



### CALIFANO COULD BE THE MAN TO TEST P.L. 93-641 EFFECTIVENESS

WASHINGTON — The nation's new health planning apparatus will produce results helpful to people or be attacked by new HEW Secretary Joseph A. Califano, Jr. He's that kind of man.

An inveterate trouble shooter, he believes in rapid, computerized data gathering and decisions based on rationality instead of conventional wisdom. He has a track record for effective, evaluable program implementation.

A computerized review of his own public statements in recent years reveals a strong populist bent on matters inside and outside HEW's jurisdiction.

This bias has sometimes misled him, but not often. His populist bent led him to criticize President Nixon frequently, once joining Senator Hubert Humphrey (D-Minn.) in 1971 in demanding that Administration-blocked funds be released. This was before the anti-impoundment battle was in full swing. He gave the press data on funds withheld from model cities, public housing, health, and education.

Secretary of Treasury might have been an alternative appointment for Califano, for the new HEW chief has repeatedly expressed his populism on taxation issues. He complained publicly in 1971 that 3% of the population controls 90% of the nation's wealth. The same year, while discussing election



Joseph A. Califano, Jr.

campaign funding, he called private wealth "the most corrupting force in U.S. politics."

He has said that federal social programs operate at a data disadvantage that leads to wrong action or prevents the right course from being found. In 1969, he contrasted HEW's data base with the Defense Department's. He backed Walter F. Mondale's proposal, when Mondale was a senator, for a White House Council of Social Advisors which would gather data on people the way the Council of Economic Advisors gathers data on money.

Califano is likely to emphasize health programs that improve patient access. He has repeatedly spoken against federal actions that give the poor a bad shake. This attitude came out several times in a discussion of the volunteer army in 1972. He said it was designed to attract poor and added that it would placate rich and middle class objectors to the View Nam War. He also argued that a cross-section of the U.S. public should participate in military service and produced calculations to show a "mercenary" army would cost more than a draft.

He opposed patch-up programs in health and welfare. In 1975 he advocated a radical restructuring of state and local government to avoid big city bankruptcy crises and to improve existing services.

One reason Califano will not tolerate health planning machinery that doesn't work is that he won't accept the bureaucratic "runaround" where action is demanded. If the planning administrators defend the machinery without producing results, he'll replace them. He has many times attacked public officials who did not perform their given duties. In 1975, he accused the Interior Department of failing to give wilderness areas full protection under the law.

Members of Califano's transition staff were alert in early January to Ford Administration attempts to push out health program dollars in last moments acts of largesse to the faithful. He was already getting a firm grip on HEW reins. ■

### NIH ACCEPTS TECHNOLOGY TRANSFER CHARGE; STEERS CLEAR OF COMMUNITY PARTICIPATION

WASHINGTON — National Institutes of Health Director Donald S. Fredrickson, M.D., has now conceded that NIH has a role in technology transfer, clearing the way for a discussion on methods and organizations to accomplish the job.

The historical reluctance of NIH leaders to transform laboratory discoveries systematically into remedies of immediate benefit to patients has not disappeared, however, NIH has finally seen that the Congress means business on technology transfer and the "campus" is searching for ways to adjust.

There is little question that NIH leaders will call on health resources development experts increasingly in coming

months. Former RMP executives have been invited to make suggestions to NIH on ways to respond to congressional pressures.

#### OLD RMP LESSONS SOUGHT

NIH is particularly eager, according to some in the director's office, to capture knowledge from the RMP program before it is dispersed entirely to warehouses and inactive files. Satellite-broadcast continuing education is an example of what's caught NIH chiefs' eyes.

Whereas NIH displayed no eagerness to invest thought, energy, and resources into the original RMP program, there is a sort of wistful recognition on the Bethesda campus that

## RMP STUDIES TEACH FUTURE PROGRAM DESIGNERS

Designers of future developmental project activities could profit immeasurably from the "lessons learned" in the Regional Medical Programs Child Health Study and the Arthritis Study, panel members discovered during the annual meeting of the NAHRD at St. Petersburg Beach.

The validity of findings was underscored by Roger Warner, of Little Rock, Arkansas, when he pointed out that "the result of the on-site visit almost completely paralleled the results obtained from the Child Study on-site interviews and in almost exactly the same order of importance."

"It is therefore apparent that there are major lessons to be learned from these activities which would be useful to those planning to initiate a new series of developmental activities."

Warner listed the following major findings:

- The most important components for success are the personal qualities of the project director, including motivation to perform and the ability to deal successfully with colleagues and community forces.
- A project management staff is needed to work closely with patient care providers in organizing action, evaluating progress, coordinating efforts and similar administrative efforts which may tend to be slighted somewhat as priorities of patient care, professional and public education demand time and effort of providers.
- False starts, on-again, off-again, because of hap-hazard funding actions are: a) wasteful of time and local momentum, b) serve as negative forces in local action.
- Demonstration projects which aim at institutionalizing new or refined regional service patterns require a more stable, longer term support base to be most effective.
- In the process of expanding existing for establishing new regional service patterns, it is crucial that a project provide for strengthening the compacity of existing specialized care centers early in order to accommodate additional service demands generated by regionalizing activities.
- Local health providers' opposition of a project increases chances for failure. If providers are disinterested or improperly approached, but not opposed, some limited successes may be noted. Where the health providers were strongly interested, success nearly always occurred.
- The presence of an existing effort prior to RMP funding greatly enhanced the RMP project chances for continuation funding approval and success.
- Strong community support of a recognized need was a major asset in developing a successful regionalization activity. Health care problems not arousing public support encountered serious problems through the developmental effort.
- For a project involving recent changes in medical practices or health care technology, continuing education for practitioners must also occur or the project will be viewed with suspicion or have minimum impact on changes in care patterns.
- In general, RMP projects offered a useful model of health service delivery patterns involving a local community of interest. Projects ably led by local practitioners, funded by multiple sources, focused around an agreed upon plan to develop regional referral patterns and effective use of resources will be successful.
- Project plan development and operation should be supported by a separate local professional staff. Support

of this nature allows local medical specialists, other professional and consumer interests time and an effective atmosphere for rational services improvement throughout the community.

"It seems crucial that this community-wide approach to services improvement be a central part of the new Public Law 93-640 for Arthritis Centers concurrently with the development of tertiary center care capability.

Discussing the site visit technique utilized in conducting this study, Warner noted that the value of the site visit extended not only to the data being collected and the report being prepared, but apparently served to be of value to many of the projects and the staff where the visits were made. Major findings regarding the on-site visit technique are as follows:

- Significant qualitative information may be elicited through this procedure.
- Perceptions regarding the project by non-RMP project personnel and RMP staff frequently differ. The visits, in some instances were the first opportunity for the disparate perceptions to be compared.
- The use of site visit teams is more useful when team members have had a prior briefing regarding the visit procedure.
- Ability of membership on the site visit teams produces more consistent results.
- The interdisciplinary background of different site visit team members adds to the range of questions, and the range of understanding responses.
- Interview guides are invaluable tools for focusing the attention on all parties to the discussion.
- In general, the projects chosen for interviews and site visits did not produce the expected range of differences in actual operational terms.

C. Ed Smith, Ph.D., President, Health Policy Analysis and Accountability Network, Inc., identified five major "lessons learned" in reporting of developmental activities through the RMP experiences it is essential:

- To define needed data and information in the context of major policy or program operation questions.
  - To involve program managers in the field in overall issue identification and dissemination of results.
  - To look to technical competence in the field for public accountability reporting rather than relying exclusively on information systems of funding agencies or external groups who may not understand the system.
  - To make the reporting interesting, understandable, and based on the sensible data.
- To assure that reports aim at specific key publics and are produced on a schedule related to a particular policy or program operations decision.

Ed. Francisco, Ph.D., Director, Northern New England Regional Medical Program, related a major lesson learned in the reporting of developmental activity concerning data collection and analysis.

A program can be successful only if the commitment is obtained at the beginning of a program from the parties involved to make changes at the appropriate time which are shown to be necessary after analyzing collected data, he said. It is essential to take appropriate actions as a result of findings based upon data analysis; otherwise, the establishment of a data base is a wasteful activity, he noted. ■



## LAW SUITS OVER P.L. 93-641 CONTINUE TO PLAGUE HEW, HSAs

WASHINGTON — HEW lawyers say in a brief that minority groups claiming that Health Systems Agency governing boards don't adequately represent minorities should take their cases to state courts. The HEW brief could inspire a wave of state court lawsuits on top of the growing number of federal suits.

While the surge of new suits is expected to bring 'I told you so' comments from the original opponents of P.L. 93-641, none of the decisions is likely to slow the trend toward the stronger federal efforts to implement P.L. 93-641.

Rather, recognition will grow that P.L. 93-641 must be used almost entirely as a regulatory statute. It's health resources development section won't matter much. What development there is to come in the next year or two will probably take place on a piecemeal basis, rather than through some overall federal funding mechanism such as P.L. 93-641.

The HEW lawyers touted state court jurisdiction over governing board make-up questions when minority groups sued to block the HEW secretary's designation of a Syracuse, N.Y., group as a Health Systems Agency. The Syracuse would-be HSA included on its board a black woman from a rural area living on Social Security. The HSA boosters claimed she represented females, blacks, and the lower end of the income scale. HEW argued that P.L. 93-641 didn't require a separate representative for each population group.

The main law suit against the principle underpinning P.L. 93-641 is still in process. The State of Missouri and the National Association of Regional Councils are trying to win a U.S. Court of Appeals decision that P.L. 93-641 is unconstitutional because it turns public duties over to private groups.

This is the basic issue type of suit that could make or break the law. Meanwhile nibbling at the edges, sometimes taking big bites, are suits on governing body make-up, area jurisdiction, and suits on related regulatory work that don't immediately involve HSAs but which will have an impact on their eventual efforts to regulate.

A Fresno, California group of whites has filed a class action charging HSA discrimination because so much attention was given to thorough representation of minorities on the HSA board that the majority suffered. The whites said that two California counties in the HSA territory were represented only by 44 per cent of the consumer members on the HSA board. Only four of 16 members of the HSA board are white, the plaintiffs stated, far less than the percentage of whites in the HSA area.

## Certificate of Need Suits Bloom

Coming HSA regulatory troubles were presaged by suits in New Jersey and Minnesota involving certificate of need laws. In both states regulation moved into the private doctor's office, the ultimate affront to medical association interests who opposed P.L. 93-641 on the grounds that the law would do just that.

The law passed with assurances by its supporters that it would do no such thing.

But House Health Subcommittee Chairman Paul Rogers (D-Fla.) told a National Health Council meeting a few months ago that, after success in institutional regulation, P.L. 93-641 must be extended to MD regulation.

In New Jersey a doctor "stepped outside private practice" when he sought to buy a CAT scanner for his office, according to N. J. Health Department's planners. The physician was therefore required to get approval for the purchase, N.J. authorities said. So he sued.

Purchase of a CAT scanner in Minnesota by a private physician was regarded by the Minneapolis-St. Paul HSA as a possible evasion of the state certificate of need law. The idea was that private purchase by the unregulated doctor's office could be a collusive device used by hospitals, ones cooperating with the doctor, to avoid state certificate of need review.

The hearing examiner for the state board of health, which administers the certification law, heard the HSA's plea. Local hospitals with CAT scanners supported the HSA. The local medical society opposed it, saying that HSA review of the private purchase would invade the area of private practice. The board decided against the HSA.

The state board agreed there was no collusion proven and HSA answered with a lawsuit in a state district court, appealing the board decision.

### HSA Jurisdictional Disputes Reach Court

A decision, one of the few from the first wave of cases against provisions of P.L. 93-641 or its implementation, came in federal court September 30 with the dismissal of the State of Alabama's suit that an HSA area crossing state lines to achieve Standard Metropolitan Statistical Area coverage was unconstitutional.

Alabama said the SMSA concept was arbitrary and violated the idea of federalism, state's rights, in government. The court disagreed.

The big issue, P.L. 93-641 constitutionality, moved closer to one decision in North Carolina when the American Medical Association's and State of North Carolina's suit to invalidate the planning law was assigned to a federal court. The American Association for Comprehensive Health Planning was allowed to take part on the side of defendant HEW.

### Law Suits Serve As Warnings

While all these suits have little direct bearing on current health resources development work, since HSAs are not yet exercising full regulatory power, the legal actions nevertheless indicate how development work can be hit by P.L. 93-641 entirely apart from the law's choking off of development funds.

There is some money in each of a dozen HEW programs for health systems development, though the program goals are not usually stated in "development" terminology. The money in each program is small. But experienced grants - persons can manage to put components together from several sources to make a viable project.

What the law suits do today is provide a warning for what kinds of development projects are apt to run into P.L. 93-641 review problems.

One thing is sure: P.L. 93-641's regulatory power won't go away. Washington is so aggravated by rising health care charges that the only possible trend in the immediate future is for more regulation, not less. ■

# HEALTH COMMITTEE VETERANS LISTED: NEW MEMBERS TO BE NAMED IN FEBRUARY

WASHINGTON — Even though several new members will appear on House and Senate health authorization and appropriation committees, more important are the veteran members returning for service in the 95 th Congress. They are listed below.

The Senate planned to spend much of January juggling its committee structure in an effort to reduce the assignments for each senator, allowing each more time to spend on a subject. There would be fewer committees. At this writing, it was un-

clear whether any important realignment would take place, but the Senate was giving priority treatment to its own reorganization.

None of the Senate health authorization or appropriation committees was scheduled to be affected in early versions of the reorganization. The House is not reorganizing its committees.

New members of these committees will probably be known in February, though a few changes and trading will take place in March.

## SENATE COMMITTEE ON APPROPRIATIONS 94th CONGRESS

### Democrats:

John L. McClellan (Arkansas)  
\*Warren G. Magnuson (Washington)  
\*John C. Stennis (Mississippi)  
John O. Pastore (Rhode Island) - *Not Returning*  
\*Robert C. Byrd (West Virginia)  
Gale W. McGee (Wyoming) - *Not Returning*  
Mike Mansfield (Montana) - *Not Returning*  
\*William Proxmire (Wisconsin)  
Daniel K. Inouye (Hawaii)  
\*Ernest F. Hollings (South Carolina)  
\*Birch Bayh, Jr. (Indiana)  
\*Thomas Eagleton (Missouri)  
\*Lawton Chiles (Florida)  
J. Bennett Johnston, Jr. (Louisiana)  
Walter Huddleston (Kentucky)

### Republican:

Milton R. Young (North Dakota)  
Roman L. Hruska (Nebraska) - *Not Returning*  
\*Clifford P. Case (New Jersey)  
\*Hiram K. Fong (Hawaii) - *Not Returning*  
\*Edward W. Brooke (Massachusetts)  
Mark O. Hatfield (Oregon)  
\*Ted Stevens (Alaska)  
Charles McC Mathias, Jr. (Maryland)  
\*Richard S. Schweiker (Pennsylvania)  
Henry Bellmon (Oklahoma)  
\*Members of the Subcommittee on Labor/HEW Appropriations. Two vacancies.

## HOUSE COMMITTEE ON APPROPRIATIONS 94th CONGRESS

### Democrats:

George H. Mahon (Texas)  
Jamie L. Whitten (Mississippi)  
Robert L. F. Sikes (Florida)  
Otto E. Passman (Louisiana) - *Not Returning*  
Joe L. Evin (Tennessee) - *Not Returning*  
Edward P. Boland (Massachusetts)  
\*William H. Natcher (Kentucky)  
\*Daniel J. Flood (Pennsylvania)  
Tom Steed (Oklahoma)  
George E. Shipley (Illinois)  
John M. Slack (West Virginia)  
John J. Flynt Jr. (Georgia)  
\*Neal Smith (Iowa)  
Robert N. Giaimo (Connecticut)  
Joseph P. Addabbo (New York)  
John J. McFall (California)  
\*Edward J. Patten (New Jersey)  
Clarence D. Long (Maryland)  
Sidney R. Yates (Illinois)  
Frank E. Evans (Colorado)  
\*David R. Obey (Wisconsin)  
\*Edward R. Roybal (California)  
\*Louis Stokes (Ohio)  
J. Edward Roush (Indiana) - *Not Returning*  
Gunn McKay (Utah)  
Tom Bevill (Alabama)  
Bill Chappell (Florida)  
Bill D. Burlison (Missouri)

Bill Alexander (Arkansas)  
Edward I. Koch (New York)  
Yvonne Brathwaite Burke (California)  
John P. Murtha (Pennsylvania)  
Bob Traxler (Michigan)  
Robert Duncan (Oregon)  
\*Joseph D. Early (Massachusetts)  
Max Baucus (Montana)  
**Republicans:**  
Elford A. Cederberg (Michigan)  
\*Robert H. Michel (Illinois)  
\*Silvio O. Conte (Massachusetts)  
\*Garner E. Shriver (Kansas) - *Not Returning*  
Joseph M. McDade (Pennsylvania)  
Mark Andrews (North Dakota)  
Burt L. Talcott (California) - *Not Returning*  
Jack Edwards (Alabama)  
Robert C. McEwen (New York)  
John T. Myers (Indiana)  
J. Kenneth Robinson (Virginia)  
Clarence E. Miller (Ohio)  
Lawrence Coughlin (Pennsylvania)  
C. W. Bill Young (Florida)  
Jack F. Kemp (New York)  
William L. Armstrong (Colorado)  
Ralph S. Regula (Ohio)  
Clair W. Burgener (California)  
\*Members of Subcommittee on Labor/HEW Appropriations.  
One vacancy.

SENATE COMMITTEE ON LABOR  
AND PUBLIC WELFARE  
94th CONGRESS

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**Democrats:**

\*Harrison A. Williams, Jr. (New Jersey)  
Jennings Randolph (West Virginia)  
\*Claiborne Pell (Rhode Island)  
\*Edward Kennedy (Massachusetts)  
\*Gaylord Nelson (Wisconsin)  
\*Walter F. Mondale (Minnesota) - *Not Returning*  
\*Thomas Eagleton (Missouri)  
\*Alan Cranston (California)  
William D. Hathaway (Maine)  
John A. Durkin (New Hampshire)

**Republicans:**

\*Jacob Javits (New York)  
\*Richard S. Schweiker (Pennsylvania)  
\*Robert Taft, Jr. (Ohio) - *Not Returning*  
\*J. Glenn Beall, Jr. (Maryland) - *Not Returning*  
Robert T. Stafford (Vermont)  
Paul Laxalt (Nevada)  
\*Members of the Subcommittee on Health. There are three vacancies.

HOUSE COMMITTEE ON INTERSTATE  
AND FOREIGN COMMERCE  
94th CONGRESS

**Democrats:**

Harley O. Staggers (West Virginia)  
Torbert H. Macdonald (Massachusetts) - *Not Returning*  
John E. Moss (California)  
John D. Dingell (Michigan)  
Lionel Van Deerlin (California)  
Fred B. Rooney (Pennsylvania)  
\*Paul Rogers (Florida)  
John M. Murphy (New York)  
\*David Satterfield (Virginia)  
Brock Adams (Washington) - *Not Returning*  
W. S. Stuckey Jr. (Georgia) - *Not Returning*  
Bob Eckhardt (Texas)  
\*Richardson Preyer (North Carolina)  
\*James W. Symington (Missouri) - *Not Returning*  
\*Charles J. Carney (Ohio)  
Ralph H. Metcalfe (Illinois)  
Goodloe E. Byron (Maryland)  
\*James H. Scheuer (New York)  
Richard L. Ottinger (New York)  
\*Henry A. Waxman (California)  
Robert (Bob) Kreuger (Texas)  
Timothy E. Wirth (Colorado)  
Philip R. Sharp (Indiana)

William M. Brodhead (Michigan)  
W. G. (Bill) Hefner (North Carolina)  
\*James J. Florio (New Jersey)  
Anthony Tobey Moffett (Connecticut)  
Jim Santini (Nevada)

\*Andrew Maguire (New Jersey)

**Republicans:**

\*Samuel L. Devine (Ohio)  
\*James T. Broyhill (North Carolina)  
\*Tim Lee Carter (Kentucky)  
Clarence J. Brown (Ohio)  
Joe Skubitz (Kansas)  
James F. Hastings (New York) - *Not Returning*  
James Collins (Texas)  
Lou Frey Jr. (Florida)  
John Y. McCollister (Nebraska) - *Not Returning*  
Norman F. Lent (New York)  
\*John H. Heinz (Pennsylvania) - *Not Returning*  
\*Edward R. Madigan (Illinois)  
Carlos J. Moorhead (California)  
Matthew J. Rinaldo (New Jersey)  
\*Members of the Subcommittee on Health and the Environment. There are two vacancies.

## FUTURE OF HEALTH RESOURCES DEVELOPMENT

ST. PETERSBURG BEACH — What are the prospects for health resources development now that Regional Medical Programs are out of the picture? This was the topic of speculation for a panel led by C. E. Smith, Ph.D., vice chairperson of NARMP on Tuesday morning, September 14th. The panel included Evangeline L. Hebbeler, MPH, Associate Director for Health Services for the Council of Public Education for Kentucky; Leonard N. Wolf, Ph.D., Coordinator Greater Delaware Valley RMP and Theodore D. Lampton, M.D., Coordinator Mississippi RMP.

Panelists were pessimistic concerning chances for significant support for health resources development in the near future, but agreed on the importance of examining the strengths of the RMP experience and marshalling the remaining RMP resources in order to conserve and make use of the process developed over the years.

Describing PL 93-641 as "primarily a cost control act," Wolf predicted that little worthwhile developmental support could be expected from that source. He felt that effort should be made through NAHRD to make effective use of the resources left behind by RMP. He suggested that as a group through which other agencies can contract, Health Policy Analysis and Accountability Network, Inc., is capable of performing any function to do with health resources development.

Smith noted that RMP's coordinating functions and ability

to bring about voluntary action would be missed. However, the Great Society is gone and has been replaced with primary concern for cutting costs. In view of this, he suggested the possibility of providing resources through organization of a National Health Service Development Bank which would provide a system for payback of funds used for development.

Although RMP has been successful in modifying many components in a positive and contributing way to improve health service delivery, Lampton saw a lack of the kind of problem-solving that requires revision of the social structure, renewal of institutions or intervention of new human arrangements. He suggested a new beginning, one in which would confront the societal challenge, not just the challenge of the medical community.

Hebbeler perceived PL 93-641 as a consequence of a tightening economy "proposed and designed to put providers in their place." She discerned, however, an unwillingness to forcefully implement PL 93-641.

For the future? We will remain on this level of "stifled creativity for perhaps a decade or so," she said, after which RMP might be reinvented with a new name and with a different set of rules.

Meanwhile she counseled recognition that the political process is inevitably involved with decision-making and urged participants to remain in a "watch dog" role, ready to take advantage of opportunity when presented. ■

## NIH STRUGGLES WITH PRESSURES FROM HILL ON COMMUNITY WORK

WASHINGTON — The National Institutes of Health is now committed to testing specific programs for reaching the public, health practitioners and research scientists with current news of research results — technology transfer, in other words.

This commitment follows orders from congressional appropriators and responds to separate inquiries from senators and Capitol Hill staffers, all leading to the inescapable conclusion that NIH had better get moving or others will move it.

Senator Warren Magnuson's (D-Wash.) Labor/HEW Appropriations Subcommittee in 1973 told NIH that the subcommittee "would be anxious to review the results of information dissemination programs during next year's hearings." Then, in a September 11, 1974, report (No. 93-1146) to the Senate Magnuson said, "The hearings have been held and the committee is registering its complete disappointment with the NIH and the institutes' efforts in disseminating information."

### MAGNUSON SEES "WEAK EFFORT"

"In testimony after testimony," Magnuson said, "the institute directors talked of how many new pamphlets had been printed or possibly how many conferences had been attended. This is clearly a very weak effort and the committee instructs the director of NIH to develop a specific course of action in helping to improve the situation . . . A complete action report with recommendations and a plan for implementation is to be given the committee no later than four months following the enactment of this bill . . ."

"Until citizens actually receive some type of assistance from the many facets of research carried out by the NIH the total tax dollar has not been effectively utilized."

On March 7, 1975, NIH completed a review of its dissemination of research and made some recommendations for new work.

It recommended that a central NIH unit be created to stimulate, coordinate and evaluate NIH's dissemination work, using the advice of non-federal health professionals and communications experts.

On January 28, 1976, NIH told Magnuson that it had followed through by creating an Office of Communications inside of the NIH director's office. His Office of Communications is helped by a Task Force made up of executives and research administrators from NIH's own campus, no outsiders.

### PROGRAM DEVELOPMENT BEGINS

NIH told Magnuson that its Task Force had started to pay for travel of consultants "who can provide insight on the problems addressed by the Task Force."

About six months later a delegation from the National Association of Regional Medical Programs visited the NIH director to suggest a NIH contract to the Institute of Medicine for the purpose of tapping RMP expertise for NIH's communications work. This delegation was heard, but not given a response.

Strangely, in view of the cold shoulder given NARMP spokesmen, NIH went on to plan use of a communications technology satellite, which RMP pioneered in applying; and told the Senate of the great potential in medical information service by telephone, another medium pioneered by RMP.

Magnuson looked at NIH's 20-page report on communications work in progress and told the Senate on June 26, 1976 (Report No. 94-997), "The committee is pleased that the NIH has finally taken his task seriously and that the

## AACHP CRITICIZED SHARPLY IN MCGRAW-HILL REPORT

A chronic "identity crisis" afflicts the American Association of Comprehensive Health Planning (AACHP) according to McGraw Hill's Health Planning Letter. The ability of the Association to represent the new P.L. 93-641 planning agencies "seems threatened by internal problems as the Association tries to define what its role should be," says the publication in its Dec. 25th issue.

The Washington-based semi-monthly devotes one of its eight pages to troubles it perceives in the CHP organization which, it says, "is regarded in Washington as a do-nothing organization." The letter claims that some planning agency members question whether AACHP really represents their interests.

The Association is rapped by the Letter for failing to reveal the number of members it has.

A five-year renewal of P.L. 93-641 without any changes will be urged on Congress by the group, says the Letter, though House Health Chairman Rogers has indicated he will extend the law for only 12 months this year to give Carter forces a hand in rewriting it. Even so, governors' and mayors' lobbies will drive hard for strengthening their roles in the rewrite and Rogers, himself, might introduce some increases in planning agencies' regulatory power.

AACHP has a three-year, \$360,000, Robert Wood Johnson Foundation grant for technical assistance to planning agencies and a \$215,000 two-year, HEW contract to recruit professional planners. ■

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problem is being approached from a number of angles, some of which are refreshingly innovative and promising."

### TELLING THE PUBLIC ABOUT CELL BIOLOGY

Others on Capitol Hill were not so appreciative. For instance, where NIH addressed the needed "increase in output of health education information by the mass media," to some Hill staffers the Bethesda campus seemed to be blowing its own horn, rather than educating the public. NIH interpreted the need to "improve the dissemination of research information" to mean giving science reporters a view of the "state of the art" in several basic areas, such as cell biology, progress in eye research, fertility and the working woman, hypertension, and immunology. Briefings scheduled for 1976 were designed to cover virus research, environmental factors in health, and cell surface receptors. In fact, NIH told the Senate, "This . . . is providing the public with a new depth of understanding of the purposes and products of biomedical research.

When Capitol Hill staffers began preparing 1977 hearing plans, the word got around Washington that NIH would be raked over the coals in a way rougher than the institutes have ever experienced. The prelude to the ordeal came when the Kennedy Health Subcommittee in the Senate held hearings on the report by the President's Panel on Biomedical Research.

In effect, the subcommittee called the report unresponsive and asked the kind of questions that indicated it clearly felt that NIH has to do more than merely put the word out; must go further and demonstrate a real impact on the care delivery system, including helping control care costs by providing scientific evaluations of the readiness of new equipment and new therapeutic measures for mass introduction. ■

# NIH ACCEPTS (Continued from page 1)

NIH once had the mechanism to do exactly what the Congress is now demanding be done. Some in Bethesda think NIH's National Library of Medicine should do the job.

At the moment, NIH leadership is determined to limit its involvement in technology transfer to identify precisely what will be done then go to the Congress for extra funds to do it. It is possible, but not at all certain, that coming months will bring more of a positive attitude on the part of NIH executives toward technology transfer. Certainly the Congress will increase the pressure.

HEW Secretary Califano will very likely pinpoint technology transfer as an explicit administrative area for discrete programming, direct financing and evaluation. Position papers on the matter are in preparation. It is not at all certain that the job will be left at NIH.

## CALIFANO WILL RAISE QUESTION: WHY NIH?

The reason the discussion has centered on NIH so far is that the DHEW Health Resources Administration and Health Services Administration have operated in such a diffuse way, continuing to dip into an old grab-bag of health projects and approaches without following any overall strategy, that NIH seemed the simplest, most direct way to begin. And the Congress naturally goes where the big money is. NIH spends about as much as the other two administrations combined.

It is too early to tell whether NIH will continue to be the focus of the technology transfer discussion. But if it is, Fredrickson's words are important.

He admits in interoffice memos that, "The manner of introducing new knowledge derived from research into the health care system has become an issue of major concern." The admission is a decade late, but welcome to resource development people.

He also says that, "The NIH, as principal supporter of bio-medical research, and the rest of the scientific community, must assume greater responsibility in the selection and use of that knowledge pertinent to disease diagnosis and treatment, which is to become accepted health practice."

In order to discharge this responsibility, he says, each NIH institute should get together with its advisory board and identify research results useful to practitioners.

He says that each institute should set up new procedures for "development of consensus" concerning the usefulness of any particular promising research result.

## NIH SEES THE LIGHT — DIMLY

There is nothing in Fredrickson's writing that indicates he is familiar with the full scope of community, inter-professional, organizational procedures that have been tried in the past. How national and local medical leaders are involved in convocations leading to changes in therapy is not a subject sharply in focus in Fredrickson's writing.

Nor are official NIH documents cast in a sophisticated manner with regard to the exploitation at state and local levels of any national decision or consensus that a new therapy should be made standard.

In any case, the immediate NIH goal is to confine its activities to the laboratory end of the technology transfer business, and it is reported that Fredrickson hopes to convince the Congress and the new Administration that direct, administrative linkage of scientists and practitioners is not essential to the technology transfer job.

The first pass at the task which NIH has now commenced, and is happily pointing to as a good beginning, is the purchase of editorial space in the *Journal of the American Medical Association*. Research tidbits are dropped into the pages and doctors are offered more detailed information if they will contact NIH.

Some idea of the "bite" to the articles published so far was in an NIH-written piece on breast cancer chemotherapy. Results showing that post-operative chemotherapy in breast cancer were far more effective than either chemotherapy or surgery alone were emphatically clear in mid-1975. There has been a great deal of controversy over which are the best chemical combinations and for which patients various combinations of drugs are most effective. But, while that controversy boils along, all comprehensive cancer centers have, without fanfare, adopted as *de rigueur* protocols calling for post-operative chemotherapy in a wide number of cancers.

This came out in a Washington breast cancer seminar sponsored by NIH in November. It was a typical scientific seminar in a style familiar to all NIH grantsmen. A scientist reads his latest paper and answers a few questions.

In this particular seminar, because of the wide interest in breast research and therapy, a large number of medical writers attended and special press briefings were staged. Some of the writers and non-physician parties attending the seminar asked questions from the floor and, generally, were ignored or encouraged to subside the instant that the non-scientists pushed for a scientific recommendation regarding current medical practice.

In fact, the world's two leading breast cancer chemotherapy clinical trial experts, Bernard Fisher and Giovanni Bonadonna, while occupying the same podium and jointly answering questions put to them, stated different conclusions on what should be recommended at the moment.

## WHO TELLS THE DOCTOR?

The resolution of these differences was left hanging in the traditional style of controversy scientists thrive on, leaving to others, unnamed, the work of elucidation for practitioners.

NIH, however, was determined to point to this project as a sterling effort in technology transfer, despite the fact that the audience was limited to fewer than 5,000 persons, only a fraction of which were people who see patients.

A very valuable result will come from the conference, however, as NIH follows some old RMP methodology. A videotape of the entire conference was made. If doctors write in to NIH to ask for copies of papers delivered at the seminar they are told that they can get them in a publication due in May, 1977, seven months after the seminar. But they will also be able to get an edited-down version of the entire conference on videocassettes. If they have equipment to use the cassettes, they'll be able to "participate" in the conference.

Congress is not at all likely to accept that procedure, improved as it is over the usual NIH "drop it in a journal and hope" process. But for the highly motivated physician, the procedure is very useful and NIH will get some high marks for trying from some quarters.

NIH recognition of science's immediate responsibilities to the practicing community has been won. But Washington still needs organized pressure to make sure that this recognition is not lost in the shuffle, the reorganizations, the displays of "new departures" which President Carter can be expected to foster. ■

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## KNOW THE TERRITORY IS BEST STRATEGY

ST. PETERSBURG BEACH — You've got to know the territory — and your own biases before attempting community organization. The successful organizer also recognizes that he must deal with human values and perceptions rather than cold data. These were among important lessons from the RMP experience which were presented in a workshop session, Strategies for Local Community Organization for Health Resources Development.

Although special problems exist in organizing the urban community, such as difficulty in determining leadership, in defining community priorities, and in achieving communication and broad involvement, there are basic principles of organization which are common to both urban and rural areas.

With Linda Wenzel, Nassau-Suffolk RMP as chairperson, the speakers Adelbert Campbell, California Health Systems Management Corp., William Fox, Ohio Valley RMP and Jackie Walters, Arkansas RMP, agreed on the following guidelines.

1. Find out who the leaders are and who determines what the values are.
2. Respect those values, and be perceived as doing so.
3. Be aware of your own biases and of those with whom you are working.
4. Be alert to subcultural differences beneath superficial resemblances.
5. Remember that you are dealing with human values and perceptions.
6. Help the community set appropriate goals. Be sure not to raise expectations beyond levels capable of accomplishment.

Whether working in an urban or rural situation the prospective organizer will be dealing with people, and with their perception of what is important.

Panelists agreed that it is necessary for providers to learn to accept consumers as partners in improving health care. Consumers, they felt, do not necessarily want to control, but they do want a piece of the action. ■

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## CALIFANO'S BACKGROUND

Born Brooklyn May 15, 1931.

B. A. Holy Cross, Worcester, Mass.

LL.B. magna cum laude, Harvard, editor law review.

Officer candidate, Navy, 1955; commissioned ensign; 3 yrs. in judge advocate's office.

With Ballantine, Bushby, Palmer & Wood, NYC law firm — 1958-61.

Special Assistant to Defense Department general counsel, special assistant to Army secretary, '61-'63. Worked on engineers' civil functions; member of Appalachian Regional Commission.

Legal adviser to U.S. delegation investigating Panama riots for Organization of American States — '64.

Special assistant to Defense Secretary Robert McNamara; trouble shooter; liaison with White House; exec. secretary to President's Advisory Committee on Supersonic Transport; on President's Committee on Economic Impact of Defense and Disarmament; member Federal Radiation Council — '64.

Special assistant to President Johnson developing legislative program, congressional liaison, coordinating economic policies, trouble shooter on power failures, balance of payments, urban issues — '65 - '69.

Round-the-world Ford Foundation study and book on *The Student Revolution* — '69.

Books on presidential power, '75, and media and the law — '76.

Arnold & Porter, D.C. law firm, '69-'74, and Williams, Connolly & Califano since then.

Jaycee; married Gertrude Zawacki, Taunton, Mass.

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