



E001258

HEART DISEASE, CANCER, AND STROKE AMENDMENTS OF 1965

JUNE 24, 1965.—Ordered to be printed

Mr. HILL, from the Committee on Labor and Public Welfare,
submitted the following

REPORT

together with

INDIVIDUAL VIEWS

[To accompany S. 596]

The Committee on Labor and Public Welfare, to whom was referred the bill (S. 596) to amend the Public Health Service Act to assist in combating heart disease, cancer, and stroke, and other major diseases, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

BACKGROUND

The toll of heart disease, cancer, and stroke in terms of human suffering, pain, and hardship cannot be measured. But we do know that the three killers in this country affected the lives of 30 million persons and their families and friends in 1963. We also know that 1,187,558 lives of Americans ended with the cause of death listed as heart disease, cancer, or stroke in the same year.

Heart disease, cancer, and stroke account for 71 percent of the deaths in this country and for 51 percent of the deaths of our people under 65 years of age.

The economic cost to the Nation for the ravages wrought by heart disease, cancer, and stroke amounted to \$31.5 billion in 1962. This total includes an estimated \$4 to \$5 billion in direct costs of care and treatment as well as the indirect costs associated with loss of earnings due to disability and premature death.

A panel of our country's most distinguished medical authorities and laymen has reported to the President and to this committee that

2. HEART DISEASE, CANCER, AND STROKE AMENDMENTS

we can eliminate several hundred thousand unnecessary deaths each year if we bring to our citizens the full benefit of what we know today about prevention, detection, treatment, and cure in the case of heart disease, cancer, and stroke. It is to this purpose that S. 596 addresses itself.

SUMMARY

This legislation would authorize the Public Health Service to award grants-in-aid to public and other nonprofit institutions and associations to assist them in planning, establishing, and operating regional medical complexes to combat heart disease, cancer, stroke, and other major diseases.

The term "regional medical complex" denotes a group of institutions such as medical schools, research centers, hospitals, and other health activities that has adopted an organized plan for a coordinated program of demonstrations, consultations, research, and training in order to assist physicians and hospitals within the area in bringing to their patients the latest advances in prevention, diagnosis, and treatment in the fields of heart disease, cancer, or stroke and to promote new knowledge regarding one or more of these diseases and such other major diseases as may be provided for in the future.

A regional medical complex would utilize the existing network of community hospitals and other health facilities, and would not interfere with existing methods of financing patient care, with professional practice, or with the administration of hospitals.

A complex could be administered by a university, a school of medicine, a research center, or by some other public or nonprofit agency or institution, or by an association of such activities. An advisory group at the local level would assist in formulating and carrying out the program for the improvement of health services.

THE PRESIDENT'S COMMISSION ON HEART DISEASE, CANCER, AND STROKE

Over the past two decades we have invested wisely in the health of our citizens. Because of this investment we have a network of hospitals and other medical care facilities that is second to none in the world. Over the past two decades our medical schools have greatly strengthened and improved their educational programs and their faculties as opportunities for research have been expanded and as support for research training has become available. We have invested in medical research and our progress is gratifying. Leading medical scientists tell us that the past 20 years has been the most productive period in the entire history of medicine.

To obtain the maximum return on our investments we must insure that a minimum of time elapses between the discovery of new medical knowledge and its practical application.

It was the recognition of this fact that led the President to appoint a Commission on Heart Disease, Cancer, and Stroke to "recommend steps to reduce the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge we already have".

The Commission was appointed in March 1964. Under the chairmanship of Dr. Michael E. DeBakey the Commission received testimony from 166 expert witnesses and consulted 60 health organizations and associations. The final report of the Commission was

submitted in December 1964. The membership of the Commission follows:

- Dr. Samuel Bellet, professor of clinical cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.
- Mr. Barry Bingham, editor and publisher, Louisville Courier-Journal, Louisville, Ky.
- Mr. John M. Carter, editor, McCall's magazine, New York, N.Y.
- Dr. R. Lee Clark, director and surgeon in chief, the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston, Tex.
- Dr. Edward W. Dempsey, former dean, School of Medicine, Washington University, St. Louis, Mo.: Resigned on September 28, 1964, to become special assistant to the Secretary (Health and Medical Affairs), U.S. Department of Health, Education, and Welfare, Washington, D.C.
- Dr. Sidney Farber, director of research, Children's Cancer Research Foundation, and professor, Harvard Medical School, Boston, Mass.
- Dr. Marion S. Fay, former president and dean, the Woman's Medical College of Pennsylvania, Philadelphia, Pa.
- Mr. Marion B. Folsom, director, Eastman Kodak Co., Rochester, N.Y., and former Secretary of the U.S. Department of Health, Education, and Welfare, Washington, D.C.
- Mr. Emerson Foote, former chairman of the board, McCann-Erickson, Inc., New York, N.Y.
- Gen. Alfred M. Gruenther, immediate past president, American National Red Cross, Washington, D.C.
- Dr. Philip Handler, professor and chairman, Department of Biochemistry, Duke University Medical Center, Durham, N.C.
- Mr. Arthur O. Hanisch, president, Stuart Co., Pasadena, Calif.
- Dr. Frank Horsfall, Jr., president and director, Sloan-Kettering Institute for Cancer Research, New York, N.Y.
- Dr. J. Willis Hurst, professor and chairman, Department of Internal Medicine, Emory University School of Medicine Atlanta, Ga.
- Dr. Hugh H. Hussey, director, Division of Scientific Activities, American Medical Association, Chicago, Ill. Resigned as of September 5, 1964, to become special consultant to the Commission.
- Mrs. Florence Mahoney, cochairman, National Committee Against Mental Illness, Washington, D.C.
- Dr. Charles W. Mayo, emeritus staff surgeon, Mayo Clinic, Rochester, Minn.
- Dr. John S. Meyer, professor and chairman, Department of Neurology, Wayne State University College of Medicine, Detroit, Mich.
- Mr. James F. Oates, chairman of the board, Equitable Life Assurance Society, New York, N.Y.
- Dr. E. M. Papper, professor and chairman, Department of Anesthesiology, College of Physicians and Surgeons, Columbia University, New York, N.Y.
- Dr. Howard A. Rusk, professor and chairman, Department of Physical Medicine and Rehabilitation, New York University Medical Center, New York, N.Y.
- Dr. Paul W. Sanger, surgeon, Charlotte, N.C.
- Gen. David Sarnoff, chairman of the board, Radio Corp. of America, New York, N.Y.

Dr. Helen B. Taussig, emeritus professor of pediatrics, Johns Hopkins University, Baltimore, Md.

Mrs. Harry S. Truman, Independence, Mo.

Dr. Irving S. Wright, professor of clinical medicine, Cornell University, Medical College, New York, N.Y.

Dr. Jane C. Wright, adjunct associate professor of research surgery, New York University School of Medicine, New York, N.Y.

These outstanding leaders of our country carried out the most comprehensive and careful study of heart disease, cancer, and stroke that has been undertaken. They clearly spelled out the burden of heart disease, cancer, and stroke in disability and death and set forth recommendations for minimizing the toll of these three leading killers and crippers of mankind. The Commission recommends a more widespread application of existing medical knowledge and a coordinated effort to develop new discoveries to prevent, detect and cure heart disease, cancer, and stroke.

The Commission concluded its study with respect to heart disease; cancer, and stroke in these terms:

America need no longer tolerate several hundred thousand unnecessary deaths each year from heart disease, cancer, and stroke.

By bringing to all the people the full benefit of what is now known of prevention, detection, treatment, and cure, we could save, each year, a number of lives equal to the population of a major city.

Heart disease

An estimated 25 to 30 million individuals suffered from heart disease in this country in 1963. In the case of 707,830 individuals the illness terminated in death, and 28 percent of them had not reached the age of 65 years.

The direct cost of medical care and treatment for heart disease in 1962 was \$2.6 billion and the indirect costs to the Nation due to loss of income because of disability and premature death amounted to \$19.8 billion.

The cost of heart disease in this country now exceeds \$22 billion each year.

A substantial share of the 707,830 deaths in 1963 could have been prevented if there had been more widespread application of medical knowledge. Most forms of congenital heart disease can be corrected as a result of our advances in surgery. Rheumatic heart disease can now be virtually eliminated. Atherosclerosis of the major arteries of the body is being attacked surgically with gratifying results. Electrical devices such as cardiac pacemakers have been developed to restore to normal the abnormally slow rate of a diseased heart. More than 5,000 individuals are alive today because of implanted pacemakers. Drugs have been developed to control high blood pressure. Anti-coagulant drugs can prevent many acute heart attacks.

Research efforts are underway at the present time to develop an artificial heart to replace a diseased heart. Experimental models have already been tried in man. These models are being modified; and, with the aid of industry, it is hoped that an effective model may become available for widespread use in the near future.

Another development which has become possible due to increasing research into the immune responses of men has been in the field of organ transplantation. Kidneys, livers, lungs, and recently hearts have been transplanted into man from primates or from man to replace diseased organs. Though the results leave much to be desired, early work in this complicated field has shown sufficient promise to justify intensification of such research.

The advances in cardiovascular disease over the last two decades were not considered possible 50 years ago. Physicians today know more than ever before about heart and blood vessel diseases and can do something about them.

Still there is a long way to go. It is imperative that these advances be capitalized upon and the research effort intensified and accelerated if these diseases are to be brought under control.

Cancer

Cancer is our second greatest killer by a wide margin. Among children between 1 and 14 years it is the first or second most common cause of death.

Deaths due to cancer are increasing. In 1962, 278,562 Americans died of cancer; in 1963, the number rose to 285,363; and for 1964 the number will exceed 300,000.

Cancer caused 4 percent of our deaths in 1900, but 16 percent of the total in 1963.

The direct costs of diagnosing, treating, and caring for patients with cancer amounted to \$1.2 billion in 1962. The indirect costs of lost output due to disability and premature death because of cancer amounted to \$6.8 billion in 1962.

The cost of cancer in this country now totals \$8 billion each year. Using knowledge now available we can reduce the toll and the burden of cancer. Uterine cancer can be detected at an early and generally curable stage by using a simple, well-established technique, unfortunately, relatively few women seek and obtain this examination in time.

New developments in the early detection of breast cancer hold forth the promise of similar reductions in deaths from this form of cancer.

Physical examinations using modern diagnostic techniques often lead to early recognition and successful treatment of cancer in many sites.

The search for cancer-controlling drugs has already produced several which have cured cancers in animals. About 20 of these drugs have resulted in at least temporary benefit to human cancer patients with marked increase in survival and limiting of disability in patients with lymphoma including Hodgkin's disease, multiple myeloma, chorioepithelioma, melanoma, and certain tumors in children. Radiation treatment and surgery are being improved and refined to minimize side effects and maximize benefit.

Since World War II, nuclear medicine and radioactive isotopes have played a vital role in cancer diagnosis and treatment. Detection has been enhanced in cancer of the thyroid, brain, liver, and stomach. Specific radioactive isotopes have been used in therapy of cancer of the prostate, thyroid, and bone marrow. The supervoltage X-ray and gamma ray beams have made possible high-energy (megavoltage) therapy in the average metropolitan area.

Recent research in virology has shown that the leukemias of several species of animals, which are closely related to human leukemias, are definitely viral in origin. If leukemia in man proves to be initiated by viruses, preventive vaccines might well be in prospect. A few years ago we saved one of every four lives of persons afflicted with cancer. Today about one cancer patient in three is being saved. Just by applying the knowledge we now have we could save one-half of the lives of the people who contract cancer.

Stroke

The third leading cause of death in the United States is stroke, an illness now besetting an estimated 2 million of our citizens. Many of them are paralyzed. In 1963, 201,166 persons in this country died of strokes.

The direct cost of care and treatment for the victims of strokes totaled \$440 million in 1962. The indirect costs of the disease due to disability and premature death amounted to \$700 million.

The cost of stroke in this country now exceeds \$1 billion each year. The human and financial cost of disability resulting from stroke weighs heavily on the patient, as well as the family, the community, and the taxpayer. Even after the initial episode of illness is past, the majority of stroke patients who do not receive comprehensive treatment become dependent upon their families and the community for the rest of their lives. In this condition, they may survive for years.

Effective methods of prevention and treatment of various types of stroke, including some recently developed, are available. For example, three of every four patients with occlusive cerebral vascular diseases have symptoms that warn of a disabling attack. About three of every four patients with symptoms of stroke experience a discernible narrowing of the blood vessels supplying the brain, a condition which is frequently amenable to surgical correction, although the indications for surgical and medical treatment still need to be better defined. Typical warning episodes of stroke are brief attacks of loss of speech, weakness of the limbs, staggering, or loss of consciousness.

There are promising new areas for research in stroke prevention and treatment, including epidemiological studies, alteration or blood-clotting mechanisms, control of fat metabolism and hypertension, hyperbaric oxygenation (high-pressure oxygen chambers), blood vessel surgery, and new drugs to improve circulation to the brain and to prevent arteriosclerosis (hardening) of cerebral arteries.

With modern medicine, many patients anticipating stroke can be treated effectively to avert catastrophe; and, among those who have suffered severe stroke, treatment can reduce or prevent chronic disability.

Intensive modern rehabilitative care can restore as many as 80 percent of stroke survivors to relatively active and productive living.

A well-defined and tested program of medical rehabilitation has been developed which, if started early enough and carried through, can make the difference between total dependency and self-sufficiency. A few such programs are underway, but they are reaching pathetically few of the thousands who can benefit from them.

Stroke is proving to be neither inevitable nor irremediable. Slowly mounting interest over the past decade has revealed genuine hope for stroke victims, both present and future.

REGIONAL MEDICAL COMPLEXES TO COMBAT HEART DISEASE, CANCER,
AND STROKE

Since 1946 we have provided Federal assistance to the States and their communities in the construction of hospitals and health facilities under the Hill-Burton Act. Under that act we have constructed facilities at a total cost in excess of \$7 billion, including a Federal share of \$2.2 billion. As a result of this construction we are making facilities for medical care accessible to the individuals in every community across the country.

We have also invested substantial sums in medical research and our investment has yielded great advances in our understanding of the process of life and the nature of diseases. We have developed new and improved preventive measures, diagnostic methods, and medical and surgical therapies that could, with more complete application throughout the Nation, prevent the deaths of many thousands of Americans that succumb to heart disease, cancer, or stroke each year.

If we are to realize the maximum return on our investments in constructing health facilities and in developing new medical knowledge there must be closer coordination between our resources for providing health services and our resources for developing new knowledge in medicine. This legislation would facilitate such coordination by assisting communities and regions in the planning and establishment of organized programs that would provide for the conduct of demonstrations, consultations, research, and training.

The concept of regional medical complexes is endorsed by voluntary health organizations, including those most active in the fight against heart disease, cancer, and stroke:

American Heart Association

Our organization regards the proposal as one of the most significant pieces of health legislation ever to come under consideration in our country and we support its major objective without qualification. That objective, as we understand it, is—

“* * * to afford to the medical profession and the medical institutions of the Nation * * * a more abundant opportunity of making available to their patients the latest advances in the diagnosis and treatment * * *”

especially of heart disease and stroke, which are the areas of our special concern and competence. This general aim, in fact, has been an important goal of the American Heart Association for many years.

American Cancer Society

The American Cancer Society views the report of the President's Commission on Heart Disease, Cancer, and Stroke as an effective instrument in focusing attention on goals in cancer control to which the American people can rightly and sensibly aspire. The Commission has given the public a thorough analysis of problems and bold suggestions for action.

The imaginative concept of the vastly increased attack with Government funds on cancer is largely focused in areas where the American Cancer Society has not had the funds to meet the needs it has long pointed out. The traditional program of the society as a voluntary opinion leader, as a public and

professional educator, as a catalyst in organizing services for cancer patients, and as a sponsor of research, will be even more vital to insure the full effect of this increased cancer control movement.

American Hospital Association

The American Hospital Association believes S. 596, as amended, will contribute importantly toward advancing the health care of the American people. We strongly support the bill and urge its passage.

American Public Health Association

Delivery of bettered health services to more people promised in S. 596, as amended by the Committee on Labor and Public Welfare, strongly supported by the American Public Health Association. This, the first step toward complete implementation of program to conquer heart, cancer, and stroke must be enacted and supplemented by further authorizations, particulars of which American Public Health Association would be privileged to contribute.

Medical authorities are in agreement that our medical centers with the most highly trained manpower and the most complete laboratory facilities and equipment offer patients the best medical care.

The Veterans' Administration recognized this fact as long ago as 1945 when the decision was made to affiliate its hospitals with our Nation's medical education forces.

The program of affiliation and the establishment of the deans committee led to a rapid improvement in the medical care for veterans. Five years later an advisory committee under the chairmanship of Dr. Charles W. Mayo appraised the new medical care program in these terms:

One of the major reasons for the high caliber of medical care given to the veteran is the constant emphasis placed on education and research. * * * It has been amply demonstrated that the educational program in a veterans hospital, by being available to all physicians in the area, has uplifted the general level of medical practice in the entire community. * * *

The recommendations of the President's Commission on Heart Disease, Cancer, and Stroke which would be implemented through this legislation are an evolutionary outgrowth of the developments during the past 15 years in the biomedical sciences. From the historical viewpoint, biomedical research on a large scale is a new venture and the impact of this new phenomenon has been most marked in the medical schools of the country. Under the stimulus of greatly increased Federal support, provided with the broad and enthusiastic backing of the Congress and this committee, the medical schools have greatly expanded their research and training programs. The development of these programs has wrought a transformation in the quality of the medical schools and related institutions across the complete spectrum of their functions—teaching and medical service as well as research. Among the tangible evidences of increasing quality are the 3½-fold increase in full-time faculty since 1951; the significant expansion of the educational function to include more residents, graduate

students, postdoctoral fellows in the biomedical sciences, and students in other health professions; and increased faculty participation in research.

The net effect of these trends, supported by Federal assistance, has been the creation of a large number of medical centers of excellence. Within the environment of these centers, the development of the biomedical sciences is leading to rapid progress in the acquisition of new medical knowledge. But as the advancement of research has enhanced the quality of medical education—as academic and scientific medicine improve as a result of research support—there is the worrisome prospect of a differential developing between the quality of medicine in centers of excellence and at the community level. The pressure for a more effective flow between these two areas provided the impetus for the recommendations of the President's Commission. They saw the need to provide opportunities for improved services to the community in the fields of heart disease, cancer, and stroke.

These developments of the recent past have therefore created a situation which is ripe for new and positive approaches to the health needs of the Nation. The committee believes that we should exploit these opportunities to advance rather than passively meet the problems of rapid change. The provision of S. 596 provides the means to this end.

Provisions of the bill

This legislation would implement recommendations of the President's Commission. The primary thrust of this bill is to provide for the planning, establishment, and operation of regionally coordinated medical complexes for heart disease, cancer, and stroke, and other major diseases which will link together medical centers, categorical research centers, and diagnostic and treatment stations located in community hospitals or other health facilities. The bill sets the sights of the country on wider availability of the best of medical care. It is intended to provide the administrative and communication mechanisms which will strengthen the relationships between the centers of medical excellence and the health skills and resources of the community. The committee is confident that the programs authorized by this legislation will engender the fuller use of the potential for better medical service which is being created by the advance of scientific medicine.

To carry out these purposes, the bill authorizes grants (1) for the planning and development of regional medical complexes and (2) for the establishment and operations of such complexes. The components of the complexes would include a medical school or other medical institution (such as a large teaching hospital or specialized research facility) involved in postgraduate medical education, affiliated hospitals, categorical research centers, and diagnostic and treatment stations located in hospitals or other health facilities. A distinctive feature of a complex would be arrangements for the coordination of the activities of its component parts in a manner calculated to achieve the purposes of the bill—improved opportunities for research, consultation, training, prevention, and demonstration of patient care in the fields of heart disease, cancer, stroke, and other major diseases.

The bill authorizes Federal funds to pay up to 90 percent of the costs of renovating and remodeling existing space and for new equipment and facilities and the replacement of obsolete equipment.

The bill provides for the establishment of a National Advisory Council on Medical Complexes which would advise the Surgeon General on the preparation of regulations, on policy matters, and would consider all applications for grants for both the planning and operation of the complexes and make recommendations to the Surgeon General concerning approval. The bill specifically prohibits the use of grants to pay the cost of hospital, medical, or other patient care except to the extent that such care is incident to research, training, or demonstration activities. Finally, the bill calls for a report to the Congress on the activities of this program on or before June 30, 1967. This report would also contain recommendations with respect to extension or modification of the program. The bill authorizes appropriations of totaling \$650 million for the 4 fiscal years 1966-69.

Nature of the proposed program

The Committee would like to emphasize that this bill is not intended to impose a centralized and fixed pattern on the diverse situations found in the many regions of the Nation. The bill is drafted to provide the flexibility necessary to respond to local needs and to take advantage of local creativity in formulating new methods for more fruitful utilization of the medical resources found within each region. We expect that the medical complexes developed through this program will reflect the diversity that is one of the strengths of our country. It seems clear that the solutions which are especially suited to meeting the needs of a major metropolitan center may vary in detail and scope from the approach adopted in a sparsely settled area of the West. The Committee recognizes, for example, that in some situations a medical complex will include as a central focal point a medical school (or schools) and the associated components of a comprehensive medical center. However, in other situations or particular areas of the country, inclusion of a medical school would either create unusual difficulties because of geographic distances or would be inappropriate for the most effective utilization of the existing capabilities for medical excellence in these major disease fields. In these circumstances, consideration should be given, in the planning and establishment of a complex, to the development of an organizational framework and relationships that build on local strengths and provide the means to cope with unique difficulties.

The bill will permit the development of one association, representing many institutions, which will represent the individual units involved and which may be permitted to accept funds and channel them throughout the complex and in other ways to have final authority for the conduct of the program within the complex.

Another important reason for this flexibility is the advantage to be gained from maximum reliance on existing local experience in accomplishing the purposes of the bill. The Committee has learned that in many areas of the country the representatives of leading medical institutions have been discussing this program and how its benefits can be brought to bear on the needs of their communities in the battle against these major disease problems. In a number of areas, these discussions have drawn on the experience of existing programs for providing links between the centers of medical excellence and the medical resources of other communities in the region. We would

expect that the plans for this new program will be able to utilize and incorporate this existing experience. Among the areas which have already been trying to accomplish some of the purposes of this bill are the States of North Carolina, Virginia, and Vermont. The Bingham Associates program in New England has been active for a number of years in establishing relationships between the New England Medical Center in Boston and community hospitals in other parts of New England, especially in the State of Maine.

The importance of planning

In order to draw the fullest benefit from local initiative in the creative design of a complex that matches local needs and incorporates local resources, the Committee believes that the early emphasis of this program should be on planning. The planning grants provided for in the bill will allow each region to mobilize its medical leaders and other community leaders in an organized approach to the planning of a regional medical complex.

The planning phase of the development of a complex will be crucial to the ultimate effectiveness of the complex, for only through the mobilization of local initiative in a manner which meets the particular needs of the region can the Federal assistance provided through this program have its desired effect. The planning effort should also provide the basis for the orderly and systematic development of the complex consistent with the present state of local resources and their further development with the assistance provided through these grants. We would expect that most plans would provide for phased development of the complex in several stages with successive stages drawing on the experience and resources developed in the early part of the program.

Local advisory group

One of the most valuable provisions of the bill requires that a local advisory group be established to assist in formulation of the plan for the establishment and operation of the complex. This advisory group would be broadly representative of the interested organizations, institutions, and agencies which are involved in meeting the health needs of the region, as well as representatives of the general public who are familiar with the problems of the community. Represented on the advisory group would be not only the medical school and health-care institutions of the region but also the public health authorities and the voluntary health agencies. A medical school affiliated veterans hospital might also be represented on the advisory committee.

Emphasis on patient care

Certain elements of research, education and patient care will be combined. However, it is specifically intended that particular emphasis will be given to patient care and the application of new knowledge to the care of patients. The committee wishes to emphasize its intention that this program is not intended simply as an extension of existing research programs conducted by the National Institutes of Health in the areas of heart, cancer, and stroke diseases.

The Committee wishes to make clear that the development of this program should not duplicate or absorb existing Federal programs conducted by the Public Health Service or other agencies of the Depart-

ment of Health, Education, and Welfare. Instead, we believe that this program can draw upon the capabilities of the existing categorical programs as well as the total national capabilities outside of these Federal programs in providing opportunities for progress in applying the latest medical knowledge to the provision of medical service at the community level. We believe that the objective of this legislation is to build from strength and to provide those mechanisms which can link the source of strength with the needs of the community. The existing categorical programs of research, training, demonstration, and prevention which have played a significant role in the creation of our present centers of excellence have a record of outstanding accomplishment. We view these programs as essential, substantive contributors to the effectiveness of the medical complexes. We would hope that the proposed new program could have its greatest innovative effect not as a parallel set of categorical programs which overlap existing efforts but rather as a significant new extension of the capability of existing programs in bringing to bear on patient needs the benefits of scientific medicine.

HEW administration

The committee has been advised by the Surgeon General that if this bill is enacted responsibility for the administration of the programs it authorizes will be placed in the National Institutes of Health. Placement of administrative responsibility at NIH will, the committee believes, assure the most effective coordination between the development of the program of medical complexes and the existing categorical programs in related areas. In this manner the several programs can exert a complementary force in advancing the Nation's effort to conquer the major killing diseases.

National Advisory Council

The National Advisory Council on Medical Complexes provided for in the bill should fill several important roles in this program. Not only will the Council insure that the best expertise available nationally is brought to bear on the overall development of this program and in its orderly evolution, but the Council will, in addition, be one of the paramount means for bringing about coordination of the medical complexes program with the other relevant programs of the Public Health Service. In any case, the committee would expect that the Surgeon General would seek the advice of such other advisory councils as may be appropriate in the context of an application under consideration to assure effective coordination of this program with the research training and demonstration activities. One method of achieving this coordination will be through the service on the National Advisory Council on Medical Complexes of representatives from the other National Advisory Councils.

The Council will consist of the Surgeon General, the Chief Medical Director of the Veterans' Administration, and 12 appointed members. The bill specifies that the fundamental sciences, the medical sciences, hospital administration, and public affairs shall be represented on the Council. The committee expects that a representative of public health or preventive medicine shall also serve on the Council. Three of the Council members shall be expert in the areas of heart disease, cancer, or stroke.

The advantages

The focus of this effort, the coordinating mechanisms, the administrative framework, and the funds for the operation of the complexes, will be the further improvement of medical care available in the communities. Major objectives are the provision of new opportunities for medical practitioners to avail themselves of the latest advances in medical knowledge, better means for training clinical manpower, and the provision of assistance to community hospitals in upgrading the quality of their service programs through stronger relationships with comprehensive medical centers. These actions will provide a new degree of access on the part of the persons afflicted with these dread diseases to the benefits of the rapid advances in this scientific era of medicine.

Each regional medical complex would include at least one medical center that would serve as a resource for trained professional and technical personnel and at least one research center of recognized excellence for its patient care, research, and teaching in the field of heart disease, cancer, stroke, or some other major disease.

The research centers will work in close cooperation with the diagnostic and treatment stations that will be located in community hospitals or in other health facilities of the region. The stations will offer the physicians and other hospitals in the vicinity a resource of highly trained professional and technical personnel and highly technical and expensive equipment essential to offering patients the latest advances in prevention, diagnosis and treatment. The physicians of patients requiring more specialized services than those offered by the stations would be referred to the research centers.

The residents of communities would benefit by the practical application of our accumulated and developing knowledge in preventing, detecting, and treating heart disease, cancer, and stroke.

The physicians of communities would be assisted by programs of postgraduate education and by the advice of consultants highly trained in medical and surgical specialties.

The hospitals participating in the complexes would be assisted in controlling operational costs through the coordinated arrangements for sharing the expensive equipment and technical personnel that must be available in order to bring the latest advances in medicine to patients.

In the case of open heart surgery, for example, the lack of a coordinated approach for sharing expensive facilities has led to less than optimum utilization. A 1961 survey showed that three-fourths of the hospitals with the expensive equipment and facilities to perform open heart surgery performed fewer than 50 open heart operations per year. To most effectively utilize the first-class teams of manpower and technical equipment that are required, a total of 100 to 200 open heart operations per year are recommended.

Our past experience indicates that the future will yield similar advances in medicine and surgery that will require highly trained professional and technical manpower from many disciplines as well as new equipment and instruments of increasing technological complexity. Regional medical complexes will assist us in obtaining the most effective utilization.

Manpower and continuing education

A vital question which has been raised concerning this proposed program is the availability of the highly trained medical manpower that is the essential element of quality medical service. The testimony received by this Committee indicates that the medical complexes program can be correctly viewed as part of the answer to the manpower problem. Through better opportunities for clinical training in the community hospitals, through strengthened medical school programs of postgraduate medical education, and through the creation of additional clinical research and teaching opportunities, this program can have a significant effect on the additional training of physicians beyond the M.D. level. Such postgraduate training is an imperative of good medical practice in this age where the growth of medical knowledge is so impressive. No longer can a physician be content with the level of knowledge and skill he acquired in medical school. In this day of rapid scientific change professional education suffers rapid and radical obsolescence. The educational needs of a modern physician must be a concern throughout his career if he is to keep abreast of the latest developments. This is a requirement of his profession and an obligation to his patients. The medical complex can provide the environment and means for many types of effective continuing education programs and for the development of new and creative methods to carry the benefits of scientific progress to the local physician. The full-time staff in community hospitals made possible by the location in the hospital of a diagnostic and treatment station can provide the nucleus for rapid communication to the local practitioner of the latest knowledge and techniques. The contacts between the stations and the medical centers will provide natural channels for the flow of information and personnel to carry out these educational purposes. The specifics of how these educational aspects of the program will develop can emerge in many diverse ways from the variety of local plans and existing experience. Thus this program will offer new resources and new relationships to meet the old problems of continuing education of health personnel which have long concerned both the medical schools and the community hospitals.

The Committee must emphasize, however, that the medical complexes program will be only part of the answer to the medical manpower program. The undergraduate medical programs of the medical schools are in need of further strengthening if the basic supply of physicians is to adequately meet the needs of the Nation. This Committee will shortly consider a bill to extend and expand the provisions of the Health Professions Educational Assistance Act. This act was a most significant step in providing the facilities for new and expanded medical schools. Extension of these provisions and expansion to new forms of support for medical schools should be viewed as essential underpinning for the medical complexes envisioned in the programs authorized in this bill.

Financing of medical care

The bill definitely prohibits the use of these grants for the payment of the cost of medical care except for those costs which are clearly incident to research, training, or demonstration activities. In those cases where hospital care is approved as incident to the purposes of the bill, hospitals will be fully reimbursed for the cost of their services.

This program is not intended to be a substitute for current methods of financing hospital, medical, or other care of patients. The medical complexes program deals with the means to extend and advance the quality of the substance of service, not with the payment for that service. Thus the existing arrangements for the financing of medical services will not be modified.

It is also the understanding of this Committee that clinical research beds established under this program will be confined to the research centers and other parts of the medical center and will not be located in the diagnostic and treatment stations located in community hospitals.

Evaluation of the program

The bill calls for reevaluation of the program and the submission of a report to the Congress by June 30, 1967. The Committee views this requirement for accomplishments and recommendations for further development as an important and integral part of this legislation. This program provides the opportunities for major innovations. It is impossible to say with any precision at this time what the nature, extent, and diversity of these medical complexes will be in the future. We do know that these developments will be closely watched by the Congress and by the American people. The Committee does expect that, as experience is gained, the various aspects of the program may alter to deal with new problems and opportunities and to extend the coverage of the complexes into new communities and situations. The impressive endorsements of the concept of the program give a basis for launching the program as soon as possible, but the final form in all its particulars is not, and cannot be clear at this time. Therefore, the need for careful and continuous reevaluation assumes a special importance for this program. The Committee urges that the program be administered at all times with a view toward the identification of productive modifications for submission to the Congress when the extension is considered in the future.

Patent policy

The committee recognizes that the Department of Health, Education, and Welfare operates within the patent policy that was established by President Kennedy in 1963 following lengthy deliberations and consultations within and without the Government. The committee notes with satisfaction that it is the general policy of the Department that the results of federally financed research, whether the research is conducted intramurally or under grant or contract, be made widely, promptly, and freely available to the scientific community and to the public by publication and by royalty-free licensing or dedication of inventions made in the course of such research.

The committee, in maintaining its customary observation of the operations of the Department of Health, Education, and Welfare, will pay close attention to any developments which might necessitate additional legislation to safeguard the rights of the public to widespread low cost availability of medical innovations developed through Government expenditures.

HEARINGS

The Subcommittee on Health conducted hearings on S. 596 on February 9 and 10, 1965. Representatives of the American Heart

Association, the American Cancer Society, and the Association of American Medical Colleges testified in support of the legislation. Statements in support of the bill were submitted by the American Hospital Association, the American Dental Association, and the American Public Health Association.

AUTHORIZATION FOR APPROPRIATIONS

The President's Commission on Heart Disease, Cancer, and Stroke recommended a total of \$1.6 billion over a 5-year period to assist in the establishment of regional medical complexes. The Department of Health, Education, and Welfare recommended a total of \$1.1 billion over a 5-year period for the same purpose.

This committee has approved a total authorization of \$650 million for appropriations over a 4-year period to assist in planning and establishing the regional medical complexes:

Fiscal year 1966.....	\$50,000,000
Fiscal year 1967.....	100,000,000
Fiscal year 1968.....	200,000,000
Fiscal year 1969.....	300,000,000
Total.....	<u>650,000,000</u>

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
February 8, 1965.

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

DEAR MR. CHAIRMAN: This letter is in response to your request of January 25, 1965, for a report on S. 596, a bill to amend the Public Health Service Act to assist in combating heart disease, cancer, and stroke, and other major diseases.

We urge enactment of this bill.

In his health message of January 7, 1965, the President recommended "legislation to authorize a 5-year program of project grants to develop multipurpose regional medical complexes for an all-out attack on heart disease, cancer, stroke, and other major diseases." S. 596 embodies the administration's legislative proposal to carry out the President's recommendation.

Since we are scheduled to testify on Tuesday, February 9, on this legislation, we shall not burden this report with a detailed justification of its provisions. We are, however, enclosing for your convenience a section-by-section analysis of the bill.

Sincerely,

ANTHONY J. CELEBREZZE,
Secretary.

SECTION-BY-SECTION ANALYSIS

To encourage greater activity in the medical sciences and to insure that the most recent advances in the medical sciences are made available to the public, this bill authorizes the Surgeon General to make grants to public or nonprofit private institutions and agencies to assist them in planning and development, and in establishment and

operation, of regional medical complexes. Each such complex would constitute, for the area for which it is established, an administrative framework for coordinating medical facilities devoted to research, training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and other major diseases. The component units of each such complex would provide—without interfering with existing patterns or financing of patient care, professional practice, or hospital administration—demonstrations to the community of the most advanced specialized equipment and services available for patient care.

Section 1

This section provides that the bill may be cited as the "Heart Disease, Cancer, and Stroke Amendments of 1965."

Section 2

This section adds a new title IX, "Regional Medical Complexes for Research and Treatment in Heart Disease, Cancer, Stroke, and Other Major Diseases," consisting of sections 900 to 907, to the Public Health Service Act.

Section 900. Purposes.—This section provides that the purposes of title IX are (1) to assist in the establishment of regionally coordinated arrangements for research, training, and demonstration of patient care related to heart disease, cancer, stroke, and other major diseases, (2) to enable the medical profession and medical institutions to make available to their patients the latest advances in diagnosis and treatment of such diseases, and (3) to accomplish these ends without interfering with patterns or financing of patient care, professional practice, or hospital administration.

Section 901. Authorization of appropriations.—This section authorizes the appropriation of \$50 million for fiscal 1966, \$100 million for the fiscal year ending June 30, 1967, \$200 million for the fiscal year ending June 30, 1968, and \$300 million for the fiscal year ending June 30, 1969, for grants to assist in meeting all or part of the costs of planning, establishing, and operating of regional medical complexes for research, training, and demonstration activities for carrying out the purposes of this title. Grants for construction of facilities or provision of built-in equipment are limited to 90 percent of the cost thereof. Funds appropriated under this title may not be used to pay the cost of patient care not incident to research, training, or demonstration activities.

Section 902. Definitions.—This section would define the terms "regional medical complex," "medical center," "categorical research center," "diagnostic and treatment station," "nonprofit," and "construction." The regional medical complex would consist of local institutions or agencies (including at least one or more medical centers, categorical research centers, and diagnostic and treatment stations) engaged in research, training, prevention, diagnosis, and treatment relating to heart disease, cancer, or stroke, and other major diseases (those of significance to the objectives of the complex in combating heart disease, cancer, or stroke) and would serve as the administrative framework for the coordination of such units. The medical centers would serve as a source of high-quality, specialist personnel for the centers and stations. The categorical research centers would serve primarily as research and training institutions,

but would also provide highly sophisticated and costly diagnostic and treatment services that cannot be made available at the stations. The stations would serve as the primary specialized diagnostic and treatment facility of the community, but Federal funds provided pursuant to this bill for their operation would be available only for research or training activities undertaken by them or in connection with their function as the medium for conveying to the community, particularly to the local medical practitioners, the latest information on, and techniques for, diagnosis and treatment.

The term "regional medical complex" is defined to mean a group of public or nonprofit private institutions or agencies engaged in research, training, prevention, diagnosis, and treatment relating to heart disease, cancer, or stroke, and any other disease found by the Surgeon General to be of major significance to the complex and chosen by the applicant, which group (1) is situated in an appropriate geographic area, (2) consists of one or more medical centers, categorical research centers, and diagnostic and treatment stations, and (3) has in effect arrangements for the coordination of the activities of its component units.

The term "medical center" is defined to mean a medical school or other medical institution involved in postgraduate medical training and one or more hospitals affiliated with the school for teaching, research, and demonstration purposes.

The term "categorical research center" is defined to mean an institution, the primary function of which is research, training, and demonstrations and which provides specialized high-quality diagnostic and treatment services.

The term "diagnostic and treatment-station" is defined to mean a unit of a health facility, the primary function of which is to support and augment local capability for high-quality preventive, diagnostic, and treatment services.

The term "construction" is limited to renovation and alteration as well as new equipment and the replacement of obsolete equipment.

Section 903. Grants for planning and development.—This section authorizes the Surgeon General, upon the favorable recommendation of the National Advisory Council on Medical Complexes, to make grants to public or nonprofit private universities, medical schools, research institutions, hospitals, and other public or nonprofit private agencies and institutions, or associations thereof, to assist them in planning regional medical complexes. The Surgeon General may approve an application for such a grant only upon reasonable assurances that (1) grant funds will be used only for the purposes for which paid, (2) the applicant will provide adequate procedures for fiscal control and accounting of funds, (3) the applicant will make such reports, and will keep and afford access to such records, as the Surgeon General requires, and (4) the applicant will designate an advisory group to advise the applicant and the resulting regional medical complex in formulating and carrying out the plan for the establishment and operation of the complex.

The committee expects the Surgeon General to issue regulations that will permit the disposal of records required under this section after a reasonable period of time.

Section 904. Grants for establishment and operation of regional medical complexes.—This section authorizes the Surgeon General, upon the favorable recommendation of the National Advisory Council on Medical Complexes, to make grants to public or nonprofit private universities, medical schools, research institutions, hospitals, and other public or nonprofit agencies and institutions, or associations thereof, to assist them in establishment and operation of regional medical complexes. The Surgeon General may approve an application for such a grant only upon reasonable assurances that (1) grant funds will be used only for the purposes for which paid and will not be used to supplant funds otherwise available to the complex, (2) the applicant will provide adequate procedures for fiscal control and accounting of funds, (3) the applicant will make such reports, and will keep and afford access to such records, as the Surgeon General requires, (4) the applicant has designated an advisory group to advise in carrying out the plan for the complex, and (5) Davis-Bacon Act labor standards will be applied to construction projects assisted under this section.

The committee expects the Surgeon General to issue regulations that will permit the disposal of records required under this section after a reasonable period of time.

Section 905. National Advisory Council on Medical Complexes.—This section provides for the establishment of a National Advisory Council on Medical Complexes to advise and assist the Surgeon General in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this title. The Council is also to consider all applications for grants and to make recommendations to the Surgeon General with respect to approval thereof. The Surgeon General may also obtain the advice of other advisory councils.

The Council will consist of the Surgeon General, the Chief Medical Director of the Veterans' Administration, and 12 appointed members. The bill specifies that the fundamental sciences, the medical sciences, hospital administration, and public affairs shall be represented on the Council. The committee expects that a representative of public health or preventive medicine shall also serve on the Council. In addition, three of the Council members shall represent heart disease, cancer, and stroke.

Section 906. Regulations.—This section requires the Surgeon General, after consultation with the National Advisory Council on Medical Complexes, to prescribe regulations for the approval of applications for grants and for the coordination of programs assisted under this title with similar programs authorized under other acts.

Section 907. Report.—This section requires the Surgeon General, on or before June 30, 1967, to submit to the Secretary for transmission to the President and to Congress, a report of the activities under this title together with (1) a statement of the relationship between Federal financing and financing from other sources of the activities assisted under this title, (2) an appraisal of the activities assisted under this title, and (3) recommendations with respect to the extension of modification of this title.

Section 3

This section makes technical or conforming changes in the Public Health Services Act and the act of July 1, 1944 (58 Stat. 632), to take account of the amendments made by the bill.

CHANGES IN EXISTING LAW

In compliance with subsection (4) of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT, AS AMENDED**TITLE I—SHORT TITLE AND DEFINITIONS**

SHORT TITLE

SEC. 1. Titles I to [VIII] IX, inclusive, of this Act may be cited as the "Public Health Service Act".

* * * * *

**TITLE IX—REGIONAL MEDICAL COMPLEXES FOR
RESEARCH AND TREATMENT IN HEART DISEASE,
CANCER, STROKE, AND OTHER MAJOR DISEASES**

PURPOSES

SEC. 900. *The purposes of this title are—*

(a) *Through grants, to encourage and assist in the establishment of regionally coordinated arrangements among medical schools, research institutions, and hospitals for research and training and for demonstrations of patient care in the fields of heart disease, cancer, stroke, and other major diseases;*

(b) *To afford to the medical profession and the medical institutions of the Nation, through such coordinated arrangements, a more abundant opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and*

(c) *To accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals.*

AUTHORIZATION OF APPROPRIATIONS

SEC. 901. (a) *There are authorized to be appropriated \$50,000,000 for the fiscal year ending June 30, 1966, \$100,000,000 for the fiscal year ending June 30, 1967, \$200,000,000 for the fiscal year ending June 30, 1968, and \$300,000,000 for the fiscal year ending June 30, 1969, for grants to assist public or nonprofit private universities, medical schools, research institutions, hospitals, and other public or nonprofit private institutions and agencies, or associations thereof, in planning, establishing, and operating regional medical complexes for research, training, and demonstration activities for carrying out the purposes of this title. Sums appropriated under this section for any fiscal year shall remain available for making such grants until the end of the fiscal year following the fiscal year for which the appropriation is made.*

(b) *A grant under this title shall be for part or all of the cost of the planning and other activities with respect to which the application is made, except that any such grant with respect to construction of, or provision of*

built-in (as determined in accordance with regulations) equipment for, any facility may not exceed 90 per centum of the cost of such construction or equipment.

(c) Funds appropriated pursuant to this title shall not be available to pay the cost of hospital, medical, or other care of patients except to the extent it is, as determined in accordance with regulations, incident to research, training, or demonstration activities.

DEFINITIONS

SEC. 902. For the purposes of this title—

(a) The term "regional medical complex" means a group of public or nonprofit private institutions or agencies engaged in research, training, prevention, diagnosis, and treatment relating to heart disease, cancer, or stroke and, at the option of the applicant, any other disease found by the Surgeon General to be of major significance to the aforesaid objectives of such regional medical complex; but only if such group—

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

(2) consists of one or more medical centers, one or more categorical research centers, and one or more diagnostic and treatment stations; and

(3) has in effect arrangements for the coordination of the activities of its component units which the Surgeon General finds will be adequate for effectively carrying out the purposes of this title.

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

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

(d) The term "diagnostic and treatment station" means a unit of a hospital or other health facility, the primary function of which is to support and augment local capability for providing specialized, high-quality preventive, diagnostic, and treatment services to outpatients and inpatients.

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

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

GRANTS FOR PLANNING AND DEVELOPMENT

SEC. 903. (a) The Surgeon General, upon the recommendation of the National Advisory Council on Medical Complexes established by

section 905 (hereinafter in this title referred to as the "Council"), is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, hospitals, and other public or nonprofit private agencies and institutions, or associations thereof, to assist them in planning the development of regional medical complexes.

(b) Grants under this section may be made only upon application therefor approved by the Surgeon General. Any such application may be approved only if it contains or is supported by reasonable assurances that—

(1) Federal funds paid pursuant to any such grant will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder:

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

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

(4) the applicant will designate an advisory group, to advise the applicant (and the resulting regional medical complex and its component units) in formulating and carrying out the plan for the establishment and operation of such regional medical complex, which includes representatives of organizations, institutions, and agencies concerned with activities of the kind to be carried on by the complex and members of the public familiar with the need for the services provided by the complex.

GRANTS FOR ESTABLISHMENT AND OPERATION OF REGIONAL MEDICAL COMPLEXES

SEC. 904. (a) The Surgeon General, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, hospitals, and other public or nonprofit private agencies and institutions, or associations thereof, to assist in establishment and operation of regional medical complexes, including construction and equipment of facilities in connection therewith.

(b) Grants under this section may be made only upon application therefor approved by the Surgeon General. Any such application may be approved only if it contains or is supported by reasonable assurances that—

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

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

(3) the applicant will make such reports, in such form and con-

taining such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports;

(4) the applicant has designated an advisory group, described in paragraph (4) of section 903(b), to advise in carrying out the plan for the regional medical complex; and

(5) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 1332-15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

NATIONAL ADVISORY COUNCIL ON MEDICAL COMPLEXES

SEC. 905. (a) There is hereby established in the Public Health Service a National Advisory Council on Medical Complexes. The Council shall consist of the Surgeon General, who shall be the Chairman, and the Chief Medical Director of the Veterans' Administration, *ex officio*, and twelve members, not otherwise in the employ of the United States, appointed by the Surgeon General, with the approval of the Secretary and without regard to the civil service laws, who are leaders in the fields of the fundamental sciences, the medical sciences, hospital administration, or public affairs. At least one of the appointed members shall be outstanding in the study, diagnosis, or treatment of heart disease, one shall be outstanding in the study, diagnosis, or treatment of cancer, and one shall be outstanding in the study, diagnosis, or treatment of stroke.

(b) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Surgeon General at the time of appointment, four at the end of the first year, four at the end of the second year, and four at the end of the third year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms.

(c) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed expenses, including *per diem* in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

(d) The Council shall advise and assist the Surgeon General in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this title. The Council shall consider all applications for grants under this title and shall make recommendations

to the Surgeon General with respect to approval of applications for and the amounts of grants under this title; and such recommendations shall also be transmitted to any advisory council or committee, established by or pursuant to this Act, which the Surgeon General deems appropriate.

REGULATIONS

SEC. 906. The Surgeon General, after consultation with the Council, shall prescribe general regulations covering the terms and conditions for approving applications for grants under this title and the coordination of programs assisted under this title with programs for training, research, and demonstrations relating to the same diseases assisted or authorized under other titles of this Act or other Acts of Congress.

REPORT

SEC. 907. On or before June 30, 1967, the Surgeon General, after consultation with the Council, shall submit to the Secretary for transmission to the President and then to the Congress, a report of the activities under this title together with (1) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, (2) and appraisal of the activities assisted under this title in the light of their effectiveness in carrying out the purposes of this title, and (3) recommendations with respect to extension or modification of this title in the light thereof.

TITLE [IX] X—TEMPORARY AND EMERGENCY PROVISIONS AND AMENDMENTS AND REPEALS

SEC. [901]	1001.	* * *
SEC. [902]	1002.	* * *
SEC. [903]	1003.	* * *
SEC. [904]	1004.	* * *
SEC. [905]	1005.	* * *
SEC. [908]	1008.	* * *
SEC. [910]	1010.	* * *
SEC. [911]	1011.	* * *
SEC. [912]	1012.	* * *
SEC. [913]	1013.	* * *
SEC. [914]	1014.	* * *

INDIVIDUAL VIEWS OF MR. YARBOROUGH

While I enthusiastically support the broad purpose of this legislation, I feel that the bill would be greatly improved by the inclusion of a requirement that the results of research which is financed by public funds authorized under this act be made freely available to the general public. If the public pays for the research they should be entitled to the results of it. No private citizen should be allowed to acquire monopoly patent rights to the results of research which is financed with public funds.

In the case of research which is financed partly with public funds and partly with private funds, provision should be made for the granting of an exclusive right to the private researcher for a limited period of time (for instance, 3 years) if such a right is justified upon equitable considerations by the financial contribution made by the private researcher and if the action will promote the utilization of the development and the interests of the public health and welfare in the United States.

Through such a provision, the public interest would be safeguarded at the same time that the rights of private researchers were recognized.

I commend the Department of Health, Education, and Welfare for their efforts in the past to protect the public interest. I feel, however, that specific legislation is desirable in order to make clear the intent of Congress in the use of public moneys for research, and to insure that the public interest be safeguarded by law.

RALPH YARBOROUGH.