1/28/70

Mr. Chairman and Members of the Subcommittee -

I am pleased to come before you to speak to the proposed legislative extension of the Heart Disease, Cancer, and Stroke Amendments of 1968 as embodied in Senate Bill __________, introduced by the distinguished Chairman of this Subcommittee, Senator Yarborough.

I fully support the extension of Regional Medical Programs for Heart Disease, Cancer, Stroke, and Related Diseases. It is a sound program. And, as I believe these hearings will bring out, the 55 regional medical programs covering the country have become important mechanisms for bringing about constructive change in the health care system in those regions separately, and in the country as a whole. There is little in this bill with which I cannot agree.

President Nixon, in announcing my appointment as Assistant Secretary for Health and Scientific Affairs last June, took the occasion to comment on the serious nature and magnitude of the "health crisis" facing the Nation. That crisis is being examined carefully by the public, in the press, in public forums, and by virtually every organization and institution concerned with health care. The mounting costs of health care and the limitations of availability and access to that care are being felt by more and more people. This rapidly increasing public awareness of the nature of the health care crisis is forcing recognition of the need for change. And that change, indeed, is taking place.

Two specific aspects of the health care crisis might be identified in order to put the legislation under consideration in better perspective.

The first is that health care is provided neither through the public realm nor through the private sector alone. Rather, for change to be effective both components must be considered. The second aspect to which I would call attention is that our health care system is limited by the availability of resources, personnel, and facilities. We are dependent, to a very large extent in the provision of health care, on existing resources -- physicians, hospitals, and all the other health professionals and institutions. They must play an active and constructive role in that change process and not be alienated by it nor hampered in their effectiveness.

Despite increased public expenditure for health in the last decade, and especially for direct health services, the actual provision of medical care is largely within the private sector. Over 75 per cent of the care is rendered by private physicians, private group practices, voluntary hospitals, clinics, and the like. I believe these providers of care recognize with increasing clarity that they cannot arbitrarily say "No" to change. But what we in the public sector do to change the ground rules under which those in the private sector work should be carefully calculated to encourage their cooperation in the change process.

It is against the backdrop of these issues that Regional Medical Programs may be seen as a significant program. In the five years since they were first authorized, they have shown substantial potential as programs for bringing about change by developing cooperative arrangements among providers and consumers of health care at the regional level.

The need for a more effective way to diffuse technical innovation and new knowledge into the health field was strongly emphasized in the 1964 Report of the President's Commission on Heart Disease, Cancer, and Stroke. It recommended the establishment of a series of regional centers of excellence linked to a network of less highly specialized institutions as a way of improving care for patients with heart disease, cancer, or stroke. The legislative hearings on the bill which finally became P.L. 89-239 substantially modified that concept. Witnesses expressed the view that we were already overbalanced in the establishment of specialized diagnostic and treatment centers and that implementation of a Regional Medical Center bill would alienate the practicing physician, rather than enlist his cooperation. As a consequence, the concept of _regional medical programs_ built on _cooperative arrangements_ was substituted for the concept of regional medical centers. It was hoped that the program would bring the resources and energy of the existing medical centers to the less well developed resources in the rest of the system. The final legislation, as adopted, retained a strong categorical emphasis on "heart disease, cancer, stroke, and related diseases." This we can now see in retrospect was fortunate, for it gave Regional Medical Programs an orientation that permitted them to deal more readily with specific issues and problems involved in promoting quality in the health care system.

Regional Medical Programs thus began their activities with a base that was categorical, and with a model built around hubs of excellence.

Their thrust was outward; their focus was on patient care. Their strength came from the cooperation of the many individuals and institutions dedicated to improving the care of sick people.

* * *

Let me describe some of the ways in which the programs are working; and in so doing, also try to highlight for you the chief characteristics of Regional Medical Programs.

A network of coronary care units, consisting of 13 electronically monitored beds located in 8 hospitals, has been established in an isolated Appalachian area of Western North Carolina, known as the State of Franklin. It has received financial and technical assistance from the North Carolina RMP. These eight small hospitals, all with less than 50 beds, have been linked together and to the Bowman-Gray School of Medicine in Winston-Salem over 100 miles to the east by a telephone line for the transmission and analysis of EKGs. Many of the physicians practicing in this area, as well as the nurses manning these units, have received training in modern coronary care techniques. In addition, two mobile intensive coronary care ambulances with drivers trained in cardiac resuscitation, also funded by RMP, are being tested in this same area.

This activity is significant and important beyond its direct effect in improving the quality of coronary care and in making such care more readily available to those within the State of Franklin. This is an area in which all health care resources and services generally are inadequate; only one of the hospitals, for example, has a physical therapist.

The eight hospitals, having achieved the degree of cooperation required to establish the coronary care network, have begun to cooperate with respect to other resources and services, such as physical therapy and rehabilitation. This, in turn, has lead to the prospect of their achieving official hospital accreditation as a network of hospitals. Previously, each acting separately had been unable to secure accreditation.

In many of the regions the RMP is actively involved in attempts to assist representatives of the inner-city in planning for improved health services. Probably the finest example of RMP involvement in a slum area is found in the California region's project to establish the Drew Postgraduate Medical School in cooperation with the Martin Luther King, Jr. General Hospital, in the Watts-Willowbrook section of Los Angeles. This program is sponsored and financed by a number of interested health groups -- the County of Los Angeles, the Charles R. Drew Medical Society, the John and Mary Markle Foundation, UCLA and U.S.C. Medical Schools, Areas IV and V of the California RMP, and a community advisory body of health professionals and laymen.

In the Watts-Willowbrook district, RMP also has organized a community planning group, and through the organized efforts of this group the area is now identified as a separate subregion for RMP planning purposes in California. That program is gradually shifting its operating base from the two medical schools to the community, utilizing as many other health resources as possible, including voluntary agencies, consumer interests, and state and local government counterparts.

This project is a working demonstration of the concept that a medical care system can be developed which will assure that the hospital will be closely related to the ambulatory care system in the community. It is founded on the idea that the poor as well as the affluent should have ready access to high quality health care. Community service is the foremost objective,and efforts are being devoted to finding those methods and means which will best fulfill community needs. Efforts are being made to involve the public and the residents of the ghetto.

In Texas, an RMP supported rehabilitation program is responsible for bringing high quality stroke rehabilitation to a small, rural town in East Texas. The Southwestern Medical School in Dallas has developed a joint program with the East Texas Treatment Center in Kilgore, a geographically isolated community 125 miles from the Medical School. The East Texas Treatment Center is the sole rehabilitation facility within a fifty-mile radius. Prior to the implementation of this project, the East Texas Treatment Center, a modern rehabilitation facility, was under-utilized due to a lack of trained personnel and a lack of technical know-how required to provide a coordinated rehabilitation program for heart, cancer and stroke patients.

As a result of the continuing consultative relationship between the Kilgore Treatment Center and the Southwestern Medical School, permanent staff and consultative personnel have been added, the skills of existing personnel have been upgraded, techniques have been improved and a program organized whereby the local site can continue the treatment and rehabilitation process initiated in the sophisticated larger centers. An

anticipated long-range benefit of this project is the eventual self-sufficiency of the East Texas Treatment Center. In fact, it is hoped that the East Texas Treatment Center in Kilgore, and two others being similarly aided, will become links between the medical school and still other rehabilitation centers in even more remote areas.

A cardiopulmonary technician training program designed to meet the needs of local hospitals in the Spokane area for this type of personnel is underway with support from the Washington/Alaska RMP. It is cooperatively sponsored by the Spokane Community College, the county medical society, and the city's six hospitals. The community college is providing space and most of the faculty for the classroom phase; the physicians of the area, through their medical society, have helped in developing the curriculum and are assisting with the teaching; and the hospitals will, of course, eventually employ those individuals trained.

This program is exemplary of many others in which RMP is helping to meet specific local needs for certain kinds of allied health manpower; and in so doing, will be contributing to the productivity of physicians presently in a community by providing them with supporting technicians. This, in turn, also will give them more time for those critical higher level tasks and functions which require a physician.

The New Jersey RMP has assigned full-time urban health coordinators to the Newark, Trenton and Hoboken Model Cities offices to serve as health planners and identify appropriate activities for RMP coordinated support. Working with the Model Cities elected citizens panels, these RMP health planners have helped to identify priorities for health services and

developed operational plans for action which have now been submitted as integral parts of the total Model Cities operational plan, covering such areas as housing, education, social services, and law and public safety. One of the significant features of these RMP coordinators is the strong relationship they are establishing between the providers and consumers of health care. Through the Regional Medical Program, they bring the expertise of the medical schools, hospitals, and practicing profession to the consumer citizens panels which are dealing with community health problems.

In Maine, one of the major projects supported by operational funds to the Maine RMP is the development of the Upper Kennebec Valley Regional Health Agency. Located in Waterville, and originally organized as a voluntary service under a local board of trustees, this agency was activated by RMP funds and now coordinates a whole series of health-related planning and operational activities. On the planning side, it serves not only the Maine RMP activity in that area, but has also become the officially designated areawide comprehensive health planning agency serving exactly the same subregion.

On the operational side, with a combination of RMP and local funds, the agency operates a Home Health Care Service which is effectively supplementing physicians' services to chronically ill patients to give the limited number of physicians in that area more time for seeing an increased number of patients who are critically ill; operating a Regional Blood Bank which now serves 8 of the 10 hospitals in the Kennebec Valley;

with additional funds from the Department of Transportation operated a transportation and communications division to provide rapid transfer of both patients and services to raise the level of emergency care in the area; and under a young physician working half-time with that agency and half-time as the only hospital-based Director of Continuing Education in the entire Kennebec Valley, the agency is conducting a full-scale continuing education program for all health-related personnel in the area, including the nearly 125 practicing physicians. Almost ready for operational status within the agency, are additional health activities including a regionalized Medical Social Service similar to the Home Health Care Service.

It should be noted that all of these activities, and others still in the planning stage, are expected to be self-supporting within three years. This agency, one of the major efforts of Maine's Regional Medical Program, and its developing Comprehensive Health Planning program, reflects unique cooperative arrangements, not only among those who deliver health care within the Regional Medical Program, but those who also are responsible for long-range planning of health care within the Comprehensive Health Planning program.

In closing out this description of some of the ways in which Regional Medical Programs are succeeding, let me cite one illustration of how it is closing the gaps among health groups. One of the initial actions of the Georgia RMP was to promote the establishment of local advisory groups. Among the important functions to be served by these local counterparts

to the overall regional advisory group were to translate the program -- to help local hospitals and physicians understand it better; to act as a local liaison and link with the region's core staff and committees; and to identify local needs and problems -- to communicate its priorities.

There now are 129 such hospital-based local advisory groups functioning in that region, with 478 persons serving on them. This includes 127 practicing physicians, 128 hospital administrators, 114 nurses and allied health personnel, and 109 public members.

It is because of this kind of widespread, grassroots participation in, and commitment to, Regional Medical Programs by providers and the larger public which has enabled it to move ahead as quickly as it has with activities such as described; and which, moreover, point to it as a promising mechanism for helping to bring about change in our health care system in cooperation with private physicians, voluntary hospitals, and other health professions and institutions the great majority of which are within the private sector.

* * *

It is for this reason that I fully support the extension of Regional Medical Programs. Furthermore, Senator, I am in substantial agreement with the provisions of the pending bill S.___________, which you have introduced to extend and amend the authorizing legislation for Regional Medical Programs. I should, however, like to speak to those provisions on which the Administration's position is materially different.

Specifically:

(1) That this bill authorizes only the extension of Regional Medical Programs.

We have had ample evidence, especially in the past two years, that considerable confusion exists over the respective roles of Regional Medical Programs and of Comprehensive Health Planning Agencies. We have no formal plan for the resolution of the existing ambiguities, but we believe strongly that we can work more effectively toward such resolution through the mechanism of a single bill that would extend not only Regional Medical Programs but Comprehensive Health Planning and the National Center for Health Services Research and Development, the authority for which is also due to expire on June 30, 1970. The Administration has in preparation and will shortly introduce such legislation under the title, Health Services Improvement Act of 1970. It constitutes a clear expression of our intent to achieve unified policy direction and guidance of these three programs, all of which are essential to improving the organization and delivery of health services in this country. They are essential also for further increasing the capacity of the health care system. The Administration's bill does not specifically speak to the important relationship of the capacity side of the health care system to the financing side, but I can assure you that we are keenly aware of that relationship. We believe

it essential that we coordinate, to the maximum degree we can, the programs relating to the capacity of our country to deliver high quality health care in order that reimbursement policies can be modified to insure that our health care dollars will buy more care and better care.

(2) This brings me to the second point where there is some difference, though not necessarily disagreement. Your bill does take cognizance of the need for areawide health planning agencies (authorized under Section 314(b) of the present Partnership for Health legislation) to have an opportunity to consider RMP operational proposals. Our position is that this relationship should be broader and more specific. That is, proposed RMP activities, planning as well as operational, need to be taken into account by both the state and the areawide health planning agencies; and that is should specifically require "review and comment" on such proposed RMP activities. More significantly, however, is the fact that the single legislative authorization, such as we shall be presenting providers for specific experimentation as to how one might achieve better results more quickly through greater coordination and collaboration. Such experimentation may lead to consolidation of the RMP and CHP planning efforts in some areas.

(3) The final major difference relates to "new construction of facilities for demonstrations, research and training" in connection

with RMP. We are strongly opposed to the inclusion of such authority at this time. While the desirability of certain kinds of construction, particularly as it related to continuing education facilities within the community hospitals, was indeed pointed up in the Report on Regional Medical Programs to the President and the Congress submitted in November, 1967, the critical issue is one of funds and not authority. As President Nixon himself has made abundantly clear, the nation's first priority is to win the fight against inflation. Federal fundings of all construction programs have had to be cut back, in some cases drastically. That line will be held until the struggle to control and roll back the present inflationary pressures has been won.

For the present, the present limited construction authority of RMP, and other construction authorities, will certainly suffice. There is no indication that the progress of Regional Medical Programs to date, or within the 3-5 years, will suffer in any significant way as a result.

In conclusion, let me express my appreciation for having had this opportunity to lead off in the testimony on S.__________. It is my belief that the general purposes and direction of Regional Medical Programs will be well served by the provisions of that bill. The aims of this Administration with respect to ends to be achieved by Regional Medical Programs are not

significantly different from those of S.__________. We believe that RMP should be closely coordinated with the Partnership for Health and the National Center for Health Services Research and Development. We intend to accomplish that administratively but could do so more effectively under the legislative proposal we recently have made.