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hearings before a subcommittee of the House Committee on Appropriation
April 28, 1971

Mrs. Reid: ..do you have an estimate of how much money is involved from local and State units in the regional medical programs?"

Dr. Margulies: "We find that very difficult to evaluate. As an example of the uncertainties of that kind of calculation, we have serving on our regional advisory groups, technical committees, local advisory groups and so on, well in excess of 10,000 people meeting anywhere from 3 to 8 or 10 or 15 days a year

"We don't pay consultant fees for any of these individuals. They give their time. These are hundreds of thousands of man-hours of professional time which are contributed.

"We very freqeently involve major health activities in a coordinated fashion, anything from the Appalachian program to a local county health department to make sure their investment is better designed and better aimed.

"It would be possible for us to make a calculation of what this means, but it would be misleading.....I am confident, however, that every dollar invested in the regional medical programs has an influence on many more dollars and has a vavorable influence by having them managed more effectively."

Dr. Margulies, April 28, 1971 during hearings before the subcommittee of the House Committee on Appropriations

"The initial concept of regional medical programs was to provide a vehicle by which scientific knowledge could be more readily transferred to the providers of health services and, by so doing, improve the quality of the health care provided. We believe, however, this to be but the beginning of the responsibilities and potentialities of the Regional Medical Programs Service.

"The premise upon which the Regional Medical Programs Service is based is that the providers of care in the private sector, given the opportunities, have both the innate capacity and the will to provide quality care to all Americans. Accepting this assumption, the issue has become one of how best to develop and promote these opportunities.

Dr. Margulies, April 28, 1971, during hearings before a subcommittee of the House Committee on Appropriations

"One way of describing the impact of regional medical programs upon our present health delivery system is to state that this year an estimated 30,000 physicians, or 10 percent of all practicing physicians in the country, will be involved in regional medical program-supported training activities. In terms of hospitals affected by regional medical programs, it is estimated that 1,470 hospitals presently participate in or benefit from regional medical programs. This represents 25 percent of all short term, non-Federal hospitals. Of the 1,470 hospitals mentioned, 860 are the primary sponsors or sites of the regional medical program activity."

Dr. Margulies, April 28, 1971, during hearings before a subcommittee of the House Committee on Appropriation

"...the process we are using the regional medical programs..is unique. We look on it as the Federal Government's most direct and effective access to the private health-care system. And thinking of it in these terms, we want the many regions which we have to function within their own resources and as independently as possible.

"...we have established the practice of allowing the programs to do their own project review and for the most part make their own decisions about how they invest their funds. We carry through a review process as we have in the past, but we are looking at them (the regions) more as competent institutions rather than as project mechanics as they were looked on too much in earlier days."

Dr. Margulies, April 28, 1971, during hearings before a subcommittee of the House Committee on Appropriations

..." of the funds supporting the current 600 operational projects, over one-third - 38 percent - are for patient care demonstration projects concerned with coronary and other intensive care activities, expansion and improvement of ambulatory care in neighborhood health centers, clinics and outpatient departments, and the expansion and improvement in extended and home care activities benefiting 240,000 patients. An additional 45 percent is used to support activities in the broad area of manpower training and utilization which will lead to improved care and expanded services. The training projects include the training of nurses and other existing health personnel, including physicians, in new skills as well as upgrading existing skills. Our manpower training and utilization programs involve all of the various kinds of health resources within communities - hospitals, clinics, neighborhood health centers, specialized facilities, and medical school health complexes, but indeed are not limited in any way to the latter. Finally, approximately 17 percent of our funds support projects concerned with coordinating the activities of community institutions in order to develop means of improving access to and the quality of available health services."

Dr. Margulies, April 28, 1971, during hearings before a subcomaitee of the House Committee on Appropriation

"Communities, and the health care providers within them, will be encouraged to establish carefully planned systems to furnish comprehensive care to an identified population. The success of this approach will explcit the strengths of regional medical programs to convene the key provider and consumer groups needed for planning and implementation of these critically important activities."

Dr. Margulies, April 28, 1971, during hearings before a subcommittee of the House Committee on Appropriations

"Increasingly, the regional medical programs, with their strong provider links, are being viewed and used as an important technical, professional, and data resource by State and areawide comprehensive health planning agencies in their planning for personal health services. In turn, regional medical programs are looking to comprehensive health planning agencies to express the health needs of the total community from the consumer's point of view and to set priorities for the regional medical programs service efforts."

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"That the high cost of medical care, which can be increasingly identified as being from federal sources, is going to lead to an increasing demand that we have a measurement of what we are purchasing. And one of the rising issues before 1975 is going to have to do with the quality of medical care which is being purchased by federal and private money. And this is going to produce some profound changes in attitudes.

"Public hospitals which currently provide miserable medical care for people because they are indigents are going to have to face the fact that this care is unacceptable. Payment systems are going to identify the difference between good and bad care at levels of sophistication which none of us feels ready to take on. "

"A myth we did not speak about is that biological research necessarily means better health care. We found that was not true. The second myth was that if you incrdase the ability to purchase care, the system is infinitely expansible and can respond. We found that is not true. And the third one, which we are getting into a better understanding on, is that increasing the number of people available to provide medical services is the way to overcome the manpower shortage. That is pre-eminently false. ....We are facing an in teresting dilemma as we go into the seventies and eighties. If we are to maintain expertise in the quality of medical care and make sure that it is available, what is the role of the physician and what is the role of the people? I believe the following event will occur by the eighties:

"Specialists will continue to be trained; they will be confined for the most part to hospitals; they will be governed by the hospitals rather than by other kinds of systems. The majority of medical care is

going to be provided by other individuals under a system of maintenance and supervision which will depend upon a different kind of physician. Some of this will be in group practice...

"..I think we will discover that it is not necessary to see a physician for a very large percentage of those ailments which are now brought to the attention of a physician. And if we look a little further into the seventies, I think we are going to discover that a significant portion of the time spent by professional people is spent giving attention to individuals who do not need to be into the health-care system at all.

"A major input is going to be the use of automated techniques and I believe this will include screening methods which will have their concentration on health maintenance rather than on the identification of acute kinds of illnesses.

"As a consequence, there will be a different use of allied health manpower. And although this may startle you a little, I think our current efforts to (1) increase the output of medical schools, associated with our efforts to (2) reorganize the way in which health care is being provided, will lead to a discovery somewhere along the line that we are training too many physicians. If the latter is successful, the former is unwise. If the former is pursued and the latter is not, we are gong to have to get around to it a t a later date. So all these efforts to vastly increase medical schools, with the illusion that this will provide medical care, are going to be re-examined and, in the course of time, I think are going to be dropped.

"The solution lies, not in adding to the numbers, but in making more effectiveuse of the way in which they spend their time. This means that responsibilities for all levels of providers are goi g to be increased and under supervised circumstances. And people are going to

done, which is where people are ill. I think that as a consequence there is going to be a regulation of the way in which hospitals are used.

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"Should RMP and CHP be combined? The answer to that question is unequivocably 'no.' They serve a different kind of a purpose and if I have my preferences, I would say that CHP and RMPs should operate in such a way that they have a productive tension between them, one forcing demands on the other, the other dealing with those demands. They should have a basis between them for an effective negotiation between what the community needs with a resolution in capacity, the identification of reasonable priorities, and the reaching toward those priorities by a common understanding . . .

"If we are to be effective in RMP and CHP, the problem is a double one. Not only must we be responsive to consumers, but we must be able to interpret to consumers the difference between an irrational and the rational effort to meet their basic needs. And because it is a sophisticated issue and because the health care system is complex, it means that the professional effort of an RMP or any other organization needs the full understanding, the full exploitation, and the most minute interpretation to the community so they can appreciate the difference between the visible, the glittering and the glamorous and what really is essential for health maintenance for control of cost and for the basic health of the community."

—Dr. Harold Margulies

the appropriation bills. I would have to vote against this because I think this was not an intelligent way of going about a cut. I am sorry to see you people fell in that trap.

What you are doing is harming your good RMP's and rewarding the bad ones.

Dr. MARGULIES. We propose not to continue that because I agree with what you just said. The tri-State program is currently funded at the level of $1.8 million and depending upon the availability of funds in 1972 and the way in which they come out in the total array of programs, and I would anticipate they would do very well, they would be above that level.

But it would have to be, as you indicated, at the expense of programs which are less productive and less mature and less useful.

RMP ROLE IN DEVELOPING HMO'S

Mr. CONTE. What is your assessment of RMP's in the Administration's plan to intensify efforts in the HMO and manpower areas?

Dr. MARGULIES. I think the regional medical programs can make a very major contribution to the development of health maintenance organizations in two substantial ways.

One of them is to help bring together those individuals and institutions which have to form an HMO. If you look at the array of individuals and institutions identified as partners, participants in the provider end of the health maintenance organization, they are the same people as those in the regional medical programs, already meeting together.

So they obviously have a key role.

The other aspect of the HMO which will require scrupulous attention is the character of the health care which is delivered through the device which is created in an HMO.

We will need to have ways of using manpower more effectively, of monitoring the quality of care, and of making sure that when quality is inferior it is restored to an appropriate level, all of which are exactly the kinds of things in which the regional medical programs can be effective.

RMP ROLE IN CREATING HEALTH MANPOWER

As far as manpower is concerned, I suspect the potentiality for regional medical programs has probably been underappreciated more than any other field, which is amazing, because, of all of our deficiencies, the lack of manpower to provide services is the most agonizing.

If you reflect on it for a moment, you will see that if there are more services to be provided, greater access, greater outreach, and if we are not to have enough physicians, and we won't have, it has to be done through the hands of other people, physicians' assistants, nurses and so on.

The only way in which this can be done with supervision, with approval, with measurement of quality either on an informal or formal basis, is by the providers of care who are at the present time responsible for those activities, the same people who make up our regional medical programs.

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Mr. CONTE. Right.

If a physician or group of physicians or a hospital wishes to change the patterns of medical care and utilize other kinds of individuals, they can do it rapidly, and I think with good justification, with the kinds of resources RMP's have available.

We can also retrain people, as I indicated earlier, and measure the effects of that retraining without being heavily involved in institutions.

AREA HEALTH EDUCATION CENTER

One of the other proposals which is high on the list of activities in this administration is the area health education center, which is a very attractive concept, typing together all of the service and training facilities in a community with the service needs of that community.

As described, such centers are not very remarkable, but the intriguing part of the concept, which is close to the heart of the regional medical programs, is the possibility it provides for the first time of closing the loop between services provided, the need for those services, and the training of the people who must provide the services.

At present you have education here in a hospital or junior college or university health science center and service out there, and the two relate with one another too frequently only by accident.

What we need to know is what happens when the training is measured against the services provided (or not provided). What is the relationship between the two, and having discovered the need for changes, how does one go back into the educational system and redesign it so there is continuity between what is taught and what is practiced?

This is the kind of thing which regional medical programs have been investing in effectively. In fact in the Watts-Willowbrook area we probably have the best example of an area health education center anywhere because it was designed in that troubled Black community for the purpose of building a service system and institution around the needs of the people and to let the people have a voice in what they get. This is a total institutional concept. I think we can contribute splendidly to that purpose.

Mr. CONTE. That is tremendous. I couldn't even begin to start putting it into the words you did, but you are absolutely right.

BERKSHIRE MEDICAL CENTER

In my district, the Berkshire Medical Center has taken over quite a few students from the Albany Medical School. It has gone well. They have room for maybe 30 or 40 there. It is a very good teaching hospital. At the University of Massachusetts medical school I believe we only have a dozen students. If you are going to add on to that dozen students, you are going to have to have more expensive buildings and labs and all the trimming whereas maybe there is no need for that at all if you take the students to a place like the Berkshire Medical Center. With only a little money invested there for dormitories and increased laboratory facilities, you can educate a lot more students.

Dr. MARGULIES. You know the activity at Berkshire Medical Center is supported by the Albany regional medical program.

Mr. CONTE. Right.

INFLATION AND THE NEED FOR MORE RMP FUNDS

Mr. CASEY. I think you well know, from what you heard in the questions, that it is not only the chairman but the full committee is very interested in the program. I am sorry the chairman had to leave because I think you have given some very good answers on why you need more money.

I am sure you suffer inflation and increased costs just like anyone else and if you just give the same numbers of dollars, you are not going to give the same amount of support are you?

Dr. MARGULIES. No. I think our best hope is to make sure that we trim out anything unnecessary and sharpen what we do to a very fine point.

Mr. CASEY. Are you going to have enough money to do some of the things you were telling Mr. Conte, some of these area programs you think ought to be instituted in other parts of the Nation?

Dr. MARGULIES. I think we can make a very significant contribution to them. I don't believe that regional medical programs needs to function alone or even should function alone in such activities. We can do what needs to be done in consort with other programs and other agencies.

Mr. CASEY. The trouble is most of these other programs are getting pretty tight, too. The belt is getting awful tight. At least that is what I heard. I happen to have a medical center in my district which has been helped a great deal by HEW and National Institutes of Health and all of the other programs. They all seem to be worried about the cutdown as they call it and it is a cut.

You say the same amount of money is not cut, but you can't get the same amount of service for your dollar as you did last year. They are afraid we are losing ground in research and in supplying this demand for improved medical services and better distribution of medical services.

Dr. MARGULIES. We do feel the squeeze.

MULTIPHASIC HEALTH TESTING

Mr. CONTE. Would you describe in greater detail the automatic multiphasic health testing that is mentioned on page 241 of the justifications?

Dr. MARGULIES. Regional medical programs, in cooperation with local clinics, hospitals, and neighborhood health centers, is supporting several automated multiphasic health testing activities around the country designed to provide preventive and early diagnostic services for heart and lung disease, cancer, diabetes, and other diseases and conditions. These automated testing services involve the conduct of a series of sequenced, multiple laboratory tests on such items as blood and urine samples, EKG's, and X-rays, by utilizing automated equipment and analyzing the results with computers. Within the regional medical programs, these services are developed as integral components

of larger health service programs and involve the development of close ties among local physicians, hospitals, and clinics, for referral and followup services. Many of the RMP activities are tied to neighborhood health centers and include training of local community residents to work as technicians in the programs.

Multiphasic screening activities are being carried out in the Memphis, California, Tennessee/Midsouth, Rochester, and Intermountain regional medical programs, to name a few. For example, in Salt Lake City the Intermountain regional medical program is providing automated multiphasic health testing services as part of the program of a neighborhood health center which is delivering comprehensive, accessible health care to a low, socio-economic target population. The screening activity involves extensive patient histories, physical examinations, including hearing and eye tests, and several laboratory tests, as well as the training of screening and laboratory aides who are recruited from among the community population. These, and other RMP screening activities, are helping to provide and promote preventive medical care with the expectation that through early detection efforts the cost and disabilities incurred from advanced stages of disease will be reduced.

EFFECT OF SMOKING ON PREGNANCY

Mr. CONTE. What are the statistics on the chances of smoking mothers having a significantly greater number of unsuccessful pregnancies than non-smoking mothers?

Dr. HORN. The British Perinatal Mortality Study is one of the largest studies dealing with this question. I will place in the record information gathered from more than 17,000 births recorded in 1 week throughout England, Scotland, and Wales.

(The information follows:)

[Per 1,000 births]

	Neonatal death rates	Stillbirth rates
Smoking mothers	17.2	27.6
Nonsmoking mothers	13.1	19.3

Analysis of these rates shows that smoking mothers had 31.3 percent more neonatal deaths than nonsmoking mothers and smoking mothers had 43 percent more stillbirths than nonsmoking mothers. There were no data concerning abortions and miscarriages.

In another study of more than 2,000 births in England, Russell found that smoking mothers had significantly more unsuccessful pregnancies due to stillbirth, neonatal death, and abortions than the nonsmoking mothers. He concluded that 20 percent of the unsuccessful pregnancies in women who smoke regularly would have been successful if the mother had not been a regular smoker.

It is the objective of the Regional Medical Programs to improve availability of and access to high quality health care to all Americans through improvements in the development and more efficient utilization of health manpower and other resources.

As for why grants are being reduced, I can only repeat what Mr. Meyer has said earlier that this is essentially a holding action until some sense of integration exists among already existing efforts and those newly proposed.

IMPROVED DESIGN FOR INTENSIVE CARE

Mr. CONTE. On page one of your statement you mention improved design for intensive care that has resulted from efforts under this program. What is the improved design that has been brought about?

Dr. MARGULIES. The improved design that I made reference to relates largely to putting together the several essential pieces required for the larger "system" of intensive care. It did not refer to "design" in the more commonly understood sense of that word; that is, the planning and layout of intensive or specialized coronary care units physically. While it is true that an intensive care system, whether of a more generalized character such as that for treating accident victims or a more specialized one such as that intended for victims of heart attacks, requires an intensive or coronary care unit or beds, that is but one element. The unit itself is of little use if other equally essential elements are not present.

Its effective functioning requires that there be an adequate transportation system for getting the victim to the hospital promptly, ambulances that have a coronary care capacity—and here I am not talking about so-called mobile coronary care units, which will help keep the patient alive while he is enroute, or tying into the Army's Medical Assistance to Safety and Traffic (MAST) program which provides helicopters for emergency transportation in those areas where it is being tried and tested.

It also requires having nurses adequately trained to staff such units around-the-clock. In many small, remote rural hospitals, a telephone tie line to another larger hospital at some distance is an alternative. For it permits trained nurses in that larger hospital to monitor and, in the event of a crisis, prescribe appropriate emergency treatment for the patient being cared for in a CCU in the remote hospital.

Such "improved design" also means, and this is most important, that the planning for such intensive care systems, or currently missing elements, make adequate provision for continued support once initial regional medical program grant support is terminated: that is, that there be reasonable assurance that the operating costs can be absorbed within the regular health care financing system within a 2- or 3-year period.

It was in this sense that I referred to RMP activities as leading to "improved design for intensive care." For the 55 regional medical

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programs have in large measure sought to make certain they were contributing to building such larger systems of intensive care rather than being content with simply putting one element in place, and hoping that the others which are equally important somehow would materialize.

Mr. CONTE. That is all, Mr. Chairman.

Mr. CASEY. Mr. Hall?

NATIONAL CLEARINGHOUSE FOR SMOKING AND HEALTH

Mr. HALL. Dr. Margulies, am I correct in thinking that the National Clearinghouse for Smoking and Health is a part of your organization?

Dr. MARGULIES. Yes.

Mr. HALL. Dr. Margulies, would you describe for us what you consider to be the duties of the National Clearinghouse for Smoking and Health?

Dr. MARGULIES. The National Clearinghouse for Smoking and Health was established in 1965 following the admonition of the Surgeon General's Advisory Committee that, "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." Its purpose is to help reduce the illness and early death associated with cigarette smoking through education and research.

THE LINK BETWEEN SMOKING AND ILLNESS

Mr. HALL. I have a copy of a letter that a Robert S. Hutchings of the Clearinghouse sent to pharmacists around the country requesting that an enclosed poster be displayed and stating that "The Link Between Cigarette Smoking and Lung Cancer, Emphysema and Other Diseases is Now Well Established." Now, to me "link" means the same thing as "cause." I believe that as late as January or February of this year the National Institutes of Health were providing spot radio announcements which stated that we don't know the cause of emphysema but suspect combinations of various suspects, such as chemical and exhaust fumes, viruses and germs and allergies. These radio spots suggested that the listeners write and ask for publication No. 1414. Now, I have obtained a copy of this pamphlet and it states on page six that the cause of emphysema is unknown. Just what is the truth here? Is the Clearinghouse saying it knows the cause of emphysema, when the National Institutes of Health say they do not, but rather list a number of suspects?

Dr. HORN. Mr. Hutchings' letter quoted C. Albert Olson, president of the American Pharmaceutical Association's Academy of General Practice of Pharmacy. Mr. Olson states that "the link between cigarette smoking and lung cancer, emphysema, and other diseases is now well established." This statement seems to be well supported by the

Estimate	Increase or Decrease	
Amount	Pos.	Amount
$4,756,000	--	+$ 320,000
82,515,000	--	+84,545,000
87,271,000	--	+$4,865,000

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Regional Medical Programs:

	1971 Estimate	1972 Estimate	Increase or Decrease
(a) Grants	$70,298,000	$75,000,000	+$4,702,000

Grants are awarded to assist in the planning, establishment and operation of Regional Medical Programs for research, training and demonstrations of patient care.

It is the objective of the Regional Medical Programs to improve availability of and access to high quality health care to all Americans through improvements in the development and more efficient utilization of health manpower and other resources. Approximately 2,700 institutions including all medical schools, 1,500 hospitals and a variety of State and voluntary health organizations are now participating in this effort to improve the quality of care and the adoption of the latest techniques in the delivery of health services.

The Regional Medical Programs Service seeks to assist the established Regional Medical Programs to develop a framework of cooperative relationships for improving the organization and delivery of services to people. This framework is structured by developing the voluntary cooperation of the various providers of service, both public and private, in identifying the patients' needs. When these have been determined, the local groups and institutions develop projects and programs to meet these needs. The activities of Regional Medical Programs include the full spectrum of health care: prevention, primary care, specialized care using the latest scientific techniques, and rehabilitation. Regional Medical Programs provide funds for organizing a system of health care locally acceptable and responsive, but linked to regional resources not available locally.

Program for 1971 and 1972

Fifty-five Regional Medical Programs are now conducting operational activities.

During the past year, events in the various regions have provided significant directions for the future. The newly emerging cooperative arrangements within the regions have demonstrated the role the Regional Medical Programs can play as a recognizable and locally acceptable force not only for health planning but for improving the organization and delivery of health care as well. These changing patterns in the health care system brought about through operational activities are affording the consumer immediate and direct benefits.

service for physicians through the cooperation of the neurological staffs of the three medical centers, and a family-patient education unit, designed to help patients and their families learn to cope with the long-term effects of stroke disability.

A broad array of manpower activities is being developed to impact on the health care delivery system. Estimated numbers of health professionals who will be trained in 1971 as a result of Regional Medical Program activities are as follows:

Doctors	31,628
Nurses	55,295
Allied/Other Health	39,000
Total	125,923

In addition, over 25,000 emergency health personnel (firemen, ambulance drivers, policemen, etc.) will receive training. These programs will include both the teaching of new skills and also the upgrading of existing skills as well as training new people in the allied and other health areas.

Many Regional Medical Programs have conducted studies to determine the need for, willingness to accept and feasibility of training categories of manpower to extend the services of physicians. Most of these are related to the physicians' assistant concept. Some Regional Medical Programs are designing such projects and several have funded operational projects in this area.

In Alabama, the Regional Medical Program is sponsoring a program to formulate and implement training programs for allied health technicians through the cooperative use of funds, manpower, and facilities already in existence at the junior college and vocational technical training schools level. By linking the resources of the University of Alabama, Regional Technical Institute, the Appalachian Development Commission, and 17 state supported junior colleges, Alabama is taking a giant step toward solution of its health manpower shortage.

A Guest Residency Program, started two years ago with Regional Medical Program funds, has helped pave the way for what is a significant innovation in medical education (WAMI) by demonstrating the practicality of its decentralization. The new medical education plan, taking its name from the four States involved (Washington, Alaska, Montana, Idaho), recently received a $1 million grant from the Commonwealth Fund. Alaska was selected as the first State to implement the new plan because of the close ties already created by the Washington/Alaska Regional Medical Program between the University of Washington Medical School and Alaska academic and medical communities.

Virtually all Regional Medical Programs have projects designed to augment the knowledge and level of performance of health professionals and paraprofessionals. Many of these projects lead to the utilization of personnel in new ways. Perhaps the greatest Regional Medical Program thrust in this area is the training of coronary care unit nurses; over 7,000 registered nurses and licensed practical nurses have been trained to date.

Although Regional Medical Programs does not provide for patient services directly, it often gets involved in planning for and helping to establish those health care components which will deliver service. This includes a broad range of patient care demonstrations, including screening and early diagnosis activities, projects relating to coronary care, and stroke rehabilitation programs.

Currently demonstrations are being funded for activities such as:

Coronary and other intensive care - 114 coronary care units and 8 mobile units	$13,800,000
Ambulatory care - 24 neighborhood health centers, clinics and out-patient departments	3,900,000
Extended and home care	2,200,000
Other - such as emergency and transportation services	1,300,000
Total	$21,200,000

As a result of these demonstrations, communities and hospitals not directly involved in these projects have been spurred to make much needed improvements. For example, in 1966 there were only 375-425 coronary care units and 1,100 other intensive care units in the United States. By 1969 these had increased to 2,101 coronary care units and 2,556 other intensive care units, corresponding to 500 percent and 150 percent increases, respectively.

This range of activity and the types of operational components being carried on varies from region to region. In providing a mechanism for planning, decision-making, and sharing limited health manpower and facilities, the stress has been on local initiative and control to match local needs, problems, and available resources.

It is expected that an increasing portion of available funds during 1972 ...ll be directed toward the following general areas:

- Activities which lead to more effective and efficient utilization of health manpower, especially in patient care settings. Training for new types of health manpower (e.g., physician assistants) will be emphasized, as will new organizational patterns which make greater use of paramedical personnel.
- Operational activities with increased emphasis on regionalization of health resources and services, with the focus on strengthening linkages between those institutions providing specialized care, such as the medical centers and affiliated hospitals, and primary care, being provided by smaller community hospitals, neighborhood health centers, and other community health facilities.
- Conjoint and collaborative efforts with Areawide Comprehensive Health Planning agencies and similar agencies which foster community-based planning and programs that can begin to materially effect resource allocations/distribution for health at the local level.
- Projects which emphasize disease prevention and early detection, including early and easy access to care.
- Activities which encourage and support the development, operation and success of the emerging Health Maintenance Organizations.

The increase in total fun... provide $75,000,000 in 1972. ... struction of a regional cancer ... States. The balance will be u... selected programs based on reli...

In exercising the current ... planning and evaluation, in ad... and contracts, these funds will ... services required to prepare, ... Such consultative services woul... of part-time or intermittent co...

Regional Medical Programs:

(b) Direct operations	197... Pos.
Personnel compensation and benefits.....	$1
Other expenses.....	--
Total.....	$1

This activity supports staf... administration of grants; pro... Regional Medical Programs in t... develops and maintains appropr... agencies concerned with improv... services.