
E000225

PART ONE: OVERVIEW

A. EXECUTIVE SUMMARY

OF THE FORWARD PLAN FOR HEALTH

FOR FY 1976-1980

In much abbreviated form the Forward Plan for Health, FY 1976-1980, is highlighted in the next 26 pages. The first section indicates the major dimensions of the national condition of and trends in the health industry over this time period. It also reiterates the several roles for the Federal Government operating in that health context.

The second and major section of the summary describes the five themes which have guided the development of the forward plan:

I. Prevention

II. Preparing for National Health Insurance

A. Planning and Regulation (including cost containment)

B. Primary Care

X 1. Structural Reform (modifying Training and Service Delivery Institutions)

X 2. Scarcity Area Focus

III. Quality Assurance

IV. Tracking Health Status and the Health Industry

V. Knowledge Development

The discussions of the five themes will highlight the major initiatives being proposed in the Forward Plan. Since the pursuit of many of these major initiatives requires the commitment and participation of all the agencies and regional health offices, the Assistant Secretary for Health is also focusing on the development of the necessary innovative inter-agency management techniques. An overview of this effort is also presented in this summary.

Thirdly, the summary will display all the DHEW health programs by "areas of Federal responsibility." These areas are grouped under the three major headings of (1) protection/prevention, (2) improving health care, and (3) knowledge development. This section presents at the rather macroscopic level the Department's health program, highlighting the proposed changes in those programs for FY 1976.

Finally, there is described the PHS planning process which led to the plan and, in the form of a summary financial table, the budgetary implications of the proposed program changes.

SECTION ONE: THE HEALTH INDUSTRY AND THE FEDERAL GOVERNMENT

The major dimensions of the health industry can be suggested by a few sets of statistics on: health status, health resources, health service utilization, and costs-expenditures-financing.

Health Status: Descriptions of the extent of illness (morbidity), disability, and death (mortality) due to "disease" provide a quantitative basis for assessing health status. It should be remembered, however, that these data, while instructive, are both non-qualitative and static. Currently, valid measures of qualitative status are not available, and reliable trend data, using even these quantitative indicators, are also in very short supply.

With all these caveats, we can note that in 1972 there were about 450 million episodes of illness or injury. Over half of these episodes were a consequence of respiratory conditions, one-third of which were influenza or pneumonia; about 47 million episodes were caused by infective or parasitic diseases, of which 2.5 million were venereal in origin. About 68 million episodes were injuries, of which 5 million were caused by motor vehicle accidents. As a consequence of chronic conditions during 1972, 13 percent of the population experienced limitation of activity, while 3 percent suffered some limitation of mobility.

Illness and injury now led to an annual total of over 4 billion disability days, of which 3 billion are spent in non-institutional settings. Almost one-fifth of the population suffers one or more disability days annually, although less than 3 percent of the population (those with long-term disabilities) account for 43 percent of the total days of disability.

Over the last several decades the total death rate has remained fairly constant at about 1,000 per 100,000 population. However, differences have existed among various segments of the population. In 1971 the death rates, adjusted by the age differences for sex and race, were 703 per 100,000 total, 917 for male versus 526 for females, and 669 for whites versus 1,003 for nonwhites. Furthermore, while the infant mortality rate continued to decline, reaching 19.1 per 100,000 live births, it was 17.1 for whites versus 28.5 for nonwhites and was about 50 percent higher for those with incomes less than $5,000 than those with greater than $5,000.

Health Care Resources: Some data on both facilities and manpower will outline the gross dimensions of the current scene. For example, the total number of inpatient health facilities now number over 35,000, containing over 3 million beds and employing almost 4 million persons. There are about 7,000 hospitals and 2.7 million hospital personnel, and over 22,000 nursing care homes employing 600,000 personnel. Over the

last decade the number of acute beds increased by about 210,000 to a current total of about 850,000, while the number of unoccupied beds has risen from 178,000 to 228,000 (a rise of 28%). The distribution of beds for hospitals and nursing care homes varies significantly by region of the country.

As of 1971, the total health manpower pool was almost 4 1/2 million. Physicians numbered 345,000, representing an increase of about 26 percent during the last decade, and projected to increase by another one-third by 1980. Of the 287,000 physicians involved with direct care of patients, about one-third were involved with primary care. The geographical distribution of physicians varied greatly, with the population to physician ratio decreasing as the area-wide population increased (from 2,497:1 to 521:1). The patient contact of physicians also varied geographically, with the number of patient visits per physician per week decreasing as the area-wide population increased (from 233 to 124). The number of allied health practitioners involved with patient care numbered almost 3 million in 1971, while the number of other health personnel not involved in patient care numbered about 1 million.

Utilization of Services: During 1970, nine percent of the population accounted for all 30 million inpatient hospital admissions (resulting in 235 million hospital days). The nine percent were not spread evenly over the entire population. Although the percent of persons admitted to hospitals was the same for both sexes, as a function of "person years" of life, females were admitted about 50 percent more frequently (16 per hundred person years versus 11). A traditional pattern of utilization by age was demonstrated during 1970: that is, relatively low rates for children, relatively high rates in the 18-34 year range (including pregnancy admissions), a drop-off in utilization in the middle years of life, and the highest rates among the older age groups. On the other hand, the traditionally flat distribution of use by different income groups has changed significantly over the last decade; by 1970, the lower income groups had admission rates significantly higher than the higher income groups. A consistent relationship between admissions and place of residence was also demonstrated--the highest rates for the rural non-farm population and the lowest rates for the large, urban-area population. It is significant to note that while the admission rates for nonwhites and inner-city residents were lower, the length of stay for such patients was greater. The trend since 1950 has been a steady increase in hospital admissions (from 110 per 1,000 persons to 149 in 1972). In the same period, an increase in hospital days has occurred from 900 days per 1,000 population in 1950, to almost 1,200 per 1,000 in 1970-72; a decreasing average length of stay accounts for the recent levelling-off of hospital days at the 1200 level. During 1971, the number of admissions to nursing care homes exceeded one million, representing a sizable rate of increase over the last decade.

During 1970 over 14 million surgical procedures were performed, representing an aggregate average of six procedures per 100 person years. This represents a slight increase over the last decade (from five per 100 person years). During the 1960's there was a shift in the number of surgical procedures by income, from a direct to an inverse relationship to income (parallelling the trend in hospital admissions). The number of surgical procedures for females was slightly higher, and the number for the elderly slightly higher. There were, however, no urban/rural differences documented.

Outpatient hospital visits in 1972 totalled about 200 million, representing an increase of over 40 percent from 1970 and accelerating the trend evident over the last two decades. The 1955 figure was 329 visits per 1,000 population; the 1972 figure was 809 visits per 1,000 population.

During 1970 there were over 800 million physician encounters. Major differences in utilization were documented by race, with 70 percent of the white population seeing a physician, with an average of 4.1 visits, while only 58 percent of the nonwhite population saw a physician, with an average of 3.6 visits. Although the gap between low and high income persons seeing physicians narrowed over the decade (65 percent for low income versus 71 percent for high income), once seeing a doctor the number of visits was higher for low income persons (4.9 visits versus 3.6 visits). On the other hand, traditional patterns of utilization by age and sex were maintained, with the percentage of persons seeing a physician being about equal for all ages, except for the elderly; use by females was both more common and more frequent (71 percent versus 65 percent for males and 4.5 visits versus 3.6 visits). The percentage of persons seeing a physician was highest among those in urban areas other than the central city, and lowest among those from rural farm areas. Significantly, however, over the decade there was a decrease in the average number of visits per person by all measures, except for an increase for children and those aged 55 to 64.

About 70 percent of physician encounters were in physician offices, although this rate was about 10 percent less for nonwhite persons; about 10 percent of encounters were at hospital clinics or emergency rooms, although the rate was twice as high among nonwhites and 50 percent higher for those with incomes below $3,000; about 12 percent of encounters were over the telephone, although the rate was half for nonwhites and those with incomes below $3,000. About 60 percent of all visits were handled by general practitioners, 12 percent by internists, 10 percent by pediatricians, 6 percent by obstetricians/gynecologists, and 3 percent by surgeons. About 75 percent of the encounters were for diagnosis and treatment, 10 percent for general checkups, 4 percent for prenatal care, and 4 percent for immunizations.

Costs, Expenditures, Financing: Total expenditures resulting from illness and injury in 1973 amounted to over $200 billion; $80 billion represents the direct costs for personal health care services (of the $94 billion the total health expenditures); the balance stems from the indirect costs of work loss, etc. It has been estimated that the direct costs figure for FY 1976 will be $125 billion.

The rise in personal care expenditures has been dramatic over the last two decades, from $10.4 billion in 1950 to $22.7 billion in 1960 to $59.1 billion in 1970. Average per capita expenditures increased from $172 in 1966 to $285 in 1970 to $375 in 1973.

Hospital expenditures in 1973 accounted for $36.2 billion of the total, and physician expenditures $18.0 billion. These expenditures also represented significant increases over the last two decades; hospital expenditures increased from $3.9 billion in 1950 to $9.1 billion in 1960 to $27.5 billion in 1970, while physician expenditures increased from $2.7 billion to $5.7 billion to $14.6 billion, respectively.

The estimated average family expenditure in 1970 was $750, although almost half the families spent $300 or less. These averages varied depending on income, with families of less than $5,000 spending an average of $550 and families with greater than $10,000 spending an average of $850. Significant variations were also documented for out-of-pocket costs; for example, 27.7 percent of families with incomes less than $3,000 and 3.3 percent of families with incomes greater than $15,000 had no out-of-pocket costs, although those with incomes less than $5,000 spent an average of $209 out-of-pocket versus $478 for those with greater than $10,000.

Coincident to the rise in expenditures since 1950 has been increasing costs and charges. For example, hospital costs per admission have risen from $127 in 1950 to $245 in 1960 to $669 in 1970 and to $830 in 1972; similarly, semi-private room charges have risen from $30 in 1950 to $57 in 1960 to $145 in 1970 and $174 in 1972.

Analysis of these increases reveal that increases in prices accounted for almost one-half of the overall increases and that population increases accounted for another one-fifth, leaving only about one-third of the increases as a consequence of increased utilization, either of existing services or the addition of new services. Significantly, this rise in prices was greater than the CPI in general. Similar ratios accounting for expenditure increases have been demonstrated for physician services. The highest rate of increases in prices was demonstrated for the years 1967-71 (during the period following the introduction of Medicare and Medicaid, and prior to the implementation of the economic stabilization program). There is a problem, however, in analyzing these data, since "medical care" remains the only item in the Consumer Price Index where a dollar's increase in price shows as a dollar's increase in cost, as a result of the great difficulty of accounting for "product improvements" in medical care.

Also coincident to the rise in expenditures has been a redistribution of the sources of financing. While the percentage of government funds for personal care services remained fairly constant at about 20 percent until the implementation of Medicare and Medicaid it has increased since then to 38 percent (1973). The percentage of financing by private insurance grew steadily from 9 percent in 1950 to 25 percent by the time of Medicare/Medicaid, but has since remained fairly constant. Out-of-pocket health expenditures represented 68 percent of the total in 1950 and about 50 percent of the total just prior to Medicare/Medicaid; only about one-third of health expenditures are currently paid "out of pocket." The most dramatic change has been for hospitalization, with third parties now covering over 90 percent of total expenditures for hospitalization. Public sources now pay about one-third of total expenditures for persons under age 65, and two-thirds for persons over 65.

There remain two major areas of inadequacies with third-party (government and private insurance) financing. The first is incomplete and non-uniform coverage: one out of ten persons has no coverage and most others have inadequate coverage, while significant variations in coverage exist for persons of different income levels. The second area is the coverage itself, especially the bias towards hospitalization and high cost care and the lack of incentives to contain costs.

In sum, we have serious problems in health status, especially for some population groups, problems at least in the distribution and productivity of many of our health care resources, extensive, but widely varying utilization of health services--all tied to an enormous and rapidly escalating national investment in the health industry.

The Roles of the Federal Government

The Federal Government's involvement with the health industry has several traditions. The longest are the traditions of providing direct care to Federal beneficiaries and providing some major public health functions, primarily, but not exclusively, disease control and, subsequently, protection from hazardous products. Next in longevity are the roles of conducting and supporting (through grants) research on biomedical and behavioral problems. These traditions are now so well established, and the need for their continuation so clear, that, as national public policy, they are not questioned.

There is nearly a 30-year history of Federal financing of the costs of constructing health care facilities, primarily hospitals. Much more recently the Federal Government has become heavily involved in the partial financing of health care for major segments of the population, in the partial financing of health manpower development, and in the partial, sometimes total, financing of innovative health planning and service delivery agencies, such as community mental health centers, neighborhood health centers, comprehensive health planning agencies, etc. The

experience of the last decade has been enormously varied, challenging, and often disappointing. The Federal resources have been marshalled in response to widely acknowledged health care problems which did not seem to yield to the normal forces of the marketplace. Federal intervention in those instances has mostly responded well enough to the immediate problem, but often at high cost--such as exacerbating a condition of rapidly rising prices for health care, or raising the expectations of various groups of disadvantaged people beyond a level that could be realized within available resources. If nothing else, these experiences have significantly heightened national consciousness of the nature of the health industry, with all its strengths and weaknesses.

Emerging from that decade of experience is a growing consensus, at least at the Federal level, that the major health industry problems--assuring financial access to high quality care, and better rationalizing the deployment of resources while containing their costs--will not yield to less than a well-planned, concerted set of interventions by the Federal Government--working in full cooperation with the major components of the total industry--the providers, product manufacturers, consumers, third party payors, training institutions, and State and local governments. It is that growing consensus which sets the context for planning the DHEW health programs through the remainder of the 1970s. That growing consensus on the need for concerted Federal health efforts also highlights the importance of inter-relating the planning process for health with the forward planning processes of the two HEW agencies which finance most Federally-supported health services, SSA and SRS.

SECTION TWO: HEALTH PLANNING THEMES, FY 1976-1980

This segment of the Forward Plan is developed with each theme first defined and described in terms of the broad goals and objectives which the Assistant Secretary for Health wants to emphasize over this planning period. Second, the difficulties of achieving those goals are discussed--out of which flows a strategic approach to overcoming them. Finally, each theme discussion includes the highlights of the major initiatives which we are proposing to undertake, emphasizing those initiatives which call for resources in fiscal year 1976. In the following summary of the five major themes, only the objectives and the major initiatives will be discussed in any length.

I. PREVENTION

Preventing illness, injury, and premature death must be a major component of this Nation's health strategy. Prevention not only alleviates human suffering, it also holds the key to the lock on our present and foreseeable health care problems, including their costs. The importance of preventive activities is nearly equaled, however, by our ignorance of effective ways to accomplish prevention. Therefore, a fundamental component of our emphasis on prevention is a full commitment to research, evaluation, and the generation of new knowledge.

Perhaps because of our ignorance, tempered by knowledge in a few areas, it is very difficult to define the boundaries of the prevention theme. It has often been asserted, for example, that changes in the socio-economic and cultural environment, affecting everything from diet and housing to life style, have a far greater impact on health status than all the preventive and acute health care services combined. Certainly one facet of our emphasis on prevention will include growing attention by the Assistant Secretary for Health to those "controllable" environmental factors which appear to have such properties. For purposes of this document, however, we will be concentrating on those research and service activities within the health sphere which relate to the prevention of illness, injury, and premature death.

The problems in the health care industry, in addition to inadequate knowledge, which tend to retard the progress of prevention include a set of attitudes which are primarily oriented toward the treatment of acute and chronic illness, the directing of the vast majority of the industry's resources toward acute and chronic care, and the consequent difficulty of effecting change. Both within the industry and within the consumer, there is need for change of attitude and change of behavior to heighten an awareness of and response to health needs rather than simply the control of illness. Such attitudinal and behavioral changes present an enormous challenge.

The major elements of our preventive strategy are to assure the concentration of all federally supported health programs on preventive health services, health maintenance, and health education. Prominent among these efforts are the CHIP proposal, CHC's, HMO's, and all the programs of ADAMHA. The community mental health centers, for example, require a set of services ("consultation and education services") which reach out into the surrounding community to strengthen the abilities of many institutional agents, e.g., school teachers, policemen, lawyers, physicians, etc., to deal with early-stage emotional problems and thus head off acute illness.

The second segment of the strategy is to focus on developing better research and evaluation methodologies needed to determine the effectiveness of our various preventive activities. Particularly necessary are some improved methods of evaluating health education activities, e.g., the anti-smoking campaign, the responsible drinking campaign, etc. One crucial component to this research approach will be the support of the behavioral sciences as they focus on understanding motivation and attitudinal and behavioral change.

The particular initiatives proposed in the body of the Plan include:

(a) Strengthening States' capacities in laboratory diagnostic technology, including technology necessary to detect periconceptive

diseases and disorders which lead to morbidity and mortality in the newborn. The total number of live-born infants affected by such problems each year is approximately one-quarter million. From that number, over 100,000 children each year are added to the six million mentally retarded persons in this country. The benefits of early detection and prevention of such problems are enormous. At the present time, most States do not have the laboratory capacities for supporting, for example, amniocentesis and other complex technologies which offer great hope for the prevention of disease and lifelong disability.

(b) Initiating a national program of supporting the fluoridation of all community sources of drinking water. For a relatively modest investment, a fluoridation program could have enormous benefits both in health and in the cost of care. Most of the NHI proposals now before the Congress would include dental care through childhood. It has been estimated that at least $2.6 billion would be saved over the first 15 years of an NHI program, provided universal fluoridation were in effect at the start of that program.

(c) Initiating special programs concentrating on occupational carcinogenesis. Research targeted on the possible carcinogenic agents found in the occupational environment is of particularly high importance in a long-term prevention strategy.

(d) Strengthening local community capacities to deal with environmental health problems beyond rodent control and lead-based paint poisoning. This initiative would consolidate and add to some existing legislative authorities to enable communities to deal with those mundane health problems which represent a gap not covered by EPA in its concentration on air and water pollution.

(e) Fully developing Phase I of the new National Center for Toxicological Research and its capacities for investigating the consequences of long-term, low-level exposure to toxic substances.

(f) Consolidating current legislative authorities for comprehensive immunization programs and venereal disease control and to allow short-term developmental assistance grants to States, enhancing their capacities to respond to needed new immunization initiatives, for example, the immunization of high risk populations against influenza.

(g) Developing a coherent set of health education initiatives coordinated by the new Bureau of Health Education, CDC. Over FY 1975, the Bureau will be doing a survey and analysis of all current health education programs supported by many agencies across the Department. An intensive research and evaluation effort will also be undertaken of selected health education activities.

II. PREPARING FOR NATIONAL HEALTH INSURANCE

A major assumption underlying this Forward Plan for Health is that by 1980 there will be some form of National Health Insurance in full operation. Furthermore, the plan is based on the conviction, bolstered by substantial evidence, that our current health care system is not well prepared for the advent of a comprehensive health care financing program. As suggested earlier, in absolute numbers, it appears that we will have sufficient manpower and facility resources to cope with the NHI demands. The major problems with our resources are threefold: (1) they are not well integrated into a coherent health care system (which calls for greatly strengthened health care planning at local, State, and regional levels); (2) we are lacking in the ability to contain the costs of health care (which calls for strengthened regulatory capacities, particularly at the level of State government); and (3) we have an acute shortage, both in absolute terms and particularly in distribution terms, of personnel and facilities geared to delivering primary care. An additional problem--assuring the quality of care--is also very pertinent here, but is dealt with as the next, separate theme. These problems would have to be addressed in any event--but the prospect of NHI heightens our sense of urgency. The infusion of significantly more purchasing power, without preparatory changes in the system, would exacerbate rather than alleviate these problems

For these reasons, the "preparing for NHI" theme emphasizes, first, the development of a planning and regulatory capacity, and, second, the strengthening of our primary care services. The primary care component has been further subdivided into two major parts: (1) structural reform of our health manpower training institutions and our health service delivery systems, and (2) a focus on geographical scarcity areas.

Planning and Regulation

The essence of this aspect of the overall strategy is embodied in the health planning legislative proposal now pending before the Congress. This proposal would support the creation of a nationwide system of locally-based planning agencies ("health system agencies"), each of which would be responsible for health planning in its clearly defined geographic area. These agencies would be private, nonprofit organizations representing every significant sector of the health industry--consumers, providers, government, financing agents, and training institutions. In addition to developing annual plans for their respective areas, the health system agencies would play a critical role in reviewing all proposed capital expenditures and all applications for Federal grant assistance for health services, health facilities, and health training programs. Additionally, there will be established State-level coordinating councils to handle those planning issues which cut across local areas, the prime example being health manpower training and deployment. With these tools, the Nation should be able to develop a much better-rationalized health care delivery system with the full participation of all concerned parties.

At the same time, as a necessary corollary to planning, and as the critical handle on the costs of health care, the proposal would encourage the development of State capacities for regulating both the development of new facilities and the rates of reimbursement for health services. A number of States are already gathering experience in these two domains, and the Department is monitoring that experience carefully.

Primary Care

The foundation for this theme is the development of appropriate training facilities and educational experiences and the attendant structural reform of the health care system necessary to increase the production of both physician and allied health workers in primary care. The first priority of our health manpower initiatives concentrates entirely on this area.

The other approach to primary care problems is to develop a concerted effort to channel primary care resources into those geographical areas which do not now have them, the so-called health scarcity areas. Our "health scarcity" strategy includes:

1. Developing a coherent Departmental policy based on compatible definitions of "scarcity areas" (to be applied across the 17 relevant health legislation authorities), compatible data systems and indicators for identifying areas, and one consistent policy development process for allocating Federal resources to health scarcity areas--an effort which will require the full participation of HRA, HSA, ADAMHA, and the Regional Offices;

2. Working on the distribution of health manpower through both the primary care initiative referred to above, and the National Health Service Corps;

3. Targeting health services and health facilities grants--particularly community health centers, migrant health projects, CMHC's, HMO's--on scarcity areas;

4. Working with the Veterans Administration and the Department of Defense to gain their cooperation in opening their health care facilities, where appropriate, in the health scarcity areas in which they are located;

5. Establishing in scarcity areas, total health care systems which utilize the team approach to health care, with greatly increased use of non-physicians, and which link scarcity area facilities and manpower with major training and service institutions for backup care and continuing education;

The major quality initiatives in the Plan flow from that strategy. For example, we will promptly initiate:

1. A very large "health care quality assurance program study." The dimensions of this study are still being developed.

2. A special grant program designed to increase our knowledge base and our methodologies for quality assessment and to enhance interest in quality assurance research.

3. Intensified evaluation of various present and proposed quality assurance mechanisms, including the effectiveness of present criteria-development and standard-setting programs.

4. Inventory of ongoing clinical trials and an international conference on the science of clinical trials, including the statistical reliability of data from clinical trials, the role of randomized, double-blind studies in the definitive resolution of issues of controversy in health, and the ethics of undertaking various kinds of clinical trials where levels of "state-of-the-art" or utilization in medical practice may vary widely.

5. The establishment within ADAMHA of a quality assurance review unit, the success of which is likely to be very central to determining the eventual insurance coverage of mental health, alcohol, and drug abuse services, all of which are so difficult to assess qualitatively.

6. The full implementation, through the States and Regions, of the recently published regulations to cover the approximately 7,000 skilled nursing facilities and the 8,500 intermediate care facilities.

7. The initial implementation of recently developed standards for ambulatory care centers in selected Community Health Centers, as preparation for efforts to certify ambulatory health centers under Medicare and Medicaid.

8. The evaluation and improvement of clinical laboratory regulation, including State, as well as intra-State laboratories, and laboratories in physicians' offices.

9. Expansion of the implementation of the PSRO program from the 150 programs planned for FY 1975 to 203 programs in FY 1976, including expansion of the PSRO mechanism into HMO's and ambulatory and long-term care.

10. Implementation of the end-stage renal disease (ESRD) program for which the final policies were recently issued, particularly the implementation of the local Medical Review Boards system which includes standard-setting, criteria development, and patient screening and selection mechanisms.

11. Improvements in assuring the quality of drugs, biologicals, and radiological and other medical devices; increased emphasis on improving information for health workers through drug labeling and warnings about adverse effects, all of which can serve as one basis for standard-setting in PSRO's and other quality assurance programs.

As the OASH continues to develop its strategy in the quality assurance area, we expect to be proposing additional initiatives. With this nation spending well over $100 billion in health care, with more than a quarter of it in tax funds, the demand to know the quality of what we're buying is certain to grow more intense. This cross-cutting health theme cannot be neglected.

IV. TRACKING HEALTH STATUS AND THE HEALTH INDUSTRY

In many ways, achieving the goals of this theme is necessary to the pursuit of most of the other themes. The goals are to provide reliable national statistics on (a) problems and trends in health status, (b) utilization of health services and facilities, (c) production and deployment of health manpower, (d) expenditures on and costs of all services and resources, (e) national investments in research activities, (f) problems and trends in the production of health care and health-affecting products, drugs, devices, foods, etc. Such data are necessary nationally to continue modifying the kinds of policy decisions which this document proposes. They are necessary locally and regionally to guide health care planning and regulatory decisions. Furthermore, it is important that such data be collected in a coherent fashion which avoids duplication of effort and excessive demand on the sources of data, and which also adequately protects the confidentiality of health care information on individuals.

At the present time, there are major data gathering and analyzing activities in nearly every segment of the DHEW health programs, from the Office of Research and Statistics in SSA, to the National Center for Health Statistics in HRA, to the Epidemic Intelligence Service in the CDC. Most of the mental health services provided across the nation, from State mental hospitals to psychiatric units in local, general hospitals, are tracked by the biometric programs of ADAMHA. The challenge is to develop methods of targeting such data-gathering activities, and of analyzing their results, so that the nation's health policy development and planning efforts are grounded in the available knowledge of "what's going on."

The major initiatives to be advanced over the next few years in pursuit of this theme are:

1. A full utilization of the recently formed Health Data Policy Committee, co-chaired by the Director, National Center for Health Statistics, and the Director, Office of Policy Development and Planning, OASH. This committee, representing all relevant parts of the Department

Who are they?

of Health, Education, and Welfare, with the additional participation of the Director of the Division of Statistical Policy, OMB, is charged with advising the Assistant Secretary for Health on specific statistical data needed for current and long-term planning and management, on policies for coordination of health statistics activities, on proposals for major health statistics systems, and on uniform data sets. This Committee will play a key role in developing the data components of, for example, the PSRO, ESRD, and health scarcity area programs.

2. The major expenditure will be on the further development and implementation of the cooperative health statistics system by the National Center for Health Statistics. The number of participating States will be increased; all will accelerate their efforts to develop State and local capability to produce vital statistics, and statistics on manpower, health facilities, hospital ambulatory care, and long-term care to comprise a national health data system.

3. We are proposing redesigning and quadrupling the household health interview survey to provide smaller area estimates, greater in-depth descriptive data, and coverage of more topics to meet the growing demands for information on health status and health care behavior.

4. There will be a significant extension of our current capacity to collect data on costs, expenditures and financing of health care and health resource utilization. At a minimum this effort will involve the Social Security Administration, the National Center for Health Statistics, and the Biometric programs of ADAMHA.

5. For purposes of planning and evaluation, the Office of Research and Statistics, SSA, has begun work on a periodic updating of the 1966 figures in the pioneering PHS report, "Estimating the Cost of Illness."

6. A Long-term Care Management Information System is under development, linking data-gathering at headquarters, regional, and State levels, capable of providing current data on nursing home safety, certification, and deficiencies in compliance. A cost-of-care index will be maintained to serve for long-term care reimbursement as the Labor Department's cost-of-living index serves national economic and policy analysis.

V. KNOWLEDGE DEVELOPMENT

As noted above, particularly in connection with the themes on prevention and quality assurance, significant new progress in advancing the health status of the American people is dependent upon the development of new knowledge, knowledge of everything from basic physiological processes to the consequences of changing a formula for reimbursing health care providers. For convenience, that wide range of research topics is divided into two basic sub-categories: health services research and biomedical and behavioral research. Fully defined, this theme encompasses at least some of the responsibilities of every PHS agency--and the SSA and SRS as well.

Health Services Research

The focal point for this kind of research is the Bureau of Health Services Research, HRA, which, under new leadership, is undertaking the development of a long-needed coherent strategy for health services research, cutting across HRA, HSA, and ADAMHA, and closely coordinated with similar research being conducted by SSA and SRS. As a consequence of that development, we are anticipating that in addition to the initiatives already mentioned--such as increased research on issues of quality assessment and more attention to the behavioral consequences of health education--there will be at least the following ingredients to a revitalized health services research effort:

1. Assessing the range of impacts on health service delivery which the various financing schemes entail; including the impact of the advent of a comprehensive national health insurance program, various prospective reimbursement programs, etc.

2. Developing better health planning and evaluation technologies to support the State and local health planning and regulatory initiatives described earlier;

3. Developing a "price deflator" for medical care (which is important because medical care remains the only item on the consumer price index where a dollar's increase in price equals a dollar's increase in costs, resulting from the immense difficulty of deflating price increases for "product improvements");

4. Investigating the impacts on health care costs and productivity of wage and hour negotiation processes involving, in particular, the allied health and other supportive personnel.

Biomedical and Behavioral Research

While there is no serious challenge to the assertion that a major Federal role in the health industry is the support of basic biomedical and behavioral research, there are growing concerns as to the size and direction of that investment. For example, there are current questions about how priorities are set for biomedical research programs, why the cost of doing research is climbing so rapidly, what the appropriate relation should be between research and health service needs, what the effect of increasing pressure for targeted programs is, and whether there is sufficient "balance" between and around the various investment targets in the research portfolio. Depending on the answers to those kinds of questions, there are also important issues regarding the future supply of research manpower and the role of research in the education of the health professions generally. For all those reasons and more, the Secretary of HEW has announced that the President will appoint a National Commission on Biomedical Research which would consider the following:

1. National needs of biomedical research in the context of national health policy;

2. Reexamination and definition of appropriate Federal and non-Federal roles in biomedical research;

3. Analysis of the organizational, management, and financing needs of biomedical research.

Support of this National Commission on Biomedical Research initiative is a major component of our Forward Plan for FY 1976. It should be noted that the research plans for ADAMHA are growing out of a similar albeit smaller scale effort initiated two years ago by the NIMH. Although limited to "mental health research," the ten task forces which NIMH established to examine the total past and present Federal investments in such research, spanned every category of research from basic biological processes to psychological and sociological phenomena. This NIMH effort required the work of several hundred professionals over an 18-month period, the results of which are still being analyzed. Thus we do not put forward this initiative with an unreal assumption that the challenge is a simple one.

Pending progress on that first initiative, the NIH will concentrate during this planning period on areas of widely acknowledged need. The first priority is for a greater support of basic research. Progress in many of our national health objectives in disease control and prevention efforts is hampered by gaps in our understanding of the fundamental normal and pathological processes at work. Important among these cross-cutting areas of research are immunology, cell membrane research, and the cellular and molecular basis of growth, aging, and disease.

Other priority areas for the NIH are to devote sufficient resources to the new legislative mandates, such as the new Institute on Aging and the Diabetes Commission, and also to the Presidential commitments of recent years to strengthen our investments in research on cancer, and on heart, lung, and blood diseases.

Another initiative, quite akin to the first, is to undertake analysis of the three major research planning efforts which have recently been devoted to the mental health (referred to above), cancer, and the heart, blood vessel, lung, and blood disease programs. We propose to undertake a review of these efforts in order to determine their value for planning, priority-setting, and policy-making at all levels.

Another initiative will be to examine those health research efforts which cut across the health agencies. For example, this planning exercise has highlighted the fact that six components of the Public Health Service have identified "long-term, low-dose exposure to potential environmental carcinogens" as important to accomplishing their missions. We will examine these several approaches to the same area to assure that there is no unnecessary duplication of effort, and also to determine the appropriate relation of this important area of carcinogenesis research to the overall National Cancer Program.

Another important research effort which bears highlighting in this summary is that of the National Center for Toxicological Research, recently established by the Food and Drug Administration. The funds requested in FY 1976 will provide the final increment in the Phase I development of NCTR, and will provide improved detection of effects of repeated low and high level exposure to selected chemical compounds, improved detection of individual hypersensitivity to chemicals and drugs, research to improve extrapolation relative risk to man based on studies in animals, and broadened efforts to assay mutagenic effects in exposed population groups. Before proceeding to the phase two and three proposals in the NCTR plan, the success of the NCTR techniques and concepts in the phase one operation will be evaluated.

Finally, a summary of the Knowledgement Development Theme must include mention of some important international activities. For example, the U.S. - U.S.S.R. Joint Committee on Health Research is focusing on collaborative efforts in research on cancer, heart disease, environmental and occupational health, arthritis, and the basic processes of schizophrenia. The NATO Committee on the Challenges of Modern Society is the vehicle for collaborative work in emergency medical services, automated clinical laboratories, and health care quality assurance. Similarly, the U.N. Commission on Narcotic Drugs provides an opportunity for tackling on an international basis health problems which certainly know no national boundaries.

Overview: Strengthening the Management of Federal Health Responsibilities

The success of the PHS in achieving the goals and objectives set forth in the Forward Plan for Health is highly dependent upon its management capabilities. The term "management" for these purposes is construed quite broadly to include both the traditional management processes of planning, budgeting and grants, and manpower management as well as program management of high priority efforts, particularly those which cut across organizational lines. During this planning period efforts will be directed toward the strengthening of the PHS management capability.

Major initiatives to enhance the management capability for Federal health programs are:

1. Establishment of the Health Policy Board

The Health Policy Board, comprised of the Assistant Secretary for Health, the Deputy Assistant Secretaries for Health, the Executive Officer, and Agency Heads and Office Directors, has been established. It will review and make recommendations to the Assistant Secretary on major policy directions, program initiatives, and interagency coordination. The workings of the Board will be evaluated and further refined during this period.

2. New Planning/Budgeting Calendar

H will develop an adjusted "Master Calendar" in order to accommodate earlier, joint development of issues, guidelines and analytical papers upon which planning and budgeting can be based.

3. Planning/Budgeting--Work Group

A more formal coordination among OASH staff offices involved in planning, evaluation, and budgeting will be established in order to develop and implement links among management processes. This will include representation from OPDP, OAM, and other relevant offices and will be co-chaired by OPDP and OAM.

4. Tracking Policy Issues

Specific health policy issues are dealt with at various levels in PHS and through various program and management processes. It is imperative that they be tracked and that a consistent approach to their resolution be achieved. A systematic approach to identifying and tracking such issues will be developed.

5. Evaluate Evaluation

A study of the procedures in planning for and conducting evaluation in PHS will be undertaken in cooperation with P. It is expected that a major overhaul of this activity will result, including a redesign of the system and redistribution of responsibilities among the various levels.

6. LPIS

A Legislative Planning and Implementation System has been developed which sets forth clear responsibilities for the initiation of legislative proposals, for development and submission of new legislation to OMB and Congress, and for the implementation of legislation once enacted. It will be evaluated and further refined during this period.

7. Improved Manpower Management

The development of a base line manpower management system which reflects workload criteria and identifies where improved manpower utilization is needed will be completed. In addition, manpower forecasting techniques will be developed which will identify skills required to implement the program decisions made in the planning and budgeting process.

8. Equal Employment Opportunity

Continued emphasis will be given to improving the status of minorities and women in PHS. EEO objectives will be included in all work plans. A systematic approach to data collection and program evaluation,

and to problem identification and resolution will be developed. Particular concern will be paid to special emphasis groups and to the incorporation of other factors into EEO responsibilities.

9. Improved Service Grantee Management

Over this planning period, realistic and reasonable management standards will be developed and communicated to service grantees and applicants, not only to improve grantee accountability for public funds but also to reduce barriers to utilization and service delivery. A structured system for monitoring implementation of these standards will be developed. Compliance with standards will be a condition for continued funding; ability to comply with standards will become a condition for new funding.

10. "Arrangements" for High Priority and Interagency Efforts

A variety of "arrangements" will be established and tested for managing high priority, interagency efforts such as those set forth in the programmatic themes. Such arrangements will include:

- Establishing a staff in OASH. (Current examples of this arrangement are the designation of the Deputy Assistant Secretary for Health as the OASH policy focus for quality of care across all health programs, the designation of the Office of Nursing Home Affairs as the policy focus for long term care, establishment of the Office of Equal Employment Opportunity in H to develop consistent policy and practices and to provide leadership throughout PHS for EEO.)

- Designating a "lead agency." (A current example is the designation of CDC as responsible for developing an H-wide approach to health education, with the assistance of an Intradepartmental Policy Board.)

- Establishing an H-led interagency steering committee. (Current examples are the OPDP-led committees on the management of Section 222 (SSA amendments) research, and on the analysis of NHI issues. In addition, an interagency steering committee will be established to develop a comprehensive H approach to the health scarcity area policy discussed in the theme on this subject.)

- Utilizing the OPS system more extensively as a vehicle to track the management of interagency objectives.

- Establishing a program review system to assess overall health themes and other high priorities of H.