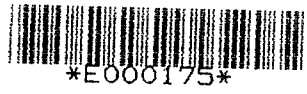
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EARMARKED AND OTHER COMMITTED FUNDS AND PROJECTS*

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In the first session of the 90th Congress, Regional Medical Programs received its first earmarked funds. Presumably this will not be the last. For both the Division and the Regions, special problems were created by these monies. I would like to take this opportunity to describe the genesis of those earmarks, and thereby the genesis of earmarks in general, the philosophy of the Division in managing these funds, and speculate about the future in relationship to designated funds. Earmarked monies offer a challenge as well as a hazard to our program.

As you may recall, there were earmarks for Coronary Care, Community Hypertension Detection and Treatment Program, Community Stroke Detection and Treatment Program, Chronic Pulmonary Disease in Pediatrics, and Emphysema. Each of these programs had their advocates. In the case of emphysema, Congress received testimony from the National Tuberculosis Association. That Association was concerned that insufficient emphasis was being placed on the training of manpower for the growing problems of chronic pulmonary disease. They requested congressional support for this activity. The National Cystic Fibrosis Foundation, facing increasing expenditures of their limited research funds for service programs in chronic pediatric pulmonary disease, urged that Congress develop support for centers for these patients. The American College of Cardiology was responsible for testimony in support of programs for

In each case the proponents pointedly stated that here were methods largely proven for improved care.

The Congressional Record of the Senate on June 23, 1967, will give you insight into the genesis. Dr. Likoff, then President of the American College of Cardiology, stated to Senator Hill: "The matter which moves this testimony is the extent to which talent and competence in the contest against heart disease will be adversely influenced if certain structured allocations are not altered. This Committee is acutely aware, I know, that heart disease is the primary health problem of our time with morbidity and mortality rates far exceeding any other disease. You, Mr. Chairman, have been the author and architect of health programs which have strongly supported research and education in an effort to modify that fact. Over the years, specific Federal resources have created and maintained health agencies such as the National Heart Institute and the National Center for Chronic Disease Control which have stimulated and enlarged the efforts of all of the life sciences involved in diseases of heart and circulatory system." Dr. Likoff continued his testimony and described the present inadequate appropriations for the National Heart Institute and the National Center for Chronic Disease Control. Further in his testimony, he stated: "The American College of Cardiology regrets the failure to provide the Heart Disease Control Program of the National Center for Chronic Disease Control sufficient funds to carry out its full purposes and dedication." Throughout the testimony the discussion related to the benefits to be accrued from the expenditure of the Federal dollar for programs in coronary care. Throughout the testimony, no reference to Regional Medical Programs was made. Testimony for the other categoric programs only related to the National Center for Chronic Disease Control or the

categoric NIH Institutes. Regional Medical Programs was not considered until early in October by Congress.

Included in the Senate action was the allowance of a million dollars for arthritis to initiate a program of pilot arthritis centers and satellite facilities.

Because of the differences between the House of Representatives and the Senate, a joint conference committee was convened in early October 1967. The committee reported as follows: "In general, the conferees are agreed on the desirability of the purposes of the Senate increase, and are also agreed that a large part of the activities for which the increase of over five million dollars was earmarked is so closely related to activities financed under 'Regional Medical Programs' that they would more properly be administered by the National Institutes of Health under that appropriation." With this in mind, the managers on the part of the House agreed to a four and a half million dollar increase for Regional Medical Programs to cover the Senate's categoric directives which incidently exceeded 5.5 million dollars. Thus, the earmarks for the National Center for Chronic Disease Control were shifted to the maximum extent determined to be feasible by the National Institutes of Health."

Dr. Shannon recognized most of these programs could be undertaken by Regional Medical Programs but in a letter to Senator Hill noted: "The scope of the Regional Medical Programs legislation would not allow us to directly support programs designed to increase the availability of techniques for delaying the crippling effects of rheumatoid arthritis."

Regional Medical Programs thus was given the responsibility under appropriation for activities in coronary care, community hypertension,

community stroke, projects in chronic pediatric pulmonary diseases, and emphysema. These programs were laid on, if you will, Regional Medical Programs. To be sure some of the activities were easily identified in planning and operational stages. Others, such as chronic pulmonary diseases in pediatrics, were essentially new activities.

In considering the methods by which these congressional mandates might be observed, two choices seemed reasonable. Either the Division could fund these under granting authority or seek to expend the funds by contract. The policy decision was made to pursue the grant route. First, had the contract route been taken, Regional Medical Programs would not have appeared different in mechanism from other governmental agencies. The opportunity to demonstrate the effectiveness of Regional Medical Programs to Congressional directives was therefore uniquely offered by pursuing the granting route. In pursuit of the grant route, however, special problems presented themselves, problems with which some of you are acquainted.

Advocates of various of the activities had long been in the habit of a direct contractural relationship with governmental agencies. For several, therefore, the problems of involvement and regionalization as represented by Regional Medical Programs seemed a cumbersome delay and a source of frustration. Secondly, the Division was faced with the problem of responding to a congressional mandate and at the same time protecting the "grassroots" nature of Regional Medical Programs. This we strove to do with fair success, although not complete.

The earmarked monies then represented basically a challenge by which the program could prove itself before Congressional and other critics. In the first go around of the earmarks, the program was able to point to activities consistent with regional planning. In the future, we may not be so fortunate. Nevertheless, earmarks are a reality and have been a method by which specific areas are identified for development. These are usually identified through the activities of special interest groups testifying before Congress. That such special interest groups will not take a continuing and increasing interest in Regional Medical Programs is highly unlikely. The reality is that we will continue to have earmarks, that the Division will pursue this to the extent possible through a granting mechanism rather than contracting; but in those instances where contractural relationships might better protect the integrity of local decision making, this route will be pursued. Further, in considering contractural relationships, the Division would expect that the contractee would be through the regional mechanism and not directly with institutions or individuals.

[Remarks on Atromid S]