead to stroke, heart attack, heart failure and kidney failure.

For these reasons, early in 1972, along with the American Heart Association, the American Medical Association, the American Nurses Association, the National Kidney Foundation, the National Medical Association, the American Hospital Association, Citizens for the Treatment of High Blood Pressure, the American College of Cardiology, the American Osteopathic Association, and many other organizations, HEW launched a campaign designed to alert the 50 percent of the people who had high blood pressure but did not know it and, as a second step, to bring about control of this disease everywhere possible.

Last year, commenting on these efforts, the House Appropriations Committee noted that the number of persons unaware that they have high blood pressure has dropped by five million—from nearly 50 percent to about 30 percent. The number of patients with good control of their high blood pressure has doubled—from about two million to over four million. While these figures are encouraging, the House report noted that there are still over seven million Americans unaware of their high blood pressure, and an even larger number who are aware but not receiving adequate therapy.

Concluding its section on high blood pressure, the House Appropriations Committee stated that "it has been informed that it is not unreasonable to expect that an all-out effort to control blood pressure in a given state or community would reduce the number of strokes by at least one-third, eliminate three-fourths of

the cases of heart failure, reduce kidney failure by ten to fifteen percent, and produce a drop in the number of heart attacks. The state-of-the-art exists, and the present resources of the health care delivery system are adequate to accomplish this task."

Working closely with the National Heart, Lung and Blood Institute, whose Coordinating Committee on High Blood Pressure is made up of the national organizations cited above plus representatives of state and city programs, the National Center for Health Statistics recently reported that over a two year period, the death rate from hypertension alone declined a remarkable twenty-one percent; the death rate from hypertensive heart and renal disease declined fourteen percent, and the stroke death declined 9.6 percent. We do not contend that this entire drop is due to our joint efforts, but we know that none of these declines in morbidity existed before the inception of the program.

The declines which have been achieved, apart from humanitarian considerations, are dramatically cost effective in holding down our nation's medical care bill. For example, circulatory problems, the common result of prolonged hypertension, are responsible for 26 million days of hospitalization each year. Furthermore, data from the Social Security Administration indicate that hypertension and its consequences account for the largest single number of disability claims.

Now to the state picture: As state health officials, our job is to bring the results of the research and educational work of the Heart Institute to the victim of high blood pressure. I could cite many examples of this, but one will have to suffice:

Several months ago, the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure released its long awaited report on Guidelines for the Detection and Treatment of High Blood Pressure. This is an invaluable tool. These Guidelines have been reprinted in full in the January 17, 1977 issue of the *Journal of the American Medical Association*, along with an editorial by Doctor William R. Barclay, Editor of the Journal, urging all physicians to give them their most careful attention. In a recent article in *National Journal* devoted to the crucial problem of bridging the gap between our rapidly accumulating research knowledge and its application to the patient, Doctor Donald Fredrickson, Director of the National Institutes, singled this report out as the most striking example of the research community working closely with the practitioners of medicine.

We will use these materials at the state and local level, but we also need funding to carry out their recommendations. An article in the *Journal of the American Medical Association*, however important, is not going to control one case of high blood pressure.

A few of the state legislatures have appropriated money for high blood pressure control, but many of the states face grave financial deficits and do not have the wherewithal to finance practical detection and treatment programs at the grass roots.

For that reason, on February 11 and 12 state health officials met with officials of the National Heart Institute and representatives of major national organizations to close our ties and to see that there is no duplication in our efforts. The Heart Institute has the major research function in hypertension; we at the state and local level have the major diagnostic and treatment responsibility.

Mr. Chairman, we understand fully the time pressures under which you are working and the necessity just now for a one year renewal of the expiring high blood pressure authorization. We believe that a minimum of \$30 million is needed in Fiscal 1978 in formula grants to the states to accomplish our objectives. We cannot let this program which has been so successful and so cost effective stand still.

On our part at the state and local level, we pledge to you continuing efforts to raise funds to carry to final success one of the great crusades in American medical history.

CYSTIC FIBROSIS FOUNDATION,
Washington, D.C., March 8, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health, Committee on Human Resources, U.S. Senate, Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR KENNEDY: The Cystic Fibrosis Foundation wishes to commend the Committee for the proposal to extend for one year the Health Services Re-

search Bill (S.754) thereby providing an opportunity for deliberate consideration during the next year on the National Heart, Lung and Blood Act and the National Research Service Awards Act.

These Acts are of vital concern to the scientific and medical community of the Foundation and to the patients who suffer from cystic fibrosis and related lung damaging diseases.

We would like to offer our support and assistance at the time substantive hearings are held to design the future of these programs.

Respectfully,

Mrs. ROBERT F. TULCIN,
President.

CYSTIC FIBROSIS FOUNDATION,
Washington, D.C., March 8, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health, Committee on Human Resources, U.S. Senate, Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR KENNEDY: On behalf of the Cystic Fibrosis Foundation, I would like to submit the enclosed statement for the record of the hearings on S. 755, the Health Services Bill.

Respectfully,

Mrs. ROBERT F. TULCIN,
President.

Enclosure.

STATEMENT OF THE CYSTIC FIBROSIS FOUNDATION ON HEALTH SERVICES BILL (S. 755) FOR THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON HUMAN RESOURCES, U.S. SENATE

Washington, D.C., March 8, 1977.

The Cystic Fibrosis Foundation would like to commend the Subcommittee on Health for the concern for maternal and child health demonstrated by the Health Services bill (S. 755).

Health care for patients with cystic fibrosis at the present time, conservatively stated, is \$50 million annually (\$200 million by 1990). The \$4.5 million provided by the Crippled Children's Programs and the \$2.2 million provided for pediatric pulmonary centers through the Bureau of Maternal and Child Health are the major sources of government funds for health care for these patients and for patients with related lung damaging diseases.

The inclusion of title V of the Social Security Act in the health programs to receive a 15-percent increase in authorization in fiscal year 1977 indicates a vital interest in the continuity of the programs funded under title V and a deep commitment to the improvement of the health of mothers and children.

The Cystic Fibrosis Foundation strongly supports a more equitable formula for the allocation of funds among the States, development of standards for uniformity in distribution of these funds, an emphasis on continuing health care for the chronically ill when they attain the age of 18-21 and increased support for related research and training programs.

The Cystic Fibrosis Foundation offers its support and assistance in the review of this program during the next year and in designing future program plans.

FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY,
Bethesda, Md., February 25, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health and Scientific Research, Committee on Human Resources, U.S. Senate, Washington, D.C.

DEAR SENATOR KENNEDY: As you know the enabling legislation for several major biomedical research activities will expire during 1977. Prominent among the programs affected are those in cancer, cardiovascular, pulmonary, and blood research as well as research training for all of the Institutes of the National Institutes of Health.

Re-enactment of the expiring authorities is of great interest to the biological community and the subject has generated widespread discussion in recent months.

From those discussions has emerged considerable support for a 1-year renewal of the authorities, with slight increases in funding levels appropriate to higher costs. The rationale for the 1-year renewal arises from the stated intent of your Committee and that in the House to hold comprehensive hearings on the nation's biomedical and behavioral research programs later this year. Additionally, there is the desirability of permitting a new Administration sufficient time to review these activities and establish its own strategy and priorities.

The Inter-Society Council for Biology and Medicine urges your support for this legislative strategy. The Council is composed of representatives of the following organizations:

Federation of American Societies for Experimental Biology,
American Institute of Biological Sciences,
American Society of Allied Health Professions,
American Society for Medical Technology,
American Society for Microbiology,
Association of American Medical Colleges,
National Society for Medical Research.

We are in complete agreement that these reviews are both timely and highly desirable and provide the opportunity for further strengthening of these programs of such importance to the health of the American people.

We reiterate our support for the 1-year renewal. Further, when the oversight hearings are scheduled, the individual organizations comprising the Council would appreciate the opportunity to testify as appropriate.

Sincerely yours,

EUGENE L. HESS, Ph. D.,
Executive Director.

HEALTH INSURANCE ASSOCIATION OF AMERICA,
Washington, D.C., February 15, 1977.

HON. EDWARD M. KENNEDY,
U.S. Senate, Russell Senate Office Building,
Washington, D.C.

DEAR SENATOR KENNEDY: I want to express our support for the proposed one year extension, without substantive amendment, of The National Health Planning and Resources Development Act of 1974, Public Law 93-641. Since 1969, the Health Insurance Association of America has favored a constructive program of Health Planning and Resources Development. We supported the original passage of Public Law 93-641 in 1974.

A 1-year extension of the Act without amendment would give the new Administration an opportunity to review the issues raised by the Act and is in the best interest of health planning for our nation. However, should amendments to the Act be discussed, the Health Insurance Association of America will have amendments to offer for your consideration. They may include:

1. A change of the makeup of the HSA boards;
2. A permanent health planning act;
3. Coverage of all health facilities by certificate-of-need requirements;
4. Development of a data consortium in each state;
5. Giving HSA's the ability to recommend and state health planning and development agencies the power to decertify excess health care services and facilities;
6. Provide funds for health facilities, that have had services decertified, to retire the debt incurred for the development of the service;
7. Increased funding for HSAs; and
8. Establish the principle of disclosure by health care institutions as a prerequisite to rate control.

These are some of the areas we believe should be considered for amendment; and will be happy to discuss them with you and your staff when you are prepared to accept substantive amendments to the Act.

Thank you for your consideration.

Sincerely,

CALVIN P. JOHNSON.

MEDICAL LIBRARY ASSOCIATION, INC.,
Washington, D.C., March 4, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health, Senate Labor and Public Welfare Committee, U.S. Senate, New Senate Office Building, Washington, D.C.

DEAR SENATOR KENNEDY: I am writing to call to your attention the strong interest and concern of the Medical Library Association in renewal of extension of the Medical Libraries Act which is part of S-754. The Regional Medical Library program brought into being by the initial Medical Library Assistance Act of 1966 is probably the single most important factor over the past 10 years in transforming a collection of physically decrepit and resource-limited group of health libraries into a modern information delivery network. Through extensions of this legislation we have seen develop a strong grass roots community hospital library program which contributes directly to enhancing the application of new health knowledge to the delivery of health care to the consumer. We have seen improvements in the technological effectiveness of information delivery systems through new non-print media. We have seen innovative computer applications to the management of libraries. We have experienced a change in the profession of medical librarianship from curatorship to active participation in the health care delivery team. All of these activities contribute to better utilization of scarce health manpower, and thus affect the quality of health care.

In urging your support of this legislation, we would also like to recommend that this bill, which is only a 1-year extension, be changed to a longer time period, i.e. 3-5 years. Also, we would urge that the Senate include an actual amount for the fiscal allocations rather than the present nonspecific language. At least \$10 million will be necessary for effectively continuing these worthwhile programs, consolidating the work that has begun and providing a base for further innovation in health information management. Information, quality information, is vital to growth and progress. Thank you for your attention.

Sincerely yours,

NINA W. MATHESON,
Chairman, Legislation Committee.

MENTAL HEALTH ASSOCIATION,
Arlington, Va., March 11, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health and Scientific Research, Committee on Human Resources, U.S. Senate, Russell Senate Office Building, Washington, D.C.

DEAR SENATOR KENNEDY: Regarding proposed legislation renewing for one year (fiscal year 1978) the Community Mental Health Centers (CMHC) Act, we will appreciate your consideration and support of our recommendations on authorizations and limited technical amendments.

We are also hopeful that the House and Senate Reports related to this year's renewal legislation will include language calling for Congress to consider several possible modifications in the Act when long term extension is considered next year.

Our recommendations on both these matters are enclosed.

Yours sincerely,

HILDA ROBBINS, *Chair*
Public Affairs/Service
Delivery Committee.

Enclosure.

STATEMENT OF THE MENTAL HEALTH ASSOCIATION ON S. 755, THE HEALTH SERVICES, HEMOPHILIA AND HEALTH PLANNING AND DEVELOPMENT EXTENSION ACT OF 1977

SUBMITTED BY IRVING H. CHASE, CHAIRMAN, COMMUNITY MENTAL HEALTH CENTERS RENEWAL SUBCOMMITTEE, PUBLIC AFFAIRS-SERVICE DELIVERY COMMITTEE, THE MENTAL HEALTH ASSOCIATION, ARLINGTON, VA., AND PRESIDENT, HENRY THAYER CO., CAMBRIDGE, MASS.

ATTACHMENT NO. 1—MENTAL HEALTH ASSOCIATION, NATIONAL HEADQUARTERS
RECOMMENDATIONS FOR AUTHORIZATIONS FOR THE COMMUNITY MENTAL HEALTH CENTERS PROGRAM
FISCAL YEAR 1978

	Recommended for new grants (millions)	Number of new grants
Initial operations.....	\$56.4	100
Planning and development.....	6.9	150
Consultation and education.....	7.8	100
Conversion.....	25.3	100
Financial distress.....	3.9	25
Total.....	100.3	

Mr. Chairman and members of the committee: My name is Irving H. Chase. I reside in Lincoln, Massachusetts, and am President of the Henry Thayer Company, engaged in the business of food processing and packaging.

I am pleased to present the views of the Mental Health Association, a national citizens' organization working to ensure adequate services for the mentally ill. I am a past president of this Association, past president of the Massachusetts Division of the Association, and currently serve on the National Public Affairs-Service Delivery Committee as Chairman of the Subcommittee on Community Mental Health Centers (CMHCs) Renewal Legislation.

Mr. Chairman, my testimony will support the early passage of S. 755 and urge an increase in the authorization level for the Community Mental Health Centers (CMHC) section of the Act.

I will also offer several preliminary recommendations in reference to long-term extension of the CMHC Act, which we understand will be reviewed soon for 1978 legislation.

I. Recommendations regarding authorization levels for CMHCs in fiscal year 1978

The Association recommends \$100,300,000 in authorizations for new community mental health services in FY 1978 (attachment #1). Following is a breakdown of our recommendations.

INITIATION GRANTS

The Association is placing particular emphasis on the need for an authorization of \$56.4 million for Initial Operations, which would fund 100 new Community Mental Health Centers (CMHCs).

There has been a sharp reduction in funding for Community Mental Health Centers since 1972. Following is a review of the recent history of Federal support to start new CMHCs.

[In millions of dollars]

Fiscal year:	Funds to start new CMHC's	Funds for new services in existing CMHC's	Construction funds	Funds for new children's services
1972.....	45.2		14.0	10.0
1973.....	40.5		18.4	11.7
1974.....	29.7		13.9	11.7
1975.....	24.0	¹ 24		
1976.....	26.5	¹ 28		
1977.....				

¹ Includes funds to convert from 5 to 12 services, and consultation and education money.

In 1972, there was \$45.1 million to start new CMHCs and that amount had decreased to \$26.5 million by 1977. If an inflation factor is added, that differential is even more startling.

It is true that as of 1975, the Federal government started to put some funds into the development of new services in existing CMHCs, in addition to providing

support to start new centers. Important as funds for new services in existing centers are, they do not help that 60 percent of the nation that still has not received its first dollar in CMHC start-up funds.

There is considerable accumulation from previous years of approved but unfunded Community Mental Health Centers grants. Currently, there are 38 communities awaiting initiation grants to start new centers, and many more will be added to that list shortly. In addition, there are 139 other grants that have not been funded, in areas related to Consultation and Education, Conversion grants, etc. The total needed to fund all of these grants, and the start-up grants, is \$51.2 million. We want to underscore again that all of these grants are a backlog from previous years. During fiscal year 1978, an equal number of grant requests is anticipated. The need is there. It is just a question of getting the additional funds.

It is also important to note that the Federal funds represent only about 35 percent of the total dollars that are being spent on CMHC services. The other largest part of the funding dollar comes from state government (30 percent), followed by local government (11 percent).

Congress has established a goal of complete national coverage of 1500 Community Mental Health Centers by 1980. Presently, there are 649 Federally funded centers. Although the Association has concluded that it will not be possible to achieve the 1980 target, it is crucial that Congress support a very substantial increase in the fiscal year 1978 funding for new centers, if the nation is to make even modest progress toward the goal of national coverage.

PLANNING AND DEVELOPMENT

The Association is recommending \$6.9 million which would provide 150 Planning and Development grants. Recognizing the strong support from the Administration for moving the CMHC program forward and anticipating continued strong support from Congress, the Association is recommending funding for 150 new Planning and Development Grants. A number of communities have held back in recent years in planning for new CMHCs because of the previous Administration's opposition to funding Centers. There are currently 40 approved but unfunded planning grants, and it is expected that the momentum of the receipt of planning grants will accelerate later in the fiscal year. Funding for 150 new Planning and Development grants would provide adequate support to meet the expected new impetus coming from communities throughout the country.

CONSULTATION AND EDUCATION (C. & E.)

The Association is recommending \$7.8 million for fiscal year 1978, which would provide for 100 new C. & E. grants.

Centers, by providing C. & E. services, reach out into the community. They consult at the local level with individuals and groups, including clergy, police, schools and courts, who are the first to come in contact with people suffering from emotional problems. This results in early case-finding, an important part of preventive mental health services. It also allows for early intervention in life crises, which can reduce the incidence of mental illness. This service is truly on the cutting edge of Community Mental Health Center care.

CONVERSION

The Mental Health Association is recommending \$25.3 million which would provide for 100 conversion grants. Funding of conversion grants for CMHCs has been seriously short in both fiscal year 1976 and fiscal year 1977. As a result, many Community Mental Health Centers that wanted to convert from 5 to the newly mandated 12 services, have been unable to do so. This is in the face of the fact that such conversion was mandated by the CMHC Act passed in 1975. \$25.3 million would be sufficient to meet the need in fiscal year 1978, assuming that centers will be given two years after receipt of the conversion grant to provide these 12 mandated services.

FINANCIAL DISTRESS

The Mental Health Association is recommending \$3.9 million, which would provide for 25 Financial Distress grants. The Association has had mixed feelings regarding their support of the financial distress program. To provide much in the way of support to the communities that have already received eight years of

federal grant support, while two-thirds of the nation goes without any federal start-up funds for CMHCs, is questionable practice. We support distress grants only where the need is well documented and the CMHC has carried out a well-planned effort to seek other funds.

CONTINUED SUPPORT FOR CHILDREN'S SERVICES UNDER THE ACT

Nineteen Children's Services (under part F of the CMHC Act of 1975) are in catchment areas not served by Centers. Current law states that unless they convert to become full fledged CMHCs, they will lose Federal funding at the end of fiscal year 1977. Many of these nineteen are special services that do not easily lend themselves to providing an adequate base to become a CMHC. We therefore would support a technical amendment to S. 755 which will provide one more year for Centers supported under the Act before the 1975 amendments to meet the requirements of Section 201.

CMHC CONVERSION GRANTS

The 1975 CMHC Act required that all Centers convert from five to twelve services within two years. However, appropriations have been inadequate to permit all CMHCs to convert to the twelve mandated services.

Centers qualifying for and unable to obtain Federal assistance because of failure to meet the requirements of the 1975 Act. The technical amendment alluded to above will provide relief especially for two groups of services. (1) free standing childrens' programs supported under provisions of Part F, and (2) a number of CMHCs with continuing funding problems.

II. Preliminary Recommendations Related to Possible Modifications In the Long-Term Extension of the CMHC Act

1. *Federal matching funds to provide states with money for development of one-year state-wide comprehensive mental health projects.*

The President has established a President's Commission on Mental Health, which will study and make recommendations regarding major unmet mental health needs in the nation. A similar study has not been conducted since the Joint Commission on Mental Illness and Health in 1961.

In follow-up to the 1961 Joint Commission Report, Federal matching funds were provided to states to carry out statewide comprehensive community mental health planning projects. These planning projects resulted in many changes in the care and treatment of the mentally ill, including the enactment of Community Mental Health Service Acts in a number of states.

The Joint Commission Report and the state mental health planning that followed were complementary. Both were needed to achieve change. The Joint Commission detailed mental health problems on a national level, but the state planning was essential if the states were to discover and take action on their own mental health needs.

In recent years, there have been major changes in the delivery of mental health services. But it is not clear that adequate services are being delivered. Indeed, there are indications of major gaps, such as failure to provide adequate assistance to patients leaving state mental hospitals.

There are many other questions and problem areas that should be addressed through a new statewide planning effort. Therefore, the Mental Health Association is recommending that in 1978, legislation be enacted that provides for Federal matching funds to states to engage in statewide comprehensive community mental health planning projects. While this would be a large scale, time limited (1 year) effort, one objective would be to assure continuing mental health planning capacity at the state level.

Specifically, the purpose of the planning effort would be to encourage the states to:

(1) Consider the advantages of developing an integrated mental health delivery system, bringing together the state mental hospitals and community mental health services. This might include having all patients who are admitted to state mental hospitals enter through the Community Mental Health care system. It might also include financial incentives to community mental health care contained in "single stream" funding. That is, it could provide funds to the Community Mental Health systems, which in turn could fund state mental hospital care, similar to the California system. It might include taking steps to develop a system which provides for continuity of care, including emphasis on the provision of

community support systems for persons leaving state mental hospitals and other mental health facilities.

(2) Begin planning for the advent of national health insurance and its impact on State funding of mental health services.

(3) Study and make recommendations concerning the development of a continuing mental health planning capacity within the state mental health authority.

(4) Consider how much of a state mental health authority's efforts should continue to be focused on the delivery of services, as opposed to becoming principally an authority for planning, financing, program review, etc., of mental health services.

(5) Examine the state mental health code in relationship to new model mental health codes now available.

(6) Plan for more adequate utilization on title XVI (Supplemental Security Income) and title XX (Social Services) funds under the Social Security Act.

(7) Review the Medicaid policy in relationship to funding of mental health services.

(8) Consider mental health research needs and possible State involvement in funding more research.

(9) Study the need for developing an ongoing mental health manpower training capacity at the state level.

2. *Consideration of permitting communities to start Community Mental Health Centers with fewer than 12 services and of providing for a longer time to achieve the 12 mandated services*

The Community Mental Health Centers Act, as amended in 1975, mandated that all new CMHCs provide twelve services, instead of just five, as required under the old legislation. It also mandated centers currently receiving Federal funds to develop the twelve services within 2 years.

The increased funding needed to start new CMHCs providing the full twelve services, and the increased money needed to convert existing centers to twelve services, have made it more difficult for those communities that have no Federal CMHC start-up money to obtain such funding. Presently, 649 communities out of 1,500 have received Federal funds to start new CMHCs.

In 1977, \$26.5 million went to start new centers, while \$28 million went to provide new services in existing centers.

The Mental Health Association recommends that this problem be studied in depth, with a view toward spreading the Federal dollar to more communities that have received no Federal funds. This might mean cutting back on the number of services required to start new CMHCs, and permitting a longer period until centers would have to provide the full spectrum of twelve services.

3. *Changes in the CMHC Act and the National Health Planning and Resources Development Act, to bring general provisions of one Act into conformity with the other*

Changes are needed in the CMHC Act and the National Health Planning and Resources Development Act to bring several provisions in the one act into conformity with the other:

(1) The CMHC Act should require that its catchment areas be changed so that none lies in more than one Health Service Area.

(2) The composition and definition of the governing board memberships should be changed in the Health Planning Act to be consistent with the CMHC Act.

(3) The CMHC Act and the Health Planning Act should be modified to require that provisions related to CMHC planning mandate their integration into the Health Systems Agency and state plans.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.,
Washington, D.C., February 28, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health and Scientific Research,
Washington, D.C.

DEAR MR. CHAIRMAN: With respect to hearings which are in progress to extend expiring programs under the Health Services Administration, I am hereby submitting statements of our President, Janice Robinson, and Treasurer, Daniel Hawkins.

These statements reflect the official position of our organization relating to the Community Health Center and Migrant Health programs, currently authorized under Sections 319 and 330 of the Public Health Service Act.

On behalf of our Association, I would appreciate your incorporating the enclosed statements as part of the official record. As always, your consideration of our views and recommendations is deeply appreciated.

Sincerely,

THOMAS J. VAN COVERDEN,
Policy Analyst.

STATEMENT OF JANICE ROBINSON, RN, M.S., PRESIDENT, NATIONAL ASSOCIATION OF
COMMUNITY HEALTH CENTERS, INC.

I am Janice Robinson, President of the National Association of Community Health Centers and Executive Director of the Neighborhood Health Services Program of St. Luke's Hospital Center, a Community Health Center in New York City serving in excess of 20,000 patients. Our organization represents both Community and Migrant Health programs throughout the United States. As my colleague will address specific issues on Migrant Health, I shall focus on Community Health Centers.

First, I want to thank you Mr. Chairman, and the Members of this Subcommittee for their support of the community and migrant health center programs. These programs have proven their effectiveness and can be termed successful by any standard. I am here today to highlight those successes and ask for your continued support.

During the past several years, Community Health Centers (CHC) have proven to be a singularity effective model for the provision of quality health services for the unserved and underserved throughout the country. Fiscal year 1976 and 1977 have seen a continuation of the management progress which has impressed even skeptics. The attached chart compares progress from 1975 through fiscal 1978 (estimates based upon revised 1978 budget). Comparing fiscal year 1975 to fiscal year 1976, the number of persons served by CHC's increased from 1,425,000 to 2,539,160, an increase of 1,114,160, over 1 million patients or 78 percent. The estimate for fiscal year 1977 is 3,328,000, an additional increase of 31 percent. These significant increases, a reflection of national economic distress and need, did not retard further advancements in providing maximally cost-effective services:

1. The number of encounters (fiscal year 1975 to fiscal year 1976) increased from 6.6 million to 10 million, an increase of 52 percent. In fiscal year 1977, the number is expected to reach 11.7 million—an additional 17 percent.
2. Cost per encounter, calculated in grant funds, decreased from \$30 to \$20, a decrease of 33 percent. In fiscal year 1977, it is expected to reach \$18—an additional 10 percent.
3. Annualized total cost per person served decreased from \$204 to \$129, a decrease of \$75 or 36 percent. This \$129 per capita cost for Community Health Center patients compares to data in the 1974 statistical abstract of the United States which indicated a per capita cost of \$214 for comparable services as a national average.
4. Third-party receipts, which have increased because of improved billing and collection procedures and other management practices, rose from \$62 million to \$93.7 million or 51 percent. The increase as a percent of total operating costs rose from 22 percent in 1975 to 29 percent in 1976. Again we expect to improve in 1977.

These data are particularly significant when compared to increases in the national inflation rate for health care during the same periods. Community Health Centers are clearly cost effective.

Statistics also indicate significant results in the improvement of health status for those served. DHEW's own data indicates that Community Health Center clients have a 34-percent lower rate of hospitalization than the overall national average.

University-based studies have confirmed the positive impact of CHC services. Chabot found a 28-percent decrease in infant mortality in areas of Denver, Colorado, served by Community Health Centers. Gordis found a 60-percent reduction in hospitalization for rheumatic fever in areas of Baltimore, Maryland, served by CHCs over a ten-year period. Klein documented a 50-percent reduction in hospital days for children in Rochester, New York, served by Community

Health Centers. Dr. Mildred Moorehead indicated a higher quality of care ratings than the 10 medical school affiliated hospital departments and seven group practices sampled.

Thus, Community Health Centers today are serving a greatly increased number of patients compared to a year ago. They are providing cost-effective, high quality services. We are pleased to see that the new administration has recommended a \$14 million increase for fiscal year 1978; however, even an appropriation of this amount would little more than offset inflationary costs for existing services.

Using data supplied by the Congressional Budget Office to determine in a realistic manner the amount required to maintain current services, the increase at which we have arrived from fiscal year 1977 to fiscal year 1978 is 6.7 percent based upon (1) a GNP deflator factor of 5.2 percent applied to administrative costs (at 23 percent of total operating costs), and (2) the CBO medical care price index of 7.1 percent applied to direct and indirect medical care costs (about 77 percent of total operating costs). Based upon a sampling review of several centers, experience shows that costs have increased steadily from 8-12 percent. If CBO's 6.7-percent projection is correct it would mean a decrease in the rate of escalation.

Using CBO's projection, the minimum necessary to continue current services through fiscal year 1978 is \$229,550,000.

I would point out, however, this calculation does not take into consideration increased utilization, which has been experienced with consistency during the past few years. Two major causes have been (1) the large numbers of unemployed in the highest of unemployed areas—the inner city, those who lack third-party coverage, and (2) greater numbers of people, both city dwellers and agricultural workers and their families, with inadequate incomes to afford health care if it were available or inadequate insurance coverage by employers. In both cases these groups are defined as medically indigent, and in many cases can only rely upon the local health center for decent health care.

With respect to 3d party receipts, the budget projects an increase of \$23.6 million for fiscal year 1978. This projection is questionable because it does not take into account proposed reductions in state Medicaid programs. As much as 85 percent of all 3d party receipts are from Medicaid. New York, for example, has recently proposed a 10 percent across-the-board reduction in their reimbursement rates in addition to a \$.50 charge for prescription drugs and elimination of some services. This alone would reduce DHEWS fiscal year 1979 projection by \$2.5 million to \$3 million. While health centers are proud of their achievements in maximizing 3d party receipts the fact remains—state budgets are strained and Medicaid appears to be a prime target. A recent survey by the National Governor's Conference notes that some 18 States are contemplating reductions in their Medicaid programs.

Moreover, a total increase in 3d party receipts does not clearly reflect the fact that in most states, Medicare and Medicaid do not either fully reimburse for the cost of services nor cover all necessary services. For example, the financial records of a center in Minneapolis show that on the average, the center loses \$19 per visit for its Medicaid patients. So although the center may collect more dollars by treating more Title XIX eligibles, it still operates at a deficit, which must be supported by other means. Further, by law, a center must provide a range of services to all individuals in its target area, regardless of ability to pay or third-party coverage.

With respect to new projects, the revised budget projects funding 90 new projects. At a minimum this would require an additional \$20 million, based upon experience. If this money is not made available, the only way services can be expanded to new areas is by reducing services in existing areas. I contend strongly this would be a mistake. To do so would reduce the effect of such programs as nutrition education, outreach, social services and transportation to mention a few. Yet it is these services which are characteristic of the Community Health Center program and have led to its success, i.e. keeping people well through prevention and continuity of care and therefore, avoiding more costly institutional care.

Finally, I would call to your attention the fact there are still some 44,900,000 people who have a shortage of personal health services, according to DHEW. Currently the Community Health Center program provides services to 4,154,000. Although we have penetrated into this area, we still are serving only 9.03 percent of the underserved population. The figures are clear, a lot more needs to be done.

Mr. Chairman, with your support I feel we have demonstrated both the effectiveness and viability of Community and Migrant Health Centers. At a time when we all are concerned with the question of "COST", our programs have done something about it.

Accordingly I urge you to support as the level of authorization for fiscal 1978 the following:

	<i>Millions</i>
Community Health Centers.....	\$280.0
Migrant Health Centers.....	52.5

Thank you.

COMMUNITY HEALTH CENTERS

Category	Fiscal year—			
	1975 actual	1976 actual	1977 estimate	1978 estimate
Total projects.....	204	302	422	512
Budget authority (in millions) (rounded).....	\$196.7	\$196.7	\$215.1	\$229.1
Number of persons served.....	1,425,000	2,539,160	3,328,000	4,154,000
Number of encounters.....	6,555,000	9,984,304	11,727,200	16,509,400
Annualized total (cost per person served).....	\$204	\$129	\$112	\$104
All grant funds (cost per person served).....	\$138	\$75	\$65	\$55
All grant funds (cost per encounter).....	\$30	\$20	\$18	\$14
3d party receipts (in millions) (rounded).....	\$62	\$93.7	\$114.5	\$156.4
3d party receipts as percent of total operating.....	22	29	31	36
Primary physician encounter (per hour).....	2.5	2.7	2.9	3.0

PREPARED STATEMENT OF DANIEL R. HAWKINS, JR., PROJECT DIRECTOR, SU CLINICA FAMILIAR, 2018 PEASE ST., HARLINGEN, TEX.

PRESENTED TO THE SENATE COMMITTEE ON HUMAN RESOURCES, SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

February 28, 1977.

Mr. Chairman and members of the committee, my name is Daniel R. Hawkins, Jr.; I am Director of a health center funded primarily under Sec. 319 of Public Law 94-63, which provides comprehensive health services to members of migrant and seasonal farmworker families in southernmost Texas. As a first order of business, I wish to express my appreciation for having been given the opportunity to speak to you on behalf of farmworkers as you consider legislation to continue the work of centers such as ours, which for thousands of Americans are the only source of accessible health care.

For the past two years, those appearing before you have painted a bleak picture of the Campesinos' health status, given the fact that Migrant Health Centers reach only 10 percent of the eligible population, and less than 5 percent qualify for coverage under titles 18 and 19. My purpose today is to bring you some good news, for a change. During the past two years, with little more than a 25-percent increase in appropriations, Migrant Health Centers have extended their services to 35 percent more patients, and have increased their productivity by better than 50 percent.¹ They have managed to reduce the overall cost per patient visit by 20 percent,² and have increased third party revenues to equal 8 percent³ of their total operating income. Surely, you will agree that this is an outstanding record of achievement by the Migrant Health Centers, and that it clearly reflects the commitment to maximum efficiency on the part of the centers' management staff and Board Members.

There is, however, a continued sordid side to this issue, one which continues to affect the centers and the communities they serve. As a direct result of increased appropriations and greater efficiency, the Migrant Health program is now reaching only 15 percent of the eligible population;⁴ worse, less than one-tenth of one percent are served by the authorization hospitalization program.

Thus, with no increased coverage by Medicare or Medicaid, more than 80 percent of the population which legislation is intended to serve are presently without access to decent health services.

¹ Justification of appropriation estimate for Committee on Appropriations, fiscal year 1978, vol. I, p. 41.

² *Ibid.*, p. 41, compared with the President's fiscal year 1977 budget request, p. 34.

³ *Ibid.*, p. 42.

⁴ *Ibid.*, p. 41.

Thus, we again find ourselves approaching you with our collective hand extended, asking for "more"; and, while we are conscious of the difficult economic situation confronting this Nation and the Congress, we cannot in good conscience continue to quietly tolerate incidents such as the recent indictment of two women on separate charges of negligent homicide—for having abandoned their newborn infants in drainage ditches, where both helpless creatures died. If it is true, as the women said that they had so acted not because the children were unwanted, but because they could not afford to care for the infants, both of whom were sick and in need of considerable medical attention, then our society must accept the role of "unindicted co-conspirator" for having allowed these incidents to occur.

At the present time, HEW's figures indicate that there are 2,700,000 members of migrant and seasonal farmworker families in the nation.⁵ If one accepts the fact that the Migrant Health Centers are rendering adequate health care to their patients at an annual cost of \$94 each—about 15 percent of the average national per capita health expenditure—then the program would require some \$255 million in order to provide sufficient outpatient care to all qualifying individuals. Assuming that as much as 20 percent of this cost were to be met with other resources—a figure which may, in fact, be unreasonably high—we are nevertheless left with a required investment of some \$204 million. Further, inpatient care needs would require an additional \$217 million.⁶

There is another matter which, I believe, merits the attention of the Subcommittee: during fiscal year 1977 some \$4.5 million—an amount roughly equivalent to the entire increase voted for Migrant Health Centers—has been conscripted for use in the Administration's rural health strategy. While I do not deny the need for developing services in presently unserved or underserved rural (and urban) areas, I must in conscience register my protest against the use of funds intended to serve farmworkers for that purpose. I argue this point for several reasons:

As a result of the Administration's action, existing Migrant Health Centers are faced with the prospect of continuing to function at existing or reduced funding levels, or of seeking funds under the rural health initiative strategy which in turn requires extension of services to a general rural population, in many instances at the expense of serving farmworkers.

Migrant and seasonal farmworkers live and work in rural areas, it is true; but existing Migrant Health Centers have developed as much because of the failure of rural health systems to relate to the special needs of campesinos as because of an insufficiency of medical manpower in those areas. The development of rural health systems in areas where migrants spend but a small part of the year will do little to accomplish the intent of this legislation.

Given the limited funding available for developmental rural health projects, and the Administration's system of measuring efficiency among such projects, it has become increasingly difficult for the projects to offer non-medical support services, such as social services and patient advocacy—services which are vitally necessary in serving farmworkers, and which have set migrant and community health centers apart from common medical care systems.

Numerous existing Migrant Health Centers face obliteration as a result of the focus on underserved areas. Consider, if you will, the case of a project located in a midwest farming area which serves 2 or 3 counties, none of which are "medically underserved", and none of which meet the "high impact" requirement of Public Law 94-63. Yet, for several months each year, thousands of migrants enter the area to work in the crop harvest. I submit that several on-going migrant health centers find themselves in such a predicament.

Should the Congress feel it appropriate to foster the development of health systems in rural and urban underserved areas, then I would suggest that such an effort be granted legislative authority. In the interim, we ask simply that such

⁵ *Ibid.*, p. 41.

⁶ Arrived at using the following formula:

No. migrants/seasonal farmworkers	2,714,000
National rate of hospitalization (percent)	X .08
No. of farmworkers needing hospitalization	217,120
1977 estimated cost/admission	X 1,000
Total cost for hospital services	\$217,120,000

an effort not be undertaken at the expense of the already-downtrodden farmworker.

In sum, migrant health centers have, over the past two years, made great strides toward providing more and better service to farmworkers, and have proven their worth as an integral component of this country's health delivery system. We are still, however, far short of meeting the existing need; to accomplish this formidable task, we ask you to reaffirm the Congressional commitment toward that end and to provide us with the necessary tools for the job. We ask for an authorization of *not less* than \$52.5 million for fiscal year 1978.

On behalf of the *campesinos* we serve, please accept my sincere gratitude for your demonstrated concern for these issues, *y que el dios les bendiga*.

MIGRANT HEALTH CENTERS

Category	Fiscal year			
	1975 actual	1976 actual	1977 estimated	1978 estimated
Total projects.....	105	97	125	125
Budget authority (in millions).....	\$19.2	\$25	\$30	\$30
Number of persons served.....	390,000	400,000	499,000	499,000
Potential eligible population.....	3,000,000	2,714,000	2,700,000	2,700,000
Migrants.....		714,000	700,000	700,000
Seasonals.....		2,000,000	2,000,000	2,000,000
Number of encounters.....	640,000	800,000	998,000	998,000
Annualized total (cost per person served).....	\$100	\$98	\$94	\$94
All grant funds (cost per person served).....	\$61	\$53	\$53	\$53
Annualized total (cost per encounter).....		\$49	\$47	\$47
All grant funds (cost per encounter).....	\$37	\$31	\$30	\$30
3d party receipts.....		\$3,120,000	\$3,800,000	\$3,800,000
3d party receipts as percent of total operating.....		8	8	8
Hospitalization program:				
Cost.....	\$2,256,000	\$2,500,000	\$3,000,000	\$3,000,000
Persons served.....	3,040	3,125	3,333	3,000
Cost per stay.....	\$742	\$800	\$900	\$1,000

NATIONAL ASSOCIATION OF COUNTIES,
Washington, D.C., February 22, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: AS Chairman of the Health and Education Policy Steering Committee for the National Association of Counties (NACo),¹ I would like

¹ NACo is the only national organization representing county government in the United States. Its membership includes urban, suburban, and rural counties which have joined together for the common purpose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government; serving as the national spokesman for county government; acting as a liaison between the Nation's counties and other levels of government; and, achieving public understanding of the role of counties in the Federal system.

to submit the following statement in support of your intention to postpone consideration of changes in Public Law 93-641 (The National Health Planning and Resources Development Act of 1974) and other expiring Public Health Service Act authorities.

With the exception of one problem in a key provision of Public Law 93-641 which can be addressed in the Committee Report, we strongly support a simple one year extension of these expiring Public Health Service Act programs. This means that we will not seek enactment of health planning amendments that we have been promoting over the last few years. These amendments would do the following:

Clarify the relationship between public Health Systems Agency (HSA) governing boards and their governing bodies. The boards should a) appoint governing body members; b) approve the agency's health systems plan and annual implementation plan; c) confirm the appointment of staff director; and, d) approve the agency's budget.

Define "Public Officials" as local elected officials or their representatives representing units of general purpose governments.

Authorize elected officials to appoint directly at least one-third of the members of a private, nonprofit HSA governing body.

NACo staff have been making site visits to a number of HSAs around the country. They have been finding deficiencies in the structural aspects of some HSAs. We are not asking for legislative changes to correct these deficiencies. We are sure that the Chairman and members of the subcommittee do not wish to perpetuate these deficiencies. They would, however, be locked in if Public Law 93-641 were extended without clarification on the part of the Committee when it reports out the 1-year bill.

Between April, 1978 and September 30, 1978 every one of the HSAs which are now conditionally designated will apply for unconditional full designation. HEW will have no middle course at that time between granting a full designation to an agency that meets very minimal standards, or withdrawing designation completely and reopening competition in a health service area. It is not realistic to assume that under these circumstances any agency but the most blatantly incompetent or abusive will fail to gain full designation. Frankly, I do not believe that a single current agency will not win approval and hence a release from many pressures to perform responsibly. If this were to occur, the Committee would then be faced with the task of writing major revisions into a fundamentally good law.

The Committee has several simple alternative options this year in order to prevent this occurrence. We ask that the current designation provisions be altered so that no HSA can be fully designated prior to 36 months of conditional designation. This will allow ample time for study and the development of creative alternatives to the current "all or nothing" provisions regarding HSA designation. Furthermore, this will give Public Law 93-641 the precise trial period that is the major reason for not making changes in the law this year. The solution might be achieved by stating in the Committee Report that it is the intent of Congress to delay full designation for a specified time.

Another alternative which would involve even less tinkering with the law than altering the current designation provision would be to extend the legislation for six months instead of a year. While this provides the same essential safeguards, it also provides much less time for study and review. The six month extension would make Public Law 93-641 subject to serious congressional attention prior to full designation of the vast majority of HSAs.

One more very technical issue would also be well served by congressional attention next year. In section 1512(b)(3)(II) the words "equal to" ironically penalize those rural health interests which they were inserted to protect. As health service areas now exist, it is not unusual in a mixed metropolitan/non-metropolitan area for the population to be more than 80 percent metropolitan even in an apparently rural area, viz., Utah. It would be a simple matter to replace "equal to" with less restrictive language that would allow better representation for diverse rural areas on HSA boards. Under the current language, board and committee memberships must often virtually exclude rural representatives.

In summary, NACo's principal concern is that private, non-profit, free standing health planning agencies might affect the health care of areas without answering directly to the citizenry for their decisions. But county and other local officials, who are accountable for supplying health care (often the health care of last resort) must then answer to the citizenry for the decisions made by these quasi-governmental agencies.

The effectiveness and accountability of the health systems agencies depend on the composition of their governing bodies. NACo stresses strong involvement by local elected officials in health planning. Specifically, local governments with substantial health involvement should directly appoint one-third of the private, nonprofit HSA board members. Local governments should be granted proportionate representation throughout the health service area. Language that expresses these concerns could be incorporated into the Committee Report on the extension of Public Law 93-641.

Mr. Chairman, NACo is ready to support your efforts to develop a rational, systematic health planning program and will continue to push for the objectives of Public Law 93-641: the control of health costs and to redress the uneven distribution and quality of care.

If you have any questions about our position, please contact Mike Gemmell of our national staff.

Sincerely,

TERRANCE PITTS, *Chairman.*

MORRIS ASSOCIATES, INC.,
Washington, D.C., March 1, 1977.

HON. EDWARD M. KENNEDY,
Chairman, Health Subcommittee, Dirksen Senate Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is a statement prepared for the National Council of Community Mental Health Centers, which we represent, concerning the fiscal year 1978 renewal of the Community Mental Health Centers Act for inclusion in the record of hearings on the Health Services Extension bill, S 755.

Thank you.

Sincerely,

CHRIS KOYANAGI.

NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS,
Washington, D.C., February 28, 1977.

STATEMENT PRESENTED TO SUBCOMMITTEE OF HEALTH, HUMAN RESOURCES COMMITTEE, U.S. SENATE, CONCERNING S. 755, HEALTH SERVICES EXTENSION ACT

This statement is submitted on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 343 community mental health centers, most of which receive federal grants under the CMHC Act, and another 176 agencies which are developing CMHC programs or which have a direct interest in community mental health.

The bill now pending before the subcommittee, would extend health services programs, including the CMHC Act, for one more year to ensure continued operations of all CMHCs pending a more substantial review of the program, which we understand the subcommittee plans later this year.

NCCMHC supports the concept that current legislation should be enacted for one more year while the new Administration reviews health services programs and devises its own policy recommendations, thus the Council urges the speedy enactment of S. 755.

S. 755 will extend the provisions passed by Congress in Public Law 94-63, title III, the 1975 amendments to the CMHC Act. This was a landmark piece of legislation. Not only did the 1975 amendments reject the administration's argument that CMHCs were so successful that the federal program should be entirely discontinued, but this marked the first time that the comprehensive services which CMHCs provide were specifically spelled out in the law.

Under the 1975 amendments, it is clear that no population group will be denied services in a CMHC, whether it be low-income persons, children, elderly, alcoholics or drug abusers. Moreover, the requirements for screening of patients released from institutions will, when fully implemented have the effect of laying the groundwork for a true system of community care for the mentally ill. There have been many documentations of the shortcomings of deinstitutional policies where no community services are in place and where no one in the community takes on the responsibility for released patients. The most recent of these is a GAO report, entitled "Returning the Mentally Disabled to the Community—Government Needs to do More".

Public Law 94-63 also stressed the importance of "community" in community mental health centers by requiring, where this is practical, that such programs be run by community boards.

All of these changes, and more, have set a standard of excellence for CMHC programs. To date, most of the previously-operating CMHCs (of which there were about 600) have adjusted their programs, added services where necessary, and are moving toward the new definition in Public Law 94-63; about half are already funded through the Public Law 94-63 grants. However, since the process of upgrading the existing centers is still underway, it is not possible to accurately assess the impact of the new standards. This is another reason why a one year extension of the law with no substantial changes is good policy. We

need to see how this new program will operate before giving serious consideration to substantive amendments to the CMHC Act.

However, in order to continue the CMHC program for another year it is necessary not only to renew the authorizations, as does S755, but also to extend the current deadline in the law for the addition of new services by those centers operating prior to enactment of Public Law 94-63. Unless this can be done, about one third to one half of the existing centers will be out of compliance during fiscal year 1978 and become ineligible for further financial assistance through continuation grants.

This has come about for several reasons—lack of funding for the newly required services, slowness in the development of policy guidelines by NIMH, failure of NIMH to publish regulations for the new services authorized under the program until November 1976 (and then only in draft form) and finally the fact that it has taken the CMHCs longer than expected to fully understand the requirements and impact of the new law. Of these problems, clearly the most significant and important is the lack of funding through the conversion grant authority, with only \$40 million having been authorized over the two year period to enable about 600 centers to add several new services each.

A one-year extension of the services requirement would enable the CMHC program to continue to function until a more thorough review can be made. In this respect, H.R. 3598 introduced by Congressman Rogers includes language which would make this extension in the services requirements, and NCCMHC urges this subcommittee to include such language in the Senate version of the bill.

On the question of specific authorizations for S755, attached is a table of NCCMHC recommendations for fiscal year 1978 funding for CMHC programs which we have forwarded to the appropriations committees. These funds are urgently needed, and indeed the funding in these recommendations is far less than that which could be profitably used. Even if this amount were appropriated many worthwhile programs would have to wait until future years for funding.

In conclusion, NCCMHC urges the subcommittee to amend S755 to include an extension of the deadline for compliance with new services requirements of Public Law 94-63, such as is included in H.R. 3598, and to include authorizations for CMHCs at least at the level which NCCMHC believes should be appropriated for the coming fiscal year.

COMMUNITY MENTAL HEALTH CENTERS PROGRAM—FEDERAL APPROPRIATIONS AND BUDGET REQUESTS

[In millions of dollars]

	Fiscal year 1977 appropriation	Fiscal year 1978 budget request	Fiscal year 1978 NCCMHC proposal
Planning (sec. 202).....	1.0	0	2.5
New operations (sec. 203(a)).....	26.5	0	50.0
Continuations: Operations/staffing and Children (secs. 203(a) and (e)).....	1170.3	1210.3	1215.3
Consultation and education (sec. 204).....	8.0	18.2	16.0
Conversion (sec. 205).....	20.0	19.4	25.0
Financial distress (sec. 211).....	8.0	15.0	12.0
Facilities (sec. 221).....	0	0	10.0
Total.....	232.8	233.0	330.8

¹ Enough for continuations only.

NATIONAL GOVERNORS' CONFERENCE,

February 24, 1977.

HON. EDWARD M. KENNEDY,
U.S. Senate,
Russell Senate Office Building,
Washington, D.C.

DEAR SENATOR KENNEDY: As you know, the Governors have some serious concerns about the present National Health Planning and Resources Development Act of 1974 (P.L. 93-641). Knowing that the law would be renewed by this session of the 95th Congress, I asked Governor Richard D. Lamm (Colorado) to

develop the position of the National Governors' Conference on amending the law.

It is clear that the Congress and President Carter would prefer to extend Public Law 93-641 for one year with the promise of full hearings at an early date. It is Governor Lamm's understanding that you would prefer to have no changes in the law—even of a technical nature. It is the position of the National Governors' Conference that technical amendments are necessary in the following respects:

1. The ability of public health systems agencies (HSA's) to govern themselves is seriously compromised. The public HSA should have the same power to approve plans, confirm staff appointments and approve its budget as is presently granted to an HSA which happens also to be a private nonprofit corporation.

2. The Governors of many States will have difficulty integrating the statewide Health Coordinating Council (SHCC) into the State's health policymaking structure. He or she should be permitted to appoint the chairperson of the SHCC.

3. The Act presently empowers the SHCC to approve or disapprove the expenditure of state funds provided through a variety of federal formula grants. The SHCC should be permitted to make recommendations to the Governor on such expenditures.

4. The Act requires the State Health Planning and Development Agency (SHPDA) to compile the plans of HSA's into a state health plan. The SHPDA should be permitted to establish a uniform format for HSA plans in order to facilitate this compilation.

5. The law presently empowers HSA's to approve each use of state funds provided through federal formula grants. The opinion of the HSA on such expenditures should be expressed to the Governor—not to the Secretary of Health, Education, and Welfare.

6. The Act specifies an appeals procedure for SHPDA decisions which is both consistent with state law and to an agency of the State other than the SHPDA. In many States, these two prescriptions are contradictory; in these States, the first level of appeal is to a higher authority within the same agency.

7. At several points, Public Law 93-641 requires that "public hearings" be held during reviews of proposed new health services. The statutory requirements for public hearings (e.g., keeping of transcripts, appointment of hearing officer, retention of counsel, etc.) are clearly inappropriate except in the case of a final decision by a state agency or official.

8. The Act now requires an HSA to enter into agreements with other planning and regulatory bodies within its area. It is unlikely that many such agencies will submit their actions to review against the priorities of an HSA. It would be helpful to ask the HSA to seek agreements which are mutually satisfactory to themselves and to the agencies with whom they must coordinate.

9. The Act has been interpreted to allow a single 90-day period for the review of a proposed new institutional health service by both the HSA and the SHPDA. A 90-day review period has proven insufficient for a competent and thorough review of major proposals.

It is our hope that you can give serious consideration to these technical changes as you extend the authorization of Public Law 93-641 for 1 year. Amendment of these aspects of the law is not a new idea: Last spring, we worked very closely with your staff to develop amendments which would address these problems. We view these as the short-range problems with the law and Governor Lamm is in the process of surveying his colleagues to identify the more serious difficulties which are being encountered as the States gain more experience with the new health planning universe.

I am in sympathy with your effort to allow the new Administration some time to develop its strategy for a national health policy. In keeping with that attitude, we are prepared to see the health planning system exist as it is for 1 year. It is a corollary of that intention that no health systems agency should be given full designation during that year.

Governor Lamm and I look forward to working with you and your colleagues toward a workable health planning system. We respect your desire to move cautiously at this time and we look forward to the opportunity to present all of our concerns to you in the near future.

Sincerely,

Gov. RICHARD K. KNEIP.
Chairman, NGC Committee on Human Resources.

JOHN H. VETNE,
Arlington, Va. April 4, 1977.

Re: S. 755, Health Services, Hemophilia and Health Planning and Development Extension Act of 1977. Amendments relating to medical student transfers.

HON. EDWARD M. KENNEDY,
Chairman, Subcommittee on Health and Scientific Research, Russell Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: I write this in anticipation of—and in opposition to—“technical” amendments to S-755. I respectfully request, further, that these comments be made a part of the hearing record on the bill.

Section 7(1)(3) of the House bill (H.R. 4976) contains a proposed amendment postponing the effective date of medical student transfer provisions of the Public Health Service Act (§ 771(b)(3)(A))¹ which would substantially and adversely affect thousands of American students studying in foreign medical schools, including approximately 2,500 American students at Guadalajara (Universidad Autonoma de Guadalajara).

In the 6 months that have passed since the Act was approved, the Department of H.E.W., disregarding the express congressional mandate that the transfer provisions are to become effective the Fall Semester of this year,² has failed to issue even proposed rules or to actively solicit public comment. It is recognized that drafting regulations may require complex considerations, however, H.E.W. could clearly publish proposed, broadly defined guidelines and receive the benefit of objective public comment, with a view to implementing regulations flexible enough to meet specific problems that may come up.

H.E.W. laid the groundwork for its foot-dragging shortly after the Act was approved by the President. In November 1976, the Department issued the following statement: “It is possible . . . that the provision could be amended before it takes effect.” In December H.E.W. published this statement: “Pending clarification of requirements, it appears that a student identified by the Secretary as eligible would not be assured of a position in a U.S. medical school, at least not in any given year.”

Thus, in arrogant disregard of the statutory time-frame, the Department of H.E.W., in ostrich-like fashion, has avoided its responsibility rather than acting upon it.

In a very brief exchange during House hearings (Tr., Vol. I, pp. 62-64), the issue was all but ignored. Rep. Rogers indicated to Dr. Margulies (Dep. Administrator, Health Resources Administration, H.E.W.), that amendments would be made to accommodate H.E.W.'s problem.

I urge you, and the members of the Health Subcommittee, when this comes up, that H.E.W.'s bureaucratic delinquency not be condoned by legislative amendment, but rather that H.E.W. witnesses be required to explain their inaction, and further, that the committee go on record by emphasizing executive branch responsibilities to carry out existing law.

My brother, and thousands like him who have a record of academic excellence and a burning desire to practice medicine, but who have found a limited and restrictive domestic medical school market, are anxious to participate in the well-conceived transfer plan. Their present frustrations with H.E.W. are complicated by National Board of Medical Examiners' action, within weeks after the law was enacted, restricting access to the examination for students studying abroad.

Your efforts, and that of the committee, are greatly appreciated.

Respectfully yours,

JOHN H. VETNE.

¹ Enacted as part of the “Health Professions Educational Assistance Act of 1976, Public Law 94-484; 90 Stat. 2243, approved Oct. 12, 1976.

² According to the terms of the act, § (3)(A), the fall 1977 semester is “the school year beginning immediately before the fiscal year” starting October 1977.

Senator SCHWEIKER. I thank the witnesses this morning. We will recess the hearing at this time.

[Whereupon at 11:45 a.m., the committee adjourned, subject to the call of the Chair.]



Some of the things I think I should mention
to you are the things that I have
written down for you in the journal, and
the things that I have written down for
you in the journal.