
E001625

NATIONAL ADVISORY COUNCIL ON

REGIONAL MEDICAL PROGRAMS

THIRTY-SECOND MEETING

Parklawn Building
Conference Room G
Rockville, Maryland

Tuesday, February 12, 1974
9:00 o'clock a.m.

ATTENDANCE:

Dr. Herbert B. Pahl, Chairman
Dr. Laurence Foye, Jr.
Mr. Edwin C. Hiroto
Mrs. Audrey M. Mars
Dr. John P. Merrill
Mrs. Mariel S. Morgan
Mr. Robert C. Ogden

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Mr. Rubel — p. 108
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P R O C E E D I N G S

CHAIRMAN PAHL: Perhaps we might get started and call the meeting to order. I want to say that I guess that I should use the telephone, because our staff now outnumbers the council by quite a few members, although we hope to have that corrected very shortly, and we have word that some new members will be coming onto the council before too long, and so hopefully we will be back to full strength.

Before introducing Dr. Endicott to you, who has I think some very important things to say to all of us this morning, I'd like to go through just a few usual announcements and first call to your attention in your books the conflict of interest statement and also remind you of the confidentiality of the meetings.

This portion of the meeting is an open meeting, and we will have the closed meeting when we discuss the specific applications later today.

I again wish to welcome Dr. Larry Foye from the Veterans Administration, who is again representing Dr. Musser on the council this morning.

I am sorry to say that neither Dr. Ochsner nor Dr. Schreiner will be able to be present with us. We have known about Dr. Ochsner's conflict of interest some time back, but we just learned yesterday about Dr. Schreiner's inability and we're sorry that he can't be with us this

morning.

We have in addition to Dr. Endicott the opportunity later today--I believe it's at 1:30, Ken?

MR. BAUM: Whenever he gets here but presumably 1:30.

CHAIRMAN PAHL: About 1:30 this afternoon, Mr. Eugene Rubel, who is the Acting Associate Director for Health Resources Planning and under a new administrative arrangement, will be having much to do with the RMP program and this council. And he will be meeting and talking with us this afternoon.

Apparently we are a small enough group that the cafeteria can accommodate us directly. So, we'll break at an appropriate time for coffee and also have lunch in the cafeteria rather than try to run through the proceedings today as we did before.

The other individuals I would like to recognize as being here specifically are Dr. Charles Lemke, who is the coordinator of the Wisconsin RMP, and Dr. Marvin Dunn, who is the Deputy Director of the Bureau of Health Resources Development in this agency, and also Dr. James Gaye, the coordinator in the New Mexico regional medical program.

And now with that and also a brief note of it's nice to be back and see my own co-workers for at least a day, I'd like to turn over the meeting to Dr. Endicott, who I think

has a number of important items for all of us.

DR. KENNETH M. ENDICOTT: I think perhaps the most important thing for me to do first is to try to share with you my view of or sense, gut feeling, of where it is that we're going in the health area these days. It has been a very confusing period for all of us. And there has been a lot of open antagonism and animosity and counter forces at work which have been I think very confusing for all of us, certainly for me.

The events which occurred about a year ago in which there was a sudden decision in the middle of a fiscal year to make meat ax cuts in the operating budget for that fiscal year and to abruptly terminate a series of health programs of the federal government imposed some stresses and strains and set into motion a sort of chain reaction of events which has continued for the entire year, with a number of quite serious consequences.

The Administration had reached a pretty firm decision to make some major changes in the federal health programs, and simply to eliminate a number of lower priority programs, programs which were felt to be less productive than they should be or which perhaps had outlived their purpose in some instances.

And, as I say, the actions were very vigorous. And in the case of RMP led to the issuing a notice that the

program would be liquidated within a few months. But this was not the only program. I think you get a feel of this thing. You have to remember that it was only part of the picture, and that there were many other programs in the same general predicament with interactions and so on, which all summed up made some major changes in the entire situation.

Basically what the Administration proposed was to pay primary attention to the financing of health services and to hammer out as principal federal responsibility in the health area some form of national health insurance which would equalize for the whole population access to the health care system.

And in the process of doing this to drop a number of direct health services or categorical grants of one form or another in the health area.

It was proposed, for example, that we set about eliminating those programs in which the federal government provided direct health services insofar as possible. And one of the things that was proposed was that we close all of the public health service hospitals.

Another thing that was proposed was that in the case of the Indian health service, for example, that steps be taken to determine whether or not provision of health care to the Indians might not be transferred to the private sector.

In the case of categorical grants, such as maternal and child care, migrant health service, community mental health centers, a whole series of categorical grants aimed at financing specific types of health services through categorical grants, primarily to states, that these programs also be phased out in favor of some form of block grant or revenue sharing with the long-term obvious intention that ultimately these programs too be folded into national health insurance.

It was proposed that in the area of higher education generally and in the area of health manpower specifically that the federal government pretty much get out of the business of subsidizing higher education or the education of those who would work in the health field by terminating any form of institutional subsidy, subsidy to the educational institutions. And that the federal effort in t he broad area of higher education and specifically in health manpower, federal effort be limited to assuring that competent students not be turned away for financial reasons and that the federal subsidy largely be limited to student aid.

There was a widespread attitude that one encountered in the department and in the Office of Management and Budget that physicians and dentists, for example, could look forward to a relatively high income when they completed

their training and that they should be paying a much larger share of the cost of their education and to this end it was proposed that access to the private money market be improved so that they could borrow money and pay more tuition and that the educational institutions find their subsidy through higher charges to the students.

In one area, for example, which represented a program that had been in existence for a long time in the National Institutes of Health, where money was provided for the training of people to work in the field of research or in the field of academic medicine, programs which were called research training grant programs or fellowship programs, it was proposed over a period of two or three years to phase these out completely, the phase-out period being extended only long enough to carry those through the pipeline who were already in some stage of advanced training.

There were a limited number of fields which the Administration recognized as appropriate for continued long-term, essentially indefinite federal sponsorship, and these included biomedical research, preventive medicine and public health, and consumer protection such as is involved obviously in the Food and Drug Administration and in certain aspects of environmental protection.

This was the basic concept. And, of course, for programs which are now part of health resources in the

Administration, this really meant that the entire Bureau of Health Manpower was expected to be eliminated. The organization resposible for the Hill-Burton Hospital Construction Program ekpected to be eliminated. RMP expected to be eliminated. All of the training grant people in NIH expected to be out of business. Those in the mental health institute who were concerned with community mental health centers and that sort of thing expected to be phased out.

Steps were set in motion to carry out reductions in force of major segments of the staff. And those who could began seeking other employment. Staffs began to wither away. And in, I suppose what you might call our clientele, those receiving grants whose employment was dependent on these grants, also began to fade away.

I suppose by now the RMP staffs out in the field, from reports reaching me, are substantially less than half what they were a year ago. Three of the 56, I believe, have gone out of business completely and perhaps a dozen or more of the remaining 53 are operating just at a bare skeleton level.

The review committees which had been in operation to provide preliminary review for this council have been abolished. And these are some of the things that have happened to RMP.

In other areas I am familiar with in the health

manpower area particularly, schools of public health which expected to be cut off last July without any further support have issued pink slips to substantial numbers of the faculty. They have gotten emergency bail out so that none of them has closed. But probably out of the 18 schools perhaps two or three which may very well not survive through the next year.

The medical schools, dental schools, and related health professional schools are faced with a reduction in training grant support, and simultaneous reductions in other forms of institutional support of one sort or another have also rolled back faculties in a number--full-time faculty have been substantially reduced in a number of these institutions.

It became evident by the end of last fiscal year that Congress was going to resist some of the changes proposed by the Administration. And the first evidence of this occurred in connection with the Public Health Service Act. About 10 or 11 major parts of that act the enabling legislation terminated last June.

The Administration had proposed to the Congress that five or six of these not be renewed. None of those, of course as you know, was RMP.

Others included included support to schools of public health, allied health, Hill-Burton, and there were

several involved. Congress, instead of eliminating these authorities in a block action, simply extended all of the expiring legislation essentially unchanged for a period of a year to give the Congress time to consider in depth what precisely ought to be done, what programs ought to be eliminated and which programs ought to be modified.

And so that was the first signal that perhaps the major changes proposed by the Administration would not all of them be carried out.

The next evidence of a substantial difference in the philosophical approach to the health problem I suppose could be and should be read into the congressional action with regard to the appropriation for fiscal 1974. First the House and then the Senate reported out and passed appropriation bills for health which very substantially exceeded the President's budget. And there was a threat of a veto if the appropriations were not rolled back.

And finally conferences were held between the Administration and the conferees, the House and the Senate conferees, which led to a compromise on the appropriation, a compromise which allowed about $1 billion more than the President had requested, and there was an understanding that this would not be subjected to impoundment and that the money would be spent. And this was sent to the White House and was signed.

On the same day it was signed, an announcement was issued that the monies which had been impounded in 1973 would be released. And so this meant that for fiscal '74 at least, programs which thought they were dying suddenly found themselves with more money perhaps than they had ever had for any one fiscal year.

But the question still remained, What about 1975 and after that?

And for us, HMRA, this is still a very important question, and it's important for several reasons. First of all, all of our legislation expires this year, every bit of it, for old, well-establised programs like national health statistics, vital statistics, birth and death records, for all areas of research in the delivery of health services, all the manpower legislation, RMP, CHP, Hill-Burton, everything, all runs out at the end of this fiscal year.

And one cannot at this point in time really predict what the Congress is going to do, because in most of these areas there aren't even bills in the hopper yet.

The House has acted to extend the authorization for health statistics and for the National Center for Health Services Research and Development. But even here they propose to consolidate them. And I for one am not at all satisfied with the action taken by the House, and I do hope that something can be done to straighten this out in the

Senate. It put some artificial limits on the number of projects that one can have in any particular area of health services research and put a limit which is absolutely artificial and there's simply no justification for it, a five million dollar ceiling on the amount of money that can be spent in any one area of health services research.

Now, to me, this is preposterous. When we're dealing with an industry that spends somewhere between eighty and a hundred billion dollars a year, to put a limitation of five million on what you can spend is looney. I do know what this represents. Congress was unhappy with what some of my predecessors did with that authority. But I do believe that they overdid it in putting these limitations on it.

There have been no bills introduced whatever in the health manpower area, no bills introduced in the construction area, and there is a little flurry of bills now as they relate to RMP, CHP, and Hill-Burton, which I'll come back to and discuss a little bit later.

But we really don't know what it is that we are going to be authorized to do six months from now. The straw in the wind, of course, is what's in the President's budget, because that was sent up a week ago. We had a press conference a week ago last Saturday, and the budget went up a week ago yesterday to the Congress. And this budget is a

very spartan budget in the health area.

As an example, the total available funds for obligation in the current fiscal year for the Health Resources Administration are in the order of the general vicinity of $1,800,000. And the budget proposed for fiscal 1975 is five hundred million. And any way you look at it, that's a whopping cut.

The problem is will we repeat last year and end up with a large amount of money over and above that budget or will that budget obtained or may it be even lower that? And frankly I don't know. And it's very hard for all of us, it's going to be hard for you, to know just what to do in the face of this degree of uncertainty.

The largest sums for this administration are not in RMP. The large sums are in health manpower and in hospital construction. And those who are concerned with the administration of our academic health science centers and so on can't help but be nervous about their future and it probably will be months before the legislation is enacted, and I wouldn't be at all surprised if it's a year before the question of appropriations is finally settled.

So, we have ahead of us a long period of uncertainty and I don't see any way out of it.

This has been sort of a kind of rambling presentation, but I think I needed to share this with you

so that you could have a better feel for just what we must attempt to do in carrying out our function over the coming months.

I'd like now to forget about manpower and hospital construction and such like programs and direct our attention to RMP, CHP, and Hill-Burton.

It is fairly clear that a consensus is beginning to emerge, bipartisan, involving both the Congress and the Administration; and I hope the public, although I'm not too sure about that. But there is clearly a consensus developing in government that these somewhat interrelated programs should be consolidated and that this consolidation represents an important step forward in preparing for national health insurance.

There is no point in my explaining to you what RMP does, because you know more about that than I do. But I should make some comments about the rest of this complex. Let's begin with the Hill-Burton hospital construction program.

This is an old program. It has been in operation at least 20 years. It was launched initially in recognition of the acute shortage of hospitals in the small towns and rural communities across the United States. And the federal government, through a formula grant program to the states, undertook to encourage the construction of health care

facilities, primarily small hospitals in small communities and rural areas. This required matching and was obviously a program which was needed. The matching was forthcoming, and I'm sure all of you can point to a number of hospitals that were constructed as a result of it.

As a matter of fact, we probably overdid it. I think there is a general consensus that in many areas of the country we are, as they say, overbedded. We have more beds than we can effectively use, and occupancy rate in some of them is very low. Some of them really have no patients at all.

During this two decades the program has been in effect, the financing of health care in the United States has changed very substantially, and a very large portion of the population is either covered with private health insurance or the elderly and the poor through Medicare and Medicaid. So that that it is now possible for hospitals to build into their day-bed costs, capital reimbursement features which make it possible for them to either fund a depreciation account or amortize consutruction loan. And the need then for federal grants for hospital construction has in effect disappeared in a number of situations.

There still remains a need, and probably an urgent one, to renovate the hospital plants in the inner city, many of which were built 30 or 40 or 50 years ago and are

hopelessly outmoded. They're not even safe from the standpoint of safety codes, and they're dreadful messes with large hideous wards and so on. They're inefficient and they need attention. And they are in communities that generally speaking can't afford to do something about it. So, this is one area that still needs attention.

Then I think probably we are undercapitalized for the provision of ambulatory care and probably long-term care. As one looks forward to national health insurance, the expectation is, I suppose, that the charity patient or indigent patient will not too far down the road disappear from the scene; and institutions which provide care to them, their position will improve with regard to ability to get money in the private money market for hospital facilities.

The expectation is also that the benefit package will be more adequate with regard to primary care and to long-term care, so that the difficulty of amortizing ambulatory care facilities will probably diminish too. But the expectations are that there will still be poverty pockets around the country, economically depressed areas, whic h will not be able to put up enough money to get into the private money market in the first place. That is, they'll not be able to make the downpayment which will permit them to get a mortgage for a new facility.

No, we are proposing, and I think the Administra-

tion will probably propose to the Congress, that a modified Hill-Burton program aimed at providing renovation and ambulatory and long-term care facilities in poverty areas will be proposed and, I imagine, enacted by the Congress.

One of the problems, of course, that would go along with this will be an intelligent decision at the community level as to what facilities are really needed. And I'm sure all of you can view with alarm facilities which have been built or are proposed to be built which are probably not needed and which would just run up our health care bill. And this is where we begin to get into the future role of CHP, RMP, and Hill-Burton. How can we develop an effective apparatus at the national, the state, and sub-state level for planning our health services, determining the resources that are needed, applying whatever regulation is necessary to hold down the costs, and allocate the available resources for the physical plant, what I'm talking about hospital, and also for services of one kind or another which require joint action and which would not get off the ground if one were dependent on the health service industry as it now exists, such things as--oh, you've had a lot to do with developing emergency medical services, coronary care units, in some instances cancer referral centers; current appropriation calls on you to create some arthritis centers, things of this sort, over and above what you would normally

find in a fee for service professional practice in a relatively limited hospital, community hospital service.

How are we going to plan these? How are we going to allocate them? How are we going to regulate them?

What has been proposed in the Congress in the legislation which is now in the Congress is interesting. I won't describe it. You probably are familiar with it. This is the Rogers-Hastings-Roy Bill which would establish at the national level a commission on health, a prestigious advisory body which would advise the executive and legislative branch on health policy.

It would create in each state a health commission with broad regulatory powers, with substantial emphasis on cost containment, and would create at the sub-state or where appropriate, the interstate level, health agencies which really would be a combination of what RMP and the CHP "B" agencies and some of the experimental health service delivery systems and some of the area health education centers have done, not only in planning but also in implementing various forms of community action in the health area.

The law prescribes how these various bodies would be appointed and what they would be composed of, provides for federal funding, essentially hundred percent funding of course of the national commission and the regional health

authority, partial funding of the state commission, and it has some provisions in it for resources that would be pumped into this system, not only to operate the system but also to carry out some of the sorts of things that you have done in RMP.

This bill would provide for a one-year period in which operational support for CHP, RMP, and Hill-Burton would continue, presumbaly at a somewhat reduced level, in order to provide a one-year period for an orderly transition from what we have now to this new thing.

The Administration is putting the final touches on its own legislative proposal, which I suppose will go forward in a matter od days or weeks.

Mr. Zwick, do you know what the schedule is right now for sending this up to the Hill?

MR.ZWICK: No, I don't think you have a date yet. It's premature. It should be within the next two or three weeks, I would say.

DR. ENDICOTT: Well, that will give you a general sense of the timing. It's not too unlike the bill in the House except that it lays greater emphasis on the regional sub-state apparatus and it is sort of silent with regard to the state function in this whole thing and perhaps emphasizes more than the House bill cost containment features.

Almost everyone who has looked at the problem feels

that there has to be a community or sub-state organization which combines some of the features of CHP and RMP and Hill-Burton. So, I think that in planning what we are going to do over the next 18 months it is safe to assume that something of this sort will happen and that we should direct our energies and our available resources as best we can in moving in an orderly way from where we are now to a situation of that kind, and we'll simply have to leave to the Congress the precise terms, precise makeup, of the advisory bodies, precise way in which they are going to be funded, and just how the state government, the local government, will participate in this regional approach which almost everyone feels should be private, non-profit, consortium kind of thing, with representation of providers, of consumers, and of relevant government officials. But just what the mix should be, I think we'll have to wait for that to be resolved.

Where do we stand specifically with RMP?

The court order has been signed directing government to release impounded funds and appropriated funds and to obligate them by the end of this fiscal year under the kinds of terms which existed prior to the time the money was impounded in the first place. And of course the Administration will obey the court order and that part of the hassle is over with.

So, let's see, this is the 12th of February. We

have from now until the 30th of June to obligate a substantial piece of money. I have never been able to find any two people that agreed exactly as to how much this is. The judge refers to $150 million. I can't find that. Others talk about a hundred million. I think that is probably a little bit low. But when the accountants get through with this complicated mess in the matter of another week or so, we'll know exactly how much it is. It's something between a hundred and a hundred and fifty million. And it's probably more than we'll quite know what to do with anyway. So, it's not all that important how much it is.

But we will certainly have enough money to do what it is that we ought to do. And I think we can leave it at that.

An objective appraisal of the situation is that the capacity of the RMP's out there to react has been substantially compromised by this long period of uncertainty and delay. Some of them clearly in worse shape than others, but I think all of them clearly have been hurt.

Furthermore, to look at it realistically, they like we have to move into a kind of uncertain future and will have to ask themselves, What can we do that's worth starting and that reasonably could be expected to continue under the new system, whatever that may be?

This will be a real challenge, and I think we can

get the job done only if each one of us sincerely tries in his own mind to picture what our society seems to be heading toward and what will likely make sense in the light of some health insurance enactment, some change in the organizational structure, and this will have to be done I think mostly at the community level. Communities are going to have to decide what sorts of things could be legally initiated under the RMP authority which they will want and will expect somehow to continue beyond this period of uncertainty.

So, the RMP's are compromised in their ability to react. We are compromised in our ability to evaluate their proposals, since our advisory committees have largely been liquidated and that to our professional and supportive staff a bomb.

In pondering about this problem myself, I think that the council and the staff must place a good bit of dependence on the regional advisory groups for sorting out their priorities, and we're going to have to stack them up one against the other as best we can with the htaff that we have, whatever consultants we can get to help us, and then what you can do yourselves in looking at the material that is assembled by the consultants and the staff for presentation to you for decision.

And I'm sure of course the next day that Herb Pahl and the members of the staff will be working out with you

what seems to be a reasonable schedule for receipt and review of applications. I imagine we'll have to give a reasonable amount of time to the RMP's and to the CHP's to think about this problem and to develop and evaluate their proposals. We don't want to do this in a hasty way. And I'm sure that neither the staff nor this council will want to take hasty action on what is presented.

The one fixed date against which we're all operating is June 30th. The money must be obligated by June 30th. And what this means is that in writing and officially we must commit ourselves as to how the money is going to be spent before June 30th. This does not mean that the recipients of the grants or the contractors have to spend the money they get by June 30th, but we have to make our commitments. And the court order directs us to choose the old and tried and true familiar methods under which the grantees expended their funds.

You know what that was better than I do, but if it is anything like the programs I am familiar with, it generally means that the money is available to the grantees for a period of 12 months after the award is made, and this has generally been subject to extension without additional funds for periods of sometimes several years beyond that period of time.

But the general intent here, the general guideline,

is for project periods that run from a year from the beginning date. And I think that is what you operate from; is that correct?

CHAIRMAN PAHL: Yes.

DR. ENDICOTT: That sort of gives us a framework. We have five months or four and a half months in which to commit monies which reasonably would be expected to be expended within the 12 months following that, under the guidelines and laws and regulations and so on that you operated with before the freeze.

My view--and I hope you will discuss this in the next day--is that in order to get this thing off the ground and flying, we probably ought to convene a national meeting of the RMP's to discuss this with them. And since they will be expected to interact with CHP and Hill-Burton agencies, they probably should be invited too, so that we all have some kind of community sense of what the heck it is that we're trying to do. And I don't know how son such a meeting could reasonably convene. Some notice will certainly be necessary, I suppose. It ought to come in March, early March, I should think.

CHAIRMAN PAHL: We have a tentative meeting of the RMP coordinators scheduled for--what is it, Bob?

MR.CHAMBLISS: March 5th and 6th.

CHAIRMAN PAHL: March 5th and 6th. At the time that that meeting was proposed, we had not invited the

Hill-Burton or CHP people other than Mr. Rubel.

DR. ENDICOTT: You ought to give some thought to this because you're going to have--some organizational changes are going to have to be effected out there, and it will vary from one community to another as to just how they would propose to consolidate, say, "B" agencies or "A" agencies in RMP and Hill-Burton agencies.

So, my feeling is that they ought to be involved, and I think we probably also are going to have to set up some way of communicating with state governments to get them on the track in this area too.

We're expecting momentarily an indication from the Conference of Governors to have a meeting with the governors to discuss this area. But I don't know just when that will come off. But clearly the states are going to have to make decisions as to just how they want to approach this on the sub-state level. Now they want to interrelate these health agencies or whatever it is we are going to call them with other state planning districts in the field of human resources, with such things as PSRO and other types of health activities, and I think it would be a serious mistake for us simply to decree how this is to be done on the national level. I think there ought to be substantial involvement of state governments in working out the best pattern for them from a geographic standpoint as to how they approach this

regional thing.

These, it seems to me, are the tasks which are immediately ahead. We have--I shouldn't say "we," because I am the one who decided to do this--I have already taken steps to consolidate the staffs of CHP, RMP, and Hill-Burton. And to do this at least for the time being within the framework of the Bureau of Health Resources Development where CHP and RMP were already located. What this amounted to was changing a situation so that the RMP staff also reports to this bureau. And Dr. Green, who is director of that bureau, has designated an associate director for health planning who will have the responsibility on an interim basis of coordinating the activities of the staffs of these three divisions. Because we have to get in position staffwise to handle the new system and at the same time to carry on activities which represent the transition from where we are to where we are going to be.

Hill-Burton, for example, has $390 million to spend for hospital construction while we're undergoing this transition, so they'll be plenty busy with their normal business. You have a hundred to a hundred and fifty million, and the CHP agencies are in the process of an intensive evaluation of all of the "A" and "B" agencies and are trying to get operational on section 1122, which some of you may be familiar with and others not. This is a provision in the

Social Security Act which requires that any capital expenditure in excess of $100,000 must be approved by the CHP agencies or it cannot be reimbursed under Medicare and Medicaid, and there are very few facilities in the United States that don't have some kind of interaction with Medicare and Medicaid. So, what this really means is that all capital outlays of $100,000 or more have to be reviewed. And with the thousands of facilities involved in this country, that is a lot of business to attend to. So, CHP has its problems, Hill-Burton has its problems, you have your problems, in just operating and at the same time carrying out a transition.

Now a word about decentralization. CHP and Hill-Burton are decentralized programs and have been decntralized to the HEW regional offices from their very inception. RMP is not. This program has been operated in a very centralized fashion, almost the entire staff being located here in Washington and with minimal participation of regional office staffs and RMP activities.

Clearly in this interim period, we are going to have to bring the RMP organization and staff into line with the others in terms of decentralization. And I have already directed my staff to study what this means and prepare for me an orderly plan for bringing this about. I don't look forward to this with any happy anticipation because we have just been through it in Manpower, which we undertook to

decentralize beginning a year ago today. So, we have abundant and ample experience as to what this means, and it's a problem. And the basic problem is that people don't want to move. And that's no news to any of you. People just hate to move and many of them will not, and we'll have to help them find other jobs and then recruit people in the regional offices to do the jobs that they would have done if they had agreed to move.

I think about 75 percent have refused to move when we were decentralizing the manpower programs. I hate it. I hate it like everything, but that's the way it is. And we'll have to go through with this if we're going to be operational a year and a half from now.

As far as the people are involved, out of the nearly 300 in manpower we're supposed to move to the regional offices, we did succeed in placing--the last count I had was something like 5 or 6 out of 300 we had not been able to place. So, people don't get hurt except they get very uneasy and apprehensive and demoralized, and it's a painful thing to go through, but it comes out all right in the end if you can just live through it.

I could go on sharing my little problems with you for quite a while but I won't. I am going to stop now and ask if there are any questions. I'll certainly try to answer them.

I know I can count on this council to pitch in and help. You alway have, and there is no concern on my part in that regard.

MR. OGDEN: Let me ask you, Dr. Endicott, do we have any authority to re-establish the review committees?

DR. ENDICOTT: It's hard for me really to answer t hat. The only way a committee can be re-established is with the approval of the secretary. He has the authority to re-establish them, in answer to your question.

MR. OGDEN: The reason The reason I am raising that simply is that if we are going to be faced with a heavy flood of applications, complicated applications, from the regions in a very short period of time, it simply physically is going to be more than the limited number of members left on this council are going to be able to accomplish.

DR. ENDICOTT: Perhaps I should not answer your question as you put it but answer it the way you should have put it. Do we have authority to get competent outside advice on these applications?

The answer is I have authority to do that. Can we establish the review committees? I don't have authority to do that, and I don't know I would do it if I could, because it's kind of a one-shot proposition anyway. But we can get consultant groups to look at these things and of course we will.

MR. OGDEN: That is really what I had in mind, whether we call them review committees or groups of consultants or something else.

DR. ENDICOTT: I have authority to convene ad hoc groups, consultants; we do it all the time. And I don't know precisely what you need. But as soon as we find out what you need, we'll do it.

MR. OGDEN: Let me ask you another question, which probably should be directed to Dr. Pahl. How many people do we have left on the staff of RMPS versus what we had before we began this cutback last June?

CHAIRMAN PAHL: Bob has the exact figure. I think it's 96.

MR. CHAMBLISS: Ninety-six on duty now.

CHAIRMAN PAHL: Ninety six on duty, and we had 245 prior to phase-out. And I'm happy to say that the division of operations, which is, as you know, the one that interacts with the regions in day-to-day affirs is almost intact. We have lost a few individuals, but it has been some of the other offices which have been decimated. So that we are in better position, relatively speaking, within the division of operations than the other units that we had prior to phase-out.

DR. ENDICOTT: We are not confronted with doing all of this simply with RMP staff. There are staffs

familiar with handling grants in other parts of HRA, and I wouldn't hesitate at all to comandeer their assistance if the workload turns out to be impossible to handle with the RMP staff.

There are people in the National Center for Health Services Research and Development and in the Bureau of Health Manpower who are old grantsmen, tried and true, and so we'll pitch in. We can even employ part-time outside help to go over emergency situations of this kind. So, we are going to be short on professional staff. What staff we do have is going to have to work like the dickens, and we'll have to improvise. I'm prepared to improvise, you know, do what's necessary.

DR. MERRILL: I think what I have to say is more of a comment than a question. But perhaps Dr. Endicott will have a comment on my comment.

You addressed yourselves to what I consider a very pressing problem, the need for renovating hospitals in poverty areas. And frequently these are the teaching hospitals of medical schools and universities. I am delighted to hear that this problem is going to be looked at very hard, but I am concerned about one aspect of it which I haven't heard discussed, and that is that in spite of the fact that federal agencies and state agencies may be sympathetic with this problem, the problem itself ends up being blocked at the community level because of the fact that these university

hospitals, as they have been traditionally set up--and I believe at least in part should be continued to be set up, are not consistent with the immediate aims of the community. Ambulatory care certainly is one of these. But at least several hospitals which I know are able and have raised funds for reconstruction and rebuilding, have had their efforts brought actually by the residents of the local community who feel that these funds are being applied to serve, let's say, people from other countries or other parts of this country rather than to give total care to the community.

Compromises have been made, but it remains a fact that renovation of good university hospitals, which are 30 and 40 years old, in spite of efforts at the state and federal level, have run into severe difficulties at the community level, to which of course state agencies must be responsible.

DR. ENDICOTT: I recognize the problem. It's a real one. I've had enough traffic with the university community to know that it is a real problem in some communities, and the only answer that I can see is that the university is going to have to develop some way to sell itself to the community, and this is not any one-shot proposition and requires constant effort. Really it's kind of a public education effort to make them aware and to get their support.

I have the feeling that from what situations I've

watched, that if the residents in the community can be given the feeling that the university puts a high priority on the requirements of the residents and that is being reasonably taken care of, that they're then much more indulgent with the regard to more far reaching university activities. But some of the universities in the ghetto, like Temple, for example, have had a hard time of it. It has taken them two or three years really to establish a rapport with the community. I don't know what we can do at the federal level except encourage universities to put this special effort in. I don't know of any legislature or anything that will holve this problem.

Perhaps you do, and I'd welcome it if you do, because it's certainly a real problem.

DR. MERRILL: No, I would agree with you completely. I don't think there is anything that can be done by fiat or legislation. I think it is a problem with education. I think the universities have realized this a little too late, and now they are paying for that tardiness.

CHAIRMAN PAHL: Are there other questions for Dr. Endicott?

DR. FOYE: Yes. You mentioned the CHP, RMP, Hill-Burton potpourri. Isn't AHEC going to be in this as well?

DR. ENDICOTT: I mentioned that once in passing.

DR. FOYE: I didn't hear that.

DR. ENDICOTT: We have not yet done anything organizationally about area health education centers, which has come to the manpower bureau or the--what do they call them, SD's?--experimental health service delivery systems which are under the National Center for Health Services Research and Development. But these are clearly involved and in some communities I think it will be the SD's which will finally emerge as the community organization around which this will be built. And in those communities, RMP and CHP will probably be collpsed into the SD's.

We wanted to make an independent appraisal of the experimental health service delivery systems from the standpoint of their contribution to health services research before slicing the pie. And we will do that.

The area health education centers which were supported out of Manpower--and I don't know what the heck you fellows called them, but you had a kind of poorman's area health education center that was funded through RMP [laughter], and they clearly both fitted into this thing. I really haven't quite sorted all this out yet. But clearly they are involved as indeed are some things which the VA has done, and this is an aside. Of course, one of the big problems that has to be faced up to at National Health Insurance is what does this mean with regard to the Veterans Administeration, and this has been discussed at the top levels in government,

and I get a blow-by-blow account, and it changes almost every day as the various people involved examine this complex problem.

There has been, so far as I can see, no thought at least at present of liquidating the VA system. But there has been serious questions asked as to how best the services provided by the VA should be financed. Should it be by appropriations out of general revenues or should it be collapsed into the trust fund operations of the Social Security Administration and this just hasn't been answered.

There is an interesting thing which you'll bump into tangentially in the coming months, and that is that the VA has been authorized to build eight new medical schools and to provide some operational subsidy in the field of health manpower. And this sort of runs parallel to or it may be at cross purposes with the HEW's own health manpower problems, and we're still trying to coordinate and resolve this between HEW and VA. And since RMP activities certainly impinge on medical schools and graduate education and manpower training, you ought to at least know that they are out there doing something. I'm not quite sure just what and neither are they. They don't know what their appropriations will be.

I think you have what--twenty-five million?

DR. FOYE: Forty-five in the House,twenty-five for the eight new state medical schools.

DR. ENDICOTT: Anybody who has started a new medical school can tell you $25 million doesn't go very far in starting eight new medical schools.

DR. FOYE: Of course, it's intended it's almost earnest money.

DR. ENDICOTT: Undoubtedly we'll be called upon to put up bricks and mortar money and capitation, and it's a complicated mess. But there is a fellow by the name of Representative Teague from Temple, Texas, who was determined to have a medical school in Temple, Texas, and this is what finally emerged.

DR. FOYE: This is also the old instant medical school business.

MRS. MORGAN: Can Hill-Burton remodelization or construction or whatever it turns out to be really be accomplished if hospitals are still in Phase Four?

DR. ENDICOTT: Well, yes, I think so. The money I'm talking about is grant money. It's close to $400 million and, you know, you just give it to them and that's the end of it. But in terms of loan guarantees and interest subsidy, this becomes more complicated. And Phase Four has never been intended to impair the institution's ability to amortize its indebtedness. It was not intended to erode their ability to service debt. If it did so, then the Cost of Living Council did it inadvertently; I'm sure that that was

never the intent. The intent was to prevent inflation and not to interfere with their paying their bills.

However, anything as big and cumbersome as that sometimes results in thing not intended, and I'm sure that you could quote some examples to me where it didn't work out just right.

This is one of our other anxieties. I thought you had enough to cope with today, so I wasn't going to bring this up.

The Cost of Living authority expires the 30th of April, and there are many people in the Administration, probably a good many on the Hill too, who feel that some areas of the economy should not be freed. And of course one of them is the energy area, which we read about every day in the newspaper, and the other one is the health area. And Congress is going to have to make some kind of decision in the next six weeks as to whether they are going to continue some form of cost control in the health area or they are not. And if they do, how are they going to do it. And the only thing that bothers me about it is that it might get sawed off on us. And that's one task I'd just as soon not have to face. I'm hopeful that the Cost of Living Council will be continued and, if they maintain controls in the health area, that those controls will be operated through the Cost of Living Council and we will not be asked to add that to what

we are already doing in capital outlay, because we're simply not ready to get into the question of rate reviews and so on for hospital services.

I'm enough of an optimist to keep thinking this won't happen to us. But I suspect that there probably will b e some continued restraint in the health area somehow even beyond Phase Four. I don't know, but I would guess that it probably will.

It seems to me that if all restraints are taken off and we enact some broader coverage in national health insurance, we are going to start an inflationary spiral just as sure as the world. And I hope that we don't do that.

The prospects for some form of national health insurance being enacted by this Congress have changed remarkably during the last few months. People like Senator Bennett were talking about enactment by 1976 just a few weeks before Christmas, and now everybody is blithely talking about enactment by this Congress, which means less than a year.

No, cost containment is something that will have to be faced up to.

CHAIRMAN PAHL: Are there other questions from the Council to Dr. Endicott?

Because of the wide range of important topics that Dr. Endicott covered, I'd like to take this opportunity also

to ask whether any members of the public have a specific question. This is an unusual opportunity to get a survey of the overall picture of current legislation and all of the RMP aspects which we will be discussing further today, and I wonder if there are any questions from those who are attending from the public sector.

Dr. Gaye, would you please identify yourself for the record.

DR. GAYE: The microphone is disconnected.

CHAIRMAN PAHL: We can hear you pretty well.

DR. GAYE: All right. I'm Dr. Gaye, the coordinator of the New Mexico Regional Medical Program, and I'd like to ask Dr. Endicott if he would encourage us out in the field to begin preparations for this new consolidation of these units, CHP, Hill-Burton, and RMP.

DR. ENDICOTT: Yes, sir, I certainly would. I ought to know New Mexico better than I do, because I'm a native of Colorado but I've been away for a while and I don't know precisely what your situation is there. I suspect that you're one of those lucky states that won't have too much trouble accommodating to this. Because, you know, those are good states out in that area [laughter].

But I would certainly encourage you to get yourselves assembled out there and decide what you in New Mexico would like to do.

CHAIRMAN PAHL: Are there other questions?

If not, I want to thank you very much, Dr. Endicott, for being able to spend this greath length of time with us and giving us all of this current information.

DR. ENDICOTT: I hope I didn't waste your time.

CHAIRMAN PAHL: Not at all. We appreciate it very much. Thank you.

Dr. Margulies is here and will be able to meet with us after the coffee break.

Harold, would you like to say anything immediately?

DR. MARGULIES: Shall we have some coffee.

CHAIRMAN PAHL: All right [laughter].

Perhaps this would be a good point to adjourn to the cafeteria for coffee and then we'll pick up again with Dr. Dunn's presentation immediately following the break, and perhaps we could come back in 15 minutes and bring our coffee with us, if possible, because I think we have a full day, and you see some of the things which we'll have to be discussing. So, try to make it 15 to 20 minutes. Thank you.

[At this point the meeting recessed for a coffee break and then reconvened as follows.]

CHAIRMAN PAHL: If we may reconvene, Dr. Margulies can spend a few more minutes with us, and I've asked him to perhaps add a few words to what Dr. Endicott said before we turn over to Dr. Dunn. Harold?

DR. HAROLD MARGULIES: Thank you. I would like to just come down more sharply on a couple of points that you may have some concern with.

I would, before I dot it though, like to comment on the fact that I'm pleased to see Dr. Pahl here. Some jughead from the Blue Sheet commented on his being away as though he was basking in the sunlight when he's down working very hard on something which very much needs to be done, which is really no joy. I don't understand how people managed to write such nonsense as was written on this particular occasion. I don't think we have any copies left. They've probably been flushed by now. But generally speaking it's a silly kind of attention getting device.

Having gotten that off my mind, let me say a couple of things to summarize more specifically what we can anticipate with RMP.

As you know, there is a court order and, although I have not seen a copy of it, I understand one has been completed. I've seen a copy of a signed order or a portion of it, and I assume that is official by now.

Has it been received officially, do you know?

CHAIRMAN PAHL: Mr. Lanman from general counsel's office, could you comment on the status of how long we have before the government may appeal for any modification in that court order?

MR. LANMAN: We have ten days from February 7th if we do want to try and mandate part of the order. It is an official final court order at this point.

MR. MARGULIES: On the assumption that the court order is going to remain as it has been written and not trying to guess about appeals and so forth, because I don't know about those kinds of processes and I assumed that they are under consideration, it does at least resolve some of the confusion about the RMP funds and does provide us a clear-cut challenge in terms of what we do in the future.

To summarize what Dr. Endicott has said and said again in response to his questions, it is a general hope that there will be an effort to move toward something at the state and intra-state level which represents what we have talked about over the last several years in this council and elsewhere, and it also represents a political structural move which has been underway for a number of years, even preceding I think the entry of the current administration into office and that is a move toward stronger state and local government activities in determining a number of social program directions.

If we move as either the bill is in the House would have us move or as the Administration is proposing or as others are proposing, the issues will be joined in some form of planning, in some method for better implementation

of actions based upon planning, and a greater emphasis on regulatory activities than I think most people had realized earlier.

One reference was made to regulation as it has to do with construction of new facilities, but there are unquestionably other regulatory activities with which we will be concerned over time. Cost of Living Council activities is one reference. But certainly if there is national health insurance, there will be additional regulations. So, we are talking about what will represent the most critical and influential elements in the future of health care delivery in this country. It will take place by some merger of current activities, hopefully drawing from the experience in all these programs, RMP, CHP, SD's, AHECS and so forth, and it will depend upon a combination on a collaborative basis of people who have been in planning, in various kinds of implementation in the types of activities RMP has been in, with a much closer tie among those, between those, and between that combination of groups and state and local government.

It clearly is up to the regional medical programs, as the court order has been written, to take the lead in determining how rapidly and how effectively we move in that direction. Nobody can force a judgment on regional advisory groups, on coordinators, and on their staffs.

What we have is a clear statement by the court that we return to the practices which were followed prior to 1973 and carry out the program as it was determined to be the correct way at that time.

The judge has no reason that I can find to take into account anything which has occurred subsejuent to the date on which the judge has determined an illegal impoundment occurred. What he has said is, "Go back to where you were and start it over again," and that is a reasonable thing to do because it was at that point that, according to the court, the proper processes were dropped and incorrect processes were adopted.

We therefore have left a process, but many of the standards and the benchmarks that we had at that time have disappeared. quite clearly relative performance levels are not what they were, and yet we have to perform in the same way.

We do have a mission statement which was adopted by this council and which is one of the points of reference in the court order.

Under these circumstances, my own judgment--and this is a personal one--I haven't compared it with the rest of the Administration, but I know that Dr. Endicott shares it--is that this decision by the court can be used to move more rapidly in the direction that Congress and the Administration

wants to go than anyone had envisaged. It provides an opportunity to work through the regional medical programs to do things which need to be done and which, so far as I can tell, the majority of them have long recognized as a sensible direction for them to move.

It would be very foolish, however, for us--certainly for me--and I think my colleagues here share it, to tell the RMP, the coordinators of the Regional Advisory Groups, that we have now decided how this program ought to be run and we'll explain it to them. In fact, that has never been the view of this staff or this council.

We have found that regional advisory groups, coordinators, staffs, and those with whom they work have wisdom which is applicable to the area within which they work, and have used with great prudence the funds which have been available to them, have learned to review and attest to the effectiveness of projects, and have begun to develop evaluative techniques which are worthwhile.

They know more about CHP "B" agencies than we do. They live with them. They know relatively less about state and local government than they ought to, but they know that, and that varies from region to region.

And what I am saying essentially is that we ought to work as rapidly as we can to work with and through the RMP's with the funds available to do the job that needs to be done

if there is agreement that that's what the job is.

There are some practicalities which are involved in this too. As Dr. Endicott indicated, the court says the money needs to be ogligated. Obligation means that we must have decided that the RMP's will receive that money in some kind of manner consistent with past practices so that it's available to them to use.

It also says that we can't put it out there and tell them you can't spend it yet. The court order clearly prohibits that.

The court order also says that you can't put that money out there and restrict the kinds of things for which it can be used so that it delimits other than has been agreed to prior to February of 1973. In other words, we can't put it out there and say it's all there but you have to spend it only on X which we decided recently is a good idea.

So, we're pretty much back in business as well as we can be to do things the way they had been before. Clearly this money needs to be expended over a long period of time than would have been the case if it had been made available in the year in which it was originally appropriated or at least in which the Appropriation Act was proposed and a continuing resolution was put in place.

So, the June 30th date has no meaning as it had up

to the present time, excepting as the court determined that those funds needed to be obligated.

I regard this as an opportunity for organizational and administrative collaboration, innovation, and probably on the part of the RMP's themselves a level of high diplomacy and compromise, so that they find that what they have achieved over this long period of effort has a firm base in the future but not of necessity representing exactly the things that they intended to do in 1971 or 1972, a new direction and a new purpose.

If there is to be a national meeting of the coordinators, and I believe that there will be and should be, I feel a little uneasy, and I'd like to have your advice to Dr. Pahl and the others on this, about trying to have a meeting as early as next month, with all the coordinators and probably some RAG representative as well as those from CHP "B" agencies, SD's, and so on. We are much more likely to have an unwieldy number of individuals with diverse views.

I think we need to move more rapidly to areas of reasonable agreement at different points and then come together very rapidly.

But, so far as I'm concerned, the most urgent issue is to act at the level of state and loca activity as rapidly as possible so that in every state where that

appears to be desirable on the part of the RMP's, CHP's, and others, there is a quick meeting and a beginning of negotiations to bring together government, providers, planners, in what will represent a new form of implementation, planning implementation and regulation.

I am confident that that is going to have to develop in a different way, accoording to the states in which we work and according to what their habits are, depending upon how much regulation they have already experienced, depending upon what their resources are. That is the nature of RMP and CHP in the past.

I think it would be very foolish to try and prescribe the manner in which this should be done. But I do think that we are going to have to do that promptly, if the money to be made available between now and June 30th is to be used as effectively as possible.

Please also note that the Court order has responded to the plaintiff suit on FY '74 funds and indicated that they also may not be impounded, that they as appropriated must be expended under the same system and with the same constraints as for the impounded funds of FY '73.

In essence, what they have said is, "You shouldn't have impounded last year, and you may not impound this year," which is fairly clear. That means that there will be a significant amount of money available to the RMP's to expend

in judicious ways. I see nothing more to add to those statements.

I think you understand the dynamics. What does concern me is the extremely short period of time which is available to do what requires a high level of imagination. The main benefit which we have had--and I suppose from every kind of wandering from the true path there is some benefit--is the fact that the regional medical program leadership has remained intact, coordinators have talked with one another, they are close to the movements of legislation, they do understand the purposes of these combinations, they do recognize that national health insurance is coming along, and they have remained available at all times.

And, as Dr. Pahl has pointed out, the key members of the operational staff rmeain here and a good many other people are available. This to me represents a real opportunity and one which was not anticipated but can be utilized in a highly effective fashion. I hope that's the way it will happen.

CHAIRMAN PAHL: Thank you, Harold.

Are there any questions on these points?

I would have one--I believe it's a correction to make which has to do with the interpretation of the court order which you have not seen.

The fiscal '74 funds must be obligated in full by

June 30th, this June 30th. There is no question about that. The fiscal '73 funds are not required to be obligated by June 30th, but we would make every effort to do so, because the wording is such that the government is directed to take such administrative action as is necessary with such speed as is administratively feasible to implement the awarding of the full appropriated sum for RMP for fiscal '73. So, we don't really have stated in the court order that it has to be June 30th for the fiscal '73 funds, but I think it's quite clear that the intent is to take actions as quickly as possible with whatever administrative requirements there are in this regard and certainly I believe we will try to accommodate both the fiscal '73 and '74 funds by this June 30th.

MR. MARGULIES: Part of the time he has been spending has been in a short course in practical law.

MR. LANMAN: If I could just add to what Dr. Pahl said, he is absolutely correct as far as the court order saying with such administrative speed as possible--or I guess administratively feasible, whatever the exact words. However, by law the FY '73 funds are available for obligation at the federal level until February 7, 1975. So, they are available for obligation for that long, and that's by reason of section 501 of 9345, the supplementary appropriations act, which says that when you get a court order relative to '73 funds,

those funds are available for one year from the date of that court order.

CHAIRMAN PAHL: Thank you very much, Mr. Lanman.

MR. LEMKE: Mr. Lemke from Wisconsin. In view of the fact that it's very urgent that action be taken immediately and also in view of the fcat that Dr. Endicott mentioned the need for decentralization--and also in my experience, every time you move you lose your files for about two or three years--and adding to that a comment that a large share of our decision process is already at the local level their own regional medical programs and in their regional advisory groups, what would your evaluation of the necessity of decentralizing the Washington staff be.

CHAIRMAN PAHL: The decentralization that Dr. Endicott is referring to is decentralization from headquarters to the regional offices. And I think the point is that this is a federal initiative for all programs, and certainly it is a major initiative in the health programs. And, as he indicated, it's a question of when and how it will be carried out. So, I think it would be somewhat inappropriate for me to comment on the advisability of it. That decision has already been made.

We will decentralize. The question is, How will this be done and the timing of it? And we have had some discussions in recent weeks with our staff which have

indicated that this is coming but I believe I heard this morning that perhaps it's a little more imminent than I for one had anticipated.

We will work do make this as orderly as possible and to try to make it as effective as possible, and I'm sure we will have the full support of our agency to give us some guidance in this matter, because certainly all decentralizations don't work well, and we'll try to benefit from prior experiences.

MR. MARGULIES: I don't think that the question of decentralization will be an issue in the very rapid kinds of activities which have to take place as they affect RMP functions in the next several months. I doubt that that will occur.

On the other hand, if there is to be as much decentralization of responsibility and function to state and local government as we anticipate, then it makes no sense for some programs to be highly decentralized, others fully decentralized, and none not decentralized at all.

I am hoping that the real decentralization which will occur will be from one kind of government to another. In other words, from federal to state. I have never felt that decentralization to a regional office is enough; but the decentralization should be extended beyond that, which is the direction we're now moving.

MR. CHAMBLISS: I think I should make the observation to the staff that about three weeks ago when we had our staff briefing on the proposed new legislation, I did make the observation that Dr. Endicott's views were that HRA should be a model for decentralization, and it's sort of inherent in that whole point, that I think this discussion about decentralization of RMP is taking place.

CHAIRMAN PAHL: We'll come back to some more of this in my report to you. But I'd like now to turn to Dr. Marvin Dunn as the Deputy Director of the Bureau of Health Resources Development in this agency. As Dr. Endicott indicated, our program has been moved from its former bureau position and under Dr. van Hoek into this new bureau, the third bureau of the Health Resources Administration. And Dr. Dunn, as Deputy Director, would like to say a few words concerning the bureau and the reorganization that has occurred.

DR. DUNN: You'll notice on the agenda that I'm down to speak for a very few minute, very briefly, and I'll try to do that.

There are two reasons why we said this would be very brief. One is that we knew Dr. Endicott would cover the major details, which in fact he has. And the second one is that organizational arrangements in the federal government are a little bit like the esoteric subatomic particles. People that deal with them describe them in great detail.

They write about them and fill the journals. But in real life they seem to last for a very brief millisecond.

What I am going to tell you about the organizational structure is as it was yesterday. I have not received word yet today that it has changed, but before your meeting is over, in fact it may change again.

I have put on the blackboard a very brief outline of the organizational structure of the Bureau of Health Resources Development. It's actually very simple in concept in that the residuum of the Bureau of Health Manpower Education is now represented by four categorical divisions, the Division of Medicine, Nursing, Dentistry, and Associated Health Professions.

The Associated Health Professions include allied health, optometry, podiatry, veterinary medicine, pharmacy, and public health.

The intent actually was to put these into a center but we're told that the Public Health Manual on organization doesn't allow us to do that. So, we're doing it functionally but not structurally. And there will be an associate director for Health Manpower who will be responsible for integrating these categorical divisions into a functional entity; hopefully it will be somewhat reflective of the way health care should be delivered in an integrated and coordinated fashion.

Likewise the initial intent was to have a center for health resources planning, and likeise the manual didn't allow that center either. So, we had a division for CHP and one for Hill-Burton which is called facilities utilization. And more recently with the activities for integrating health planning, we said there is no need for a special act of Congress to integrate the functions of RMP, CHP, and Hill-Burton. We can do this on a functional basis, and it was for that reason that Dr. Endicott said that RMP would be now viewed in this bureau for such purposes.

Mr. Eugene Rubel has been named as the Acting Associate Director for Health Resources Planning. And it's his responsibility in that position to move the three units toward an integrated form or more appropriately an integrated function, because we don't know what the form will be until the legislation actually comes out.

To finish off, as Dr. Endicott mentioned, many of the bureau's programs are decentralized to the ten HEW regional offices, and we have an associate director for operations; Dr. Harry Bruce is in that position. And his office serves as the major link then between the bureau and the ten HEW regional offices for ordinary grants and policy coordination.

I have put the names of the individuals who are the division directors if these are of interest to you at

the moment, and I don't want to give you more detail about the organizational structure than you'd really like to have.

Let me stop at this point and see if you have any questions and remind you that Gene Rubel is going to be here this afternoon and will go into whatever detail you would like to go into in terms of the proposed legislation that's in the hopper, what the Administration's proposal is, and what the thinking is at this point in time for moving in that direction.

MRS. MARS: Once these three ar integrated though, who would run them or who would direct them? Would there be a person taken from what section, in other words?

DR. DUNN: No decision whatsoever has been made in that regard.

MRS. MARS: Are you talking about the Department of Health or where would it come from, in other words?

DR. DUNN: We don't know what the form and the structure of the unified health planning program will be, for example, at the area, the regional, the state, and the national level. We know that whatever it is, that in order to work, we are going to have to draw on the strength of the current RMP's centrally and in the regions, CHP, and Hill-Burton.

Therefore, an effort must be made at this time to sustain the strength of these organizations as they now

exist. And so there will be no attempt to integrate them formally in a structural way now. And we'll make those decisions when we see what sort of organizational pattern should be developed. No one has been preselected to head this up, I can assure you that.

MRS. MARS: Yes, but I was just wondering where the director would come from, whether there was any idea at all or any conception what type of person would be chosen; who is going to dominate there, in other words, is what I am saying. Somebody is going to dominate, CHP or RMP.

DR. DUNN: I really doubt that anyone in that job is going to dominate. He would have to have the skills and the combination of Jesus Christ and Henry Kissinger and a few others to work this out [laughter].

CHAIRMAN PAHL: Are there any other questions?

Thank you very much, Dr. Dunn. All will accommodate, none will dominate [laughter].

MRS. MARS: That sounds very nice too.

CHAIRMAN PAHL: Well, you see life remains interesting.

Let me go on. We have quite a full day and we don't want to take too much time. We have several reports which we want to get to in just a moment. But let me mention one or two things which came out of this morning's activities. Obviously with the court order being signed on

February 7th, with an appeal by the government being possible up to February 17th, we have chosen not to distribute the "final" court order to you, because it has been our experience this past year that every time we distribute something which is final, we have to come back and give you another xerox copy.

So, we will wait until Mr. Lanman advises us that all hurdles have been overcome and when we have what is truly the final one, which may be in hand at the moment, then we will send to you the exact wording. You have the intent of that court order, and we'll be glad to give you as much interpretation as we can at the moment.

But with the assumption that the court order as written is what will stand as the final order, we are being called upon before June 30th to obligate the remaining '74 fiscal funds, which approximate $32 million. We are called upon to obligate with all deliberate speed the released fiscal '73 funds which approximate $95 million.

As Dr. Endicott and Dr. Margulies both either stated directly or implied, we are at this stage not quite where we were prior to the phase-out. We do not have a review committee, but we will use outside consultants as a preliminary review body prior to the next meeting of this council for the review of applications which we will request regions to submit to us.

The court order says that all funds from '73 and '74 will be obligated, and that is our intention. Therefore, we will have to ask regions to submit proposals whose sum will exceed what it is we had to distribute so that if there are decisions by the council of an adverse nature in one region or another, there will be sufficient proposals to account for all the funds that we have to make available to the regions.

We have a number of administrative problems internally which we haven't brought to you, and I don't think I will. But there are certain things as space and personnel dislocations which tend to keep things a little bit confused internally. And so we will have a very buy time over the next few months.

In this regard, I would like at this point I think, therefore, to indicate to you something about the scheduling without at the same time trying to pretend that either Mr. Chambliss or I have all the answers for all the many questions that are going to have to come up over the next few months.

It seems, first of all, that to have the March council meeting as we had originally scheduled for March 12th and 13th, is not particularly appropriate, and I would like to cancel that meeting date. We won't have any applications for you to review. And we think it's too close

to the present meeting for us to have that much to bring before you.

It has been suggested by staff, who have given considerable thought to these questions, that perhaps a rescheduling of the March meeting to March 26-27 might be appropriate, if that could be accommodated by your schedules. And the reason for that--let me just proceed a bit--is because during this interim since we last met, there has been an agreement between RMPS and the steering committee of coordinators to hold a national meeting of coordinators on March 5th and 6th. That had been scheduled for Dallas, but apparently this may be able to be shifted to the Washington area in order to accommodate the schedules of some of the agency people, such as Dr. Endicott and Dr. Margulies.

I think that we have to reconsider that date for a moment, because Dr. Margulies is a rather key individual in such a meeting, and I learned this morning that he may just be getting back from his own official trip to Russia about the same time that national coordinators meeting would occur and since that meeting is not just to deal with RMP activities but is to concern itself with CHP, RMP, AHECS, Hill-Burton, and so forth, it would seem that it's very important to make certain that we have the deputy administrator or the administrator present for a good portion of that

meeting because it is the government's position that will be of interest to those who come to such a meeting.

So, at this point what I would like to suggest is that we try to determine--and I'd like to have some advice from you as to what dates might be appropriate in your calendars, but that we reconsider, Bob, the March 5th and 6th meeting after we're able to determine whether Dr. Endicott or Dr. Margulies in fact can be present. Because, if not, the meeting would truly suffer. Too much is going on at high levels that must be imparted to those that make the trip and spend the time in Washington and it would be necessary for that.

So, we will have to reconsider the March 5th and 6th meeting. We would, however, like to say here that we would hope that all of you as council members could make all or a portion of the meeting whenever it is to occur, and we will inform you as soon as we can clear the calendar for that national coordinators meeting. So, you have that invitation and if new council members are appointed prior to that meeting, then we will extend that invitation to the new council members also.

With regard to the council meeting dates, it would seem to me appropriate to have a late March council meeting, and the staff has suggested that March 26-27 might be a good time. This would not be to take action on any applications but merely, if you will, to review and provide advice--and

we sorely need advice--as to how to proceed over the coming months in terms of policies and directions. And we don't know exactly what dates are best to have a meeting, but that seems to be one that the staff felt was appropriate.

I'd like to have an expression from you as to whether those suggested dates fit in with your calendars.

MRS. MARS: I think it's all right for me. I came off stupidly without my diary this morning. But as far as I can remember, it's all right.

MRS. MORGAN: Fine with me.

MR. HIROTO: Is there any difficulty in scheduling these meetings for say Monday and Tuesday rather than Tuesday and Wednesday?

CHAIRMAN PAHL: There is an internal difficulty, but that can be resolved. The internal difficulty has to do with such things as unavailability of xerox machines over the weekend, the things that control our lives. But that's very minor, and I'm sure the government can find a way to unlock machines for us. There is always a lot of last-minute preparation work which is difficult over a weekend when you are part of a bureaucracy. But let me say that we will arrange the dates to fit your convenience, not ours.

MR. OGDEN: I want to speak to this point again as I have before, because coming from the West Coast, this takes three days of my week. And indeed by the time I come

back on Thursday morning, my desk is loaded and the only effective day that I have in the week is Friday. So, to come to this meeting takes in effect four days out of my week. If I can fly east on a Sunday, go to a meeting here on a Monday and Tuesday, I get more effective time, and I cannot take the kind of time away from my business that this type of meeting schedule begins to require.

My time is fine except for the week of the 18th of March at which time I cannot be out of Spokane because of the annual meetings of my company.

CHAIRMAN PAHL: Let's go back and ask about Monday-Tuesday, which would be March 25-26.

MRS. MARS: I know Monday is no good for me.

CHAIRMAN PAHL: Monday is no good for you?

MRS. MARS: No, because I'll be in California and I know I'm not coming back until the 27th.

DR. MERRILL: I'm afraid I'll be in Peru.

CHAIRMAN PAHL: You don't sound disappointed.

That eliminates Monday, I think, from an effective meeting. I'm not sure that we need a two-day meeting. That is another matter. And perhaps if we just had it on one of the days, that would help matters if we had to hold it not on Monday this time, although we would try to accommodate.

MRS. MARS: What about moving it then to the end of the week, to the 28th, Thursday the 28th and Friday the 29th?

Would that be of any help?

MR. OGDEN: If it is going to begin the morning of the 28th, I have to start flying on the morning of the 27th, during the day of the 27th.

MRS. MARS: Have it Friday the 29th, and then if necessary work Saturday morning.

CHAIRMAN PAHL: Friday the 29th?

MRS. MARS: With the idea that it could be extended to the 30th.

CHAIRMAN: Let's set Friday the 29th and Saturday het 30th. And as we get closer to the point, we will be able to inform you from our point of view whether it will be necessary to move over into Saturday. But please keep both the 29th and 30th of March open then.

MR. CHAMBLISS: I think the council should know we are getting used to working Saturdays now [laughter].

CHAIRMAN PAHL: That implies something. I don't think it's true.

I'd like to look at the June council schedule possibility, because this is the time in which we will have to ask you to take action on the review and recommendations on applications. This is where the business end of the fiscal year will be accomplished, and the staff has suggested--and again this can be modified, I'm certain--they had suggested June 5th and 6th. The way we arrive at our dates, which are

suggested to you, is to back up from our workload of deadlines, of obligation documents and so forth and arrive at that point which seems to be as late as we can hold a council profitably. But again that's midweek, Wednesday, Thursday. And we can move it either way in the week, but it would be preferable, I suspect, to move it earlier than it would be later.

So, here is where a Monday, Tuesday perhaps could be accommodated, again if your calendars would permit, and then we'll make the necessary arrangements here to fit that in.

MR. OGDEN: It may be an impossibility for me.

CHAIRMAN PAHL: That week as a whole.

MRS. MARS: I just don't know.

MR. OGDEN: I say that only because I am the chairman of the board of a school that will hold graduation ceremonies that week, and I am deeply involved in several activities that will occur during that week.

MRS. MARS: I've got a granddaughter graduating that week from high school.

CHAIRMAN PAHL: Perhaps since some of you don't have your calendars and there seems to be something here, let's--

MRS. MORGAN: Can we schedule the June meeting in March, or is that enough time to get into the Federal

Register?

CHAIRMAN PAHL: It's enough time to get it in the Federal Register. It's a matter of the simple expedient of reserving rooms and things of that nature. And, of course, we may have new council members by that time. Perhaps what we should do is get in touch with you about the June meeting, because we will have to have that. That will be a crucial meeting because we will be deciding on the allocation of the funds.

MRS. MARS: Can't we decide in March on that?

CHAIRMAN PAHL: Yes. I think as soon as we get new council members we had better make the decision on the June council meeting, because one just doesn't get meeting rooms in Washington in June that easily. It's really quite complicated. And I think we will hold this off then for a little bit.

MR. CHAMBLISS: Can we get the date that would be acceptable to most?

CHAIRMAN PAHL: We can get the date that is acceptable to most, but Mrs. Mars doen't have her calendar and that week is out.

MRS. MARS: My mind is just absolutely blank about it.

CHAIRMAN PAHL: Do you have any problem?

MRS. MORGAN: I have no problem.

MR. HIROTO: I don't know when my son graduates.

DR. MERRILL: I'm all right in June.

CHAIRMAN PAHL: We'll be in touch with you in the next day or two to get your calendars, and then we'll fit that in as best as we can with new appointments that we do expect to come through hopefully quite soon and then arrange a meeting date.

In terms of other reports, and I'd like to move along rather quickly, we have two activities that have been going on which we'd like to describe to you in just a bit more detail. Dr. Endicott referred to legislation that had been introduced as well as the Administration's position. And in our organization Mr. Peterson has been intimately involved with a task force and part of a larger group within the agency in looking at the legislation which has been introduced and also the Administration's yet to be introduced bill. And I've asked him if he will please summarize that for us and also treat in a very brief fashion an important facet of the emergency medical services legislation which is very important that you understand, because it places a restriction on what RMP's will be able to do in the future in this particular area.

So, Pete, if you will give your report, and then we will have a report on the arthritis centers.

MR. PETERSON: As Dr. Endicott indicated, there has

long been talk about the merging of CHP and RMP, and we are now beginning to see some legislative reflection of that. We will be handing out to you copies both of the one bill which has been introduced and a summary of it, which is a lot easier reading. It's four versus 66 pages.

As I indicated, to date only one bill has been introduced, and that's House 12053. Essentially the best way to describe this briefly is, I think, in terms of the new sets of institutions that it would propose creating and the panoply of functions that those institutions collectively and individually would be responsible for.

The bill has four basic parts and in a sense would create four new sets of institutions, or three, depending on how you look at Hill-Burton. It would establish a national council on health policy in the executive office of the President, modeled after the Council on Environmental Quality, a high-level, prestigious, full-time council.

It would establish at what we think of now as the areawide level a series of organizations which this bill calls health service agencies which in a simplified way reflect sort of an amalgam of RMP and CHP.

It would also create at the state level a set of institutions called state health councils and in addition it would establish or re-establish or modify some kind of construction program. I'm not sure whether Hill-Burton

survives as an anstitution. That's why I said three or four.

Among them, these several new sets of institutions have I think an expanded range of functions and authorities beyond what the existing agencies have had.

For example, there is provision for the establishment of national health policy, whether that's real or not. But certainly it envisages a single voice in that regard. There continues to be a planning function. It provides for certification and recertification of all health services at the local and state level.

It envisgaes that the health services agencies, for example, would have review and approval authority over grant proposals coming under the Public Health Service Act and several other acts; so that instead of the old review and comment authority, there would be review and approval authority.

There is provision for health services development or implementation, that part which I suppose is most akin to what RMP has been up to in recent years. And there is a good deal of regulation both as it relates to certificate of need for facilities but also at state option rate review and rate setting.

In one sense, I suppose, it's a good bill in that it tends to raise most of the important issues that, it seems to me at least, require some debate and discussion. In other

ways it may be less of a good bill, but at least it gets a lot of the issues on the table.

As Dr. Endicott and others have indicated, it seems quite certain that there will be other bills. There is an Administration bill that we have been told that we could anticipate for the past two or three weeks. But I think clearly there is going to be an Administration bill. From what some of us have seen of earlier versions of it, it will probably be quite similar in many of the salient aspects.

It does not, on the other hand--or it did not--provide for a national council on health policy. It would treat Hill-Burton in a separate piece of legislation. There are--I'm sure there will be--a lot of differences as far as nomenclature is concerned and also as far as many of the particulars are concerned.

We're also likely to see a bill along these lines introduced in the Senate, probably by Kennedy and Javits. But again I stopped holding my breath waiting for that one to be dropped in the hopper.

We also are likely to see, because this bill that has been introduced in the House by Representative Rogers on behalf of himself and representatives Roy and Hastings, I think does not necessarily reflect what each of them as individuals would necessarily like to see, but it was a way of getting something on the table. And it's quite possible

that one or more of them will be introducing so-called unified health planning bills that are more closely akin to what they would like to see.

I'd like to say a few words about the prognosis for this area of legislation and when and in what form, and in doing so I think I ought to throw out two caveats. One is that this is my best professional judgment. I have tried to keep my personal biases out of it. And, secondly and perhaps more importantly, I've been wrong before. So, don't b et on it.

It's interesting to note, I think, as an aside to this that both the CHP's--and now I'm talking about the agencies out there--as well as the RMP's, and the best I can ascertain most other groups, are taking a sort of wait and see attitude. They want to see a range of bills put on the table before they officially comment or commit themselves to supporting or opposing specific bills. And that has been made explicit, certainly by the RMP Steering Committee and Executive Committee; that doesn't mean that individual coordinators may not have specific opinions about specific pieces of legislation or specific aspects of it.

Similarly I think to date we have seen very little support or opposition expressed in terms of the one bill that has been introduced. There was some sort of vague statement--that's my word--there was some sort of statement

by the AAMC that I interpret as being generally supportive of the Rogers Bill.

On the other side of the fence, the Association of State and Territorial Health Offices, I gather, are very upset, to put it mildly, by the Rogers Bill. But there haven't been many people who have chosen sides as yet in this because it is a single bill.

As I say, this is my judgment and really reflects more a synthesis of what I hear other people saying, sometimes by devious channels and a lot of them by indirect channels. But I question whether there will be legislation enacted this session, certainly not by June 30th, I think.

But we will really have a better idea of that in a month or six weeks time. If we see a wide range of bills laid out, I think that may be a signal about some things. When the Rogers Committee decides to begin holding hearings on this particular legislation may also be a clue as to whether we're likely to see legislation this session.

As I have already indicated, at least my basis for this judgment, it is my judgment, we haven't seen any really strong consensus emerge on a specific piece of legislation. I think there is a great deal of general consensus in terms of the direction in which most people would like to see things go. But there has been no strong consensus certainly expressed in terms of the Rogers Bill, a particular piece of

legislation.

The Congress I think everybody recognizes has a busy agenda this year in addition to things like energy, what to do about the Economic Stabilization Act or at least aspects of controlling prices as it relates not only to health but petroleum products. That's on their agenda. In the health field, as Dr. Endicott has indicated, we have a national health insurance proposal from the Administration. That's clearly going to be on the agenda. Almost every piece of health authority in HRA expires. Manpower, et cetera.

So, the Congress generally and the health committees specifically have got a tremendous workload, and it remains to be seen how much of that they get sorted out in any substantive fashion this year.

Finally I think, you know, it is an election year. The Congress will be trying to get home as early or as frequently as possible, and my own sneaking suspicion is that in many areas where they can safely defer taking action on what may prove to be controversial, they may be particularly sensitive to that this year.

But, as I say, that's my prognosis, that I question whether--I think the odds are less than fifty/fifty that there will be a bill enacted this year.

What form legislation will take, whether it's enacted this year or early in the next session, again I think

the only safe prediction I could make is that there will be a number of changes.

Some of the areas which I think invite a good deal of debate and difference of opinion is the extent of regulation, whether planning and implementation are to be the responsibility of a unitary entity or whether separate entities with some kind of enforced interdependence will emerge I think is another area where there will be considerable debate and difference of opinion.

The whole method by which funds get allocated, whether matching is required and, if so, to what degree. The matter of a national council on health policy. The authorization levels, I'm sure, will differ between the Administration and the Congress's bills.

And even such prosaic things as the designation of geographic areas, I think these are all aspects on which I foresee that there are quite likely to be changes in a number of these areas. So, in shot, I think it's very difficult at this juncture to predict that there will either be legislation or what form it will take this year.

I think there clearly is, on the other hand, a direction in which we're moving and we're likely to see legislation if not this year,next year, along these lines.

CHAIRMAN PAHL: Maybe we should have questions on this before discussing EMS.

MR. PETERSON: Yes, I'll cover EMS.

Are there any questions?

You have basically a summary of the proposed legislation. I would point out in the interest of detente we gave you the summary that the American Association of Comprehensive Health Planning put out.

CHAIRMAN PAHL: We thought that was tactful.

MRS. MORGAN: You gave us credit.

MR. PETERSON: Yes. Oh, yes. I thought it was a good summary.

Besides it was one I could find last night for xerox. I couldn't find John ~~Mustada's~~ NOSCATO's summary. Like most things, it's a matter of expediency.

CHAIRMAN PAHL: This will be the matter of lots of discussion and will of course be focused on in the forthcoming coordinators meeting as well as our own council in March. So, perhaps we might move on, Pete, and have you highlight an important aspect of the emergency medical services legislation.

MRS. MORGAN: How long do they have to introduce bills in this session? Is there a period of time at which bills can no longer be introduced?

MR. PETERSON: Technically there is not. On the other hand, the way the committees and subcommittees operate, you start dropping bills in the hopper in May and June you--

unless it is something extraordinary--that's why I think the next month may give us some better clues about the likelihood of some enactment this year. Because I think any bill in this area probably to get full consideration are going to have to get dropped in the hopper in four to six weeks. That will take us up to almost the first of April.

MRS. MARS: In the governing body here, it says one third consumers, one third providers, one third public elected officials. In the one third providers, what is that going to consist of? Does it say that there are so many physicians, so many physical therapists, and so many this or that?

MR. PETERSON: No, it does not, Mrs. Mars. It does define provider, the bill does, but it does not in effect sub-allocate among physicians, allied health versus hospital administrators or even for that matter public health officials.

MRS. MARS: Does that mean that in other words out of these people that there could only be one physician, for example?

MR. PETERSON: The bill wouldn't prescribe that. I think you touched upon an area which at least from feedback I've had in places where--

MRS. MARS: I would think this would be a very serious concern, that physicians would not be able to--

CHAIRMAN PAHL: This will be part of the debate.

MR. PETERSON: This will be part of the debate. I think another part of the debate is that one third consumers. CHP has had a majority of consumers, and I think one can anticipate that there will be some--they see that as a reduction. I think we've hit upon an area of some of the specifics and detail where I think it's almost impossible to predict other than that there are going to be some voices suggesting other ways of doing it.

DR. MERRILL: I'm interested in the fact that the HSA will review existing health services on a certification need basis. And also I am corresponding with the state health commission. Have the state health commissions--are they in accord with this? The state health commission in Massachusetts is very jealous of this prerogative, and I am not sure how they would react to an HSA, no matter how constituted, reviewing existing--particularly existing--health facilities and making recommendations to them.

MR. PETERSON: Not only is it existing but it calls for recertifaction, which even if it did not include existing, it would at some future time be a review of existing.

I don't know enough about the state health commission in Massachusetts, Dr. Merrill, to know whether it is the or would become the kind of state health commission that is

envisaged by this bill. Clearly there are a number of agencies at the state level who presently have a purchase, small or large, on certain functions which are now by federal legislation being prescribed in a state health commission. Certificate of need legislation is not always in CHP "A" agencies. There are state insurance commissions.

So, you know. And I think this is one of the reasons why the state health officers, as best as I can ascertain, are not very happy with the legislative proposal, because if you look at it closely--which I don't suggest you do now certainly--there is not much role for them. And I think that is part of a longer term trend.

MRS. MARS: Have they defined consumers in it?

MR. PETERSON: Yes. Whether you like the definition or whether you think it's a good definition, most of these things have been defined.

Well, I wonder in view of the time if it might not be just as well--because I would be glad to answer some other questions on the side as we break for lunch or coffee, if I have any answers, because I don't pretend to have many answers, and talk very briefly about the EMS Act of '73. EMS

As you'll recall, there had been EMS legislation passed by the Congress, vetoed by the President among other reasons because a rider had been put on for the continuation of the PHS hospital. But subsequently a compromise was

worked out and Public Law 93-154 was enacted November 16th, which did authorize EMS and $160 million over a three-year period. And, indeed, in the supplemental appropriation act for 1974, there was a supplement of $27 million voted for EMS.

That bill, while it includes authority and funds for a variety of things, feasibility studies and planning, the establishment of the initial operation of EMS systems, research, and even indeed some training--it modifies Title 7 of the Public Health Service Act.

There is buried in it, and I must confess I didn't notice it in November--nobody bothered calling it to my attention and perhaps it was because they didn't notice it either or they weren't talking about it--section 1206(e), which reads, and I think I will read this: "No funds appropriated under any provisions of this act other than section 1207 or Title 7, which is health manpower training, may be used to make a new grant or contract in any fiscal year for a purpose for which a grant or contract is authorized by this title, unless (1) all the funds authorized to be appropriated by section 1207 for such fiscal year have been appropriated and made available for obligation and (2) such ne grant or contract is made in accordance with the requirements of this title that would be applicable to such grant and contract if it were made under this title," and then

it goes on to make some definitional things.

It appears now that this--and I remember some advice my mother gave me--she said, "When you don't know and aren't certain, say so." Really, I am not going to give you a definitive legal opinion. But it appears that this would not permit RMP funds to be used to support any new EMS activities, and I would underscore new.

I think that may provide a loophole in the sense that, as you are well aware, we have been and the RMP's have been supporting and continue to support a number of EMS activities, most of which were begun late in June of '72 as a result of that special emphasis. And to the extent that they are in a second or third continuation year that had been envisaged initially, I would think that is permissible. I suspect that it would be desirable to get a definitive and most favorable legal opinion. By most favorable, it would be defining new in a way that would permit the continuation not only of certain RMP activities, because I would hasten to point out there are any number of other programs who have been supporting EMS-like activities, certainly in the National Center for Health Services R and D. I suspect some of the experimental systems' activities have. I know there has been some CHP support, at least in some planning and what have you. But we are faced here, it seems to me, with a situation because of the passage of this act, that

has some significant implications for future RMP applications and indeed council action. I certainly hope that one of the things, even by March, much less by the time the RMP's and this council have to take action, that we can do better than I have in interpreting what this really means.

But it does seem fairly clear that to start a new EMS activity under this or another program at this point in time would be in contravention of this section.

It's highly unlikely, I understand, that the $27 million that was appropriated for this fiscal year will indeed--they will indeed be able to obligate it, that is, the EMS program, which is now part of the Health Services Administration.

CHAIRMAN PAHL: We wanted to bring this activity, this possible restraint on EMS activity, to your attention because it had escaped us, with all the other things going on. And it would appear that we need a definitive legal statement, an opinion, on this.

But if the interpretation that common sense places on this, we will not be initiating new EMS activities as long as funds appropriated under the EMS legislation are still available. And this therefore would modify some of the proposed activities that regions would engage in with the funds that have been now released from either '73 or '74 impoundments.

Thank you, Pete, very much. And I find whenever we get into the legal side I usually find that my statements are somewhat in error, and I think Mr. Lanman wants to add a point here, as general counsel, to discuss just one more time the court order and perhaps we have more freedom to give you information than I had anticipated.

MR. LANMAN: Yes, I want to point out that we do have a final court order, a matter of public record; it's a final court order entered by the United States District Court for the District of Columbia.

The only way that that order can be changed is, number one, if the losing party, us, the government, decides to appeal. We have 60 days in which to file an appeal to a higher court, the Federal Court of Appeals for the District of Columbia.

In view of what you've heard here this morning as far as the Administration willing to comply with the main requirements of the order, as far as releasing the funds, I think an appeal is highly unlikely, and as far as I know it's not being contemplated either from an administrative viewpoint or from a legl viewpoint.

The other means by which this order might be changed is if the government would seek to file in the federal district court, the court that entered the order, a motion to alter or amend that order.

The only reason we would do this would be for the purpose of clarifying a minor point that is unclear and we are not sure how to proceed under the order or if there is a particular part of that order that we feel we cannot comply with, we would file a motion to alter or amend that small part of the order.

That motion under the Federal Rules of Civil Procedure must be filed within ten days after the date of the final order. Now, that normally would make the motion due on February 17th, but due to the fact that February 17th falls on a Sunday and February 18th falls on a holiday, that motion would not have to filed untal February 19th.

In all honesty I must say that such a motion is being discussed, but there is at this point no final word on it again either from a legal standpoint as to whether we should file such a motion or from an administrative standpoint.

So, I guess what I am getting at is I believe the order we have here can be distributed and it should be considered as the final order until and unless it is changed.

I might say that the motion to alter or amend is entirely within the discretion of the district court. There is no guarantee of any kind that they will change what they've said so far.

So, therefore, I think we have to assume that this is a final court order until subsequent events prove

otherwise, instead of assuming that this is an interim order and that it probably will be changed later.

CHAIRMAN PAHL: I am happy to stand corrected, and I think we should distribute what that order is, Ken, if you have copies, to council members. We just wanted to save you from receiving too many pieces of paper. But I think I appreciate better the status of it, and we'll give you copies so that you can see the wording of it.

I would like to have you turn your attention, however, if you would, not to that piece of paper but to some comments first from Mr. Chambliss and then secondly from Mr. Matt Spear, dealing with the activity that is now going on in RMP cocerning the development of a program for arthritus centers. And just let me turn it over to Bob, who has been very active in this and give you a bit of an introduction within a status report by Mr. Spear, who has been heading up the activity for us.

ARTARITIS

MR. CHAMBLISS: Very shortly we will be presenting to the council a proposed resolution concerning arthritis activities. And to prepare you for that proposed resolution, I think it in order that you hime something of a brief background as to how this came about.

Under our current appropriation legislation, there is phraseology to the effect that regional medical programs would engage in the planning and development of pilot arthritis

centers up to $4.5 million. In that appropriation the total sum is shown as $81.9 million for fiscal '74. And of that $81.9 million up to $4.5 million will be used for planning and developing these arthritis centers.

MRS. MARS: Before you go any further, may I interrupt and say what are these arthritis centers for? Is this treatment? What is this? Education, clinics, what?

MR. CHAMBLISS: Very key question and, if I may, I will come to that very shortly.

On last Saturday the RMP key staff held a meeting here in Bethesda with members of the National Arthritis Foundation, with key people from the foundation, together with two Regional Medical Program coordinators, Mr. Paul Ward of California and Dr. ~~Emanuel~~ MANU CHATTERGEE ~~Chattergi~~ of the ~~M~~Main Regional Medical Program, and the purpose of that meeting was to discuss what was the meaning of the term "pilot arthritis centers."

We did not fully work it through to what we meant or what was meant by pilot arthritis centers. But we did arrive at these points. Number one, that it would not--they would not include intensive research activities. Number two, that the centers would not engage in continuing medical education and the further education of interns, residents or fellows in arthritis. And that the centers would not engage in intensive efforts in delivering patient services.

MRS. MARS: Then what, in the name of goodness, are they going to do? What's left?

MR. CHAMBLISS: But that they would work through the RMP's and improving access, availability, improve the delivery, improve patient and physician education activities as to a basic awareness of the magnitude of the arthritis problem in the country, with the view that better patient care could be delivered.

MRS. MARS: I should think every physician in the country would know that.

MR. CHAMBLISS: That certainly is a general assumption, but even the arthritis experts admit that that is not the case. These are clinical entities in arthritis and rheumatology that have by and large not been forthrightly treated and explored by the professional community, the clinical community.

And these centers will support activities around this particular categorical area and, as a consequence, it is hoped that there will be greater public, patient, physician, community, hospital, clinic awareness about these conditions and the magnitude of them throughout the country.

DR. MERRILL: Could I interrupt you just a moment. It seems to me it's awfully important, at least for me, to know what the center is not. It's not a new physical facility; is that right?

MR. CHAMBLISS: I might say that the arthritis foundation is supporting already what it considers to be a number of centers numbering approximately 42. They vary in size, in scope, in what they do, in staffing, in emphasis, and the arthritis foundation would like us to begin working around as many of those centers as possible.

I am simply laying a groundwork for what Mr. Spear will be saying, and he will come on with further details.

Dr. Pahl calls to my attention that there has been involvement of the National Intitutes of Health, the Institute for Arthritis and Metabolic and Digestive Diseases. They have been involved in the overall planning for this effort and Matt will develop that further.

CHAIRMAN PAHL: Matt, why don't you go ahead.

MR. SPEAR: It may give some meaning to some of the comments which Mr. Chambliss made to review just briefly with you what the problem is.

Arthritis is a generic term meaining that it covers in a very broad manner some 80 to 100 diseases about which very little is known and none of which can be prevented. It affects about 50 million people in the country. Twenty million of those are affected seriously in terms of pain and crippling. The major diseases being rheumatic arthritis, gout, osteoarthritis, ankylosing spondylitis. Only gout can be treated to the complete point.

What remains that can be done is that pain can be reduced and the claim is made and it his been made consistently for some ten years or more, so I think it can be substantiated, that if the therapy is instituted early enough in the course of the disease, they can prevent crippling.

Now, that's quite important in terms of the number of people we're dealing with, because arthritis is the major crippler in this country and is second only to heart disease in terms of causing disability, days in bed, days away from work.

Opposed to this problem are some needs. The American Rheumatology Association lists some 2,000 to 2,100 members, but they open their membership to everyone who wants to be a member. So that at best count there have been identified only about 500 to 600 rheumatologists practicing in the country.

Most of the people in the field are in research and a very small number, relatively, are out providing care.

Arthritis has not been popular as a medical career. It isn't taught in every medical school, and there aren't many people out in the medical community who have a current relationship with an academic or practice approach to arthritis.

The result is that only 20 percent of these

millions of patients that I noted to you have ever seen any physician about their disease and only three percent or four percent of those patients have ever been looked at by someone trained in rheumatology.

Because of these factors I've suggested to you, there is a great frustration, a resignation that nothing can be done about arthritis, and the resignation seems to be as great on the side of the physicians as it is in the patients. And this is what needs to be overcome. We need to get the patients into the channels of therapy that will first, if I may put some priority on these matters, give them a sense that something can be done and then in the proper hands arrange for those things to be done.

Now, it's more than just going to see a rheumatologist or, depending on the disease, going to see an orthopedist. Arthritis in its various forms is systemic. It will create very serious system problems. It is in many cases a whole body disease. It requires a wide variety in its complications, a variety of specialties to deal with it.

So, given the factors that I have suggested to you, again we have a problem of how do you bring together the kind of medical teams that are required, and health teams that are required, to deal with these problems. And the evidence is that the--which is not a new one as we all know in the chronic area certainly--that physicians and surgeons and

therapists and social woraers and nurses have not necessarily been communicating together too well. And the low man on the totem pole aspect of arthritis prevails in the allied health diseases in many respects.

So, there is a sizeable problem to overcome.

The four and a half million that was stated in the Senate language represents perhaps a larger change than may be apparent because of its size. Since the demise of the old National Center for Diabetes and Arthritis, programs under the Chronic Disease Center some years ago, there has been only research money, at least from the Public Health Service, going into arthritis activity.

The NIAMD research activity in this area has run between twelve and fourteen million dollars in the last several years, and that's per year. The current year estimate as about thirteen and a half million. And that is going in mostly for laboratory work and the training of research people. So, there has been nothing of any size, and particularly if one recalls that the old D and A program was not a long-lived program, there has been nothing to contribute in a continuing sense to any creation of community program, community delivery program.

And I think it has been quite a pleasant surprise to me at least that the rheumatologists have come to the conclusion themselves that this is their greatest need and

this is what they want to reach for. They want to help build referral patterns. They want to develop outreach. They want access for the patient to have care. They want quality of care. And they want to build a multidiscipline approach.

We have a very short time. These funds fall within that group that must be obligated by June 30th. As Mr. Chambliss has suggested, we have had some intensive conversations with the experience represented in NIAMD. We have counseled with the steering committee of the coordinators. We have counseled just this past week with the Arthritis Foundation. We are in contact with the Academy of Orthopedic Surgeons and a variety of the associations of the allied health people.

In fact upstairs the initial draft of the guidelines is being typed. We hope to have them reviewed, retyped, reviewed, retyped, whatever it takes, and mail the guidelines out next week.

By May 15th we have to have those applications in here for staff to look at and to prepare for your consideration. There are obviously a number of things that the regions have to accomplish, and we have asked the arthritis people to convey to their constituents that the way to start the ballgame is to get in touch with the RMP, because that is the channel through which the program will be administered as we now see it.

CHAIRMAN PAHL: Thank you, Matt. This is one of those activities which came to us in a bit of a circuitous route. There had been a request by the arthritis foundation to place additional monies in the appropriations for the NIH, and this eventually did not work out, and through a series of steps which I don't think I have to recount at the moment, the monies were placed in the RMP legislation, which is really quite appropriate, because the purpose of the centers is to provide the outreach and not just academic centers restricted to research and teaching. And we have the rest of this fiscal year, as Mr. Spear indicated, to develop the criteria, work through the RMP's to get applications in for the establishment of a small number of such centers, to have these reviewed by a special panel, much as the emergency medical services program was developed, and then to have the recommendations of that scientific review panel come before this council again at the June council meeting so that an award for the arthritis centers up to a total of $4.5 million can be made this fiscal year. And Mr. Spear is in charge of coordinating our interest in this with what has already been initiated by the NIH throught its own separate arthritis institute programs as well as the interest and professional capabilities of those who are involved with the arthritis foundation.

And we will be submitting to you the various kinds

of documents, materials, criteria, and so forth, as they are developed. This is just one other little aspect that has to move ahead this fiscl year, and you can see that it is a very worthwhile activity and we are working very hard to do an effective job, but it is complicated again with the resources that we have to place on it in this particular time frame.

MR. OGDEN: The only comment I would make is that I would hope that in the guidelines as they are developed, some mechanism is established for the continuing support of these. If we start them, I should hate to think that this was simply a one-shot thing. We have no statutory authority to go on at least at the moment for the support of this, as I understand it, for other funds.

CHAIRMAN PAHL: We have only the statements in the appropriation language, and we have a draft resolution which perhaps should be distributed at this moment if it hasn't already been, Ken, which is very brief, which we would like to have you consider, which doesn't speak to this point that you just raised, but it would strengthen the point.

MR. CHAMBLISS: Mr. Ogden, if I might say this, there is legislation contemplted for the support of these, once they are underway.

I understand that there is a great amount of interest on the part of Senator Cranston in this area, and the arthritis people are looking forward to support beyond

that support initially provided by Regional Medical Programs.

MRS. MARS: Are we going to build buildings with this money or are we going to use it for staffing facilities that already exist?

CHAIRMAN PAHL: This is not for the construction of physical facilities, but it's primarily used for staffing and program activities, and I think, although I was unable to be present at the Saturday meeting where basically there was a small group present from both the NIH, RMPS, and representatives of the arthritis foundation and professional community in the arthritis area.

I think there certainly was, according to Mr. Chambliss' statement, an indication of the need to have these centers be rounded programs which would engage in those kinds of activities, apart from the provision of direct services.

DR. MERRILL: Having spent a year of research in such an outfit, I know they do not only research and training, but they also take care of patients. And if I were to envisage what center meant, without wanting to put words in your mouth, it would mean enabling such an outfit to expand their patient care facilities. Physical plant, all the backup people, would already be there. What these funds should do would be to enable them to take care of more patients.

CHAIRMAN PAHL: We are trying to build on the

expertise--and Bob may want to elaborate on this in just a moment--but we are trying to build on the expertise that has been developed through the NIH support of some 30 centers, what they now call centers, and which is open to serious questior because of the magnitude and diversity of activity within any one of those programs. But we are trying to build on that expertise and would basically envision expanding and strengthening and extending some of those existing "centers." And this is as close to an interagency activity as we have gotten to for some time. And perhaps, Bob, you should mention who was at the meeting and the representation, so that it will really indicate our interest in working with what is already available.

MR. CHAMBLISS: Yes, the whole concept is to build on what is already there and to augment the resources that are already in existence.

In attendance at that meeting was Dr. Engleman from Los Angeles, who is the past president of the American Arthritis Foundation; Dr. Duff, from Ann Arbor, Michigan, who now heads the last center funded by the old Chronic Disease Bureau; Dr. Decker from the National Institute of Arthritis and Metabolic Diseases and Digestive Diseases; Dr. Shulman from Johns-Hopkins, who is present president of the Arthritis Foundation; Dr. Weiss from New Orleans, who is an outstanding rheumatologist; and Mr. Shobe, who is the

liaison representative for the foundation having an office in Wasington and an office in New York.

Also in attendance, as I mentioned before, were the two regional medical program coordinators.

I think I should add one footnote that, being of the opinion that the Veterans Administration has perhaps the largest reservoir of arthritis patients, we did seek to impress upon the group that where and when possible collaborative efforts should be made with Veteran Administration facilities. I thought you'd like to know that, Dr. Foye.

CHAIRMAN PAHL: I think what we will try to do is as developments proceed--this has all been very recent on us also--we would like to keep you informed, and we would particularly appreciate if one or more members of the council would like to be in attendance at meetings where the development of such criteria and discussions are held.

We very frankly have been--and this is in part due to my absence--have been running extremely hard in a number of elections, and I think it's amazing that as much progress as has been made has been done with a variety of inputs over the recent six weeks.

So, we would like to extend an invitation to have an expression of your interest now or in the future, of keeping apace with this apart from the formal council meetings; and if one of you or one of the council members who we believe will

be appointed in the near future would like to take a specific interest, will meet. Because these applications will be coming to you this June, and we will not ask you to do the initial review, but there will need to be an understanding. We will try to keep you apprised of all the steps as we go along. And this was just an initial meeting to try to get better understanding ourselves of what the NIH had already done, as well as the arthritis foundation, because it's from there that the stimulus for the introduction of the four and a half million obviously arose. So, we are trying to find out what their thoughts were. And now that that meeting has been held, I think were in a position to superimpose the RMP philosophy, and we are intending to make these awards through the RMP's to arthritis centers, so that the local RMP is and remains involved in the activity and is not bypassed. We think that's crucial to the outreach which we are trying to have in these centers.

MRS. MORGAN: Could we have a list of where the centers are?

CHAIRMAN PAHL: Yes. We'll put together a package of those materials which seem to bring together the salient points that have developed this far and send to all of you, the list of the centers, the participants at the meeting, and anything else that may have come out of that meeting at which I wasn't able to be present.

MRS. MORGAN: Prior to this, it seems so much of the work on arthritis has been on the adults, and it's really such a crippling of children. The Veterans Hospital is here again adults mainly. Very, very little has been done for children.

MRS. MARS: Is there a schedule already put up for the meetings in the future, Mr. Chambliss?

MR. CHAMBLISS: Yes, we have a tentative schedule that we will be working against to get all of the instructional materials out to give the regions an opportunity to respond, to get them back in for review, and to get them before you in June so that awards can be made before the end of this fiscal year.

MRS. MARS: I would like to attend any of the meetings that I could, but I don't know whether I'll be here. I was a governor of the arthritis foundation at one time. So, I am particularly interested. But I just don't know if I'll be here, you see, when these meetings are held.

CHAIRMAN PAHL: Let us get this information to you as quickly as we can, and then it is an open invitation not only to you but to other members of the council as well to attend. We need assistance in a number of areas over the coming months, and we certainly need your understanding. And it has just been a very rapid pace, and I think a lot of credit should be given to both Mr. Chambliss and Mr. Spear for

moving ahead so quickly in an activity which came to us very, very late in the fiscal year. But it is moving along very well, and we're trying hard to have an effective program with a limited number of centers and building on existing knowledge and expertise from the NIH support programs.

MR. OGDEN: In connection with this resolution, I come back again to the point that I made before. This is a limited amount of money in one appropriation bill. But the resolution that we have sounds like it's a broadly based resolution in which RMP monies in general are going to be made available for this purpose.

I would be happier if we had a resolution that simply said something like the Congress has earmarked in connection with--if that's the bill, 93192--certain RMP funds for the planning and development of a pilot arthritis program so that we can resolve this with the paragraph that to the extent that funds have been appropriated for this function, because that's as far as we really can go, unless we--and under the court order I assume we can't go back now and plug something in that wasn't there in February, 1973.

CHAIRMAN PAHL: That is my understanding of the court order.

MR. OGDEN: So, we couldn't go back and take money for FY '73 or indeed even for FY '74, and turn it over to arthritis now. So, if you want to say that the Congress is--

CHAIRMAN PAHL: It has all been in the '74 funds, and it never was in the '73.

MR. OGDEN: So, if we wanted to say whereas Congress is earmarking in connection with PL 93-192 certain RMP funds for planning and development of pilot arthritis programs, be it resolved the National Advisory Council of Regional Medical Programs recommends that activities in the field of arthritis be recognized for support under Title 9 of the Public Health Service Act to the extent that funds have been appropriated for this function.

If you will make those changes, I will move the resolution.

CHAIRMAN PAHL: All right. The amended resolution has been moved. Is there a second?

MRS. MORGAN: I second.

CHAIRMAN PAHL: It has been moved and seconded. Is there further discussion.

MRS. MARS: Do you want to read it again.

MR. OGDEN: What I have written, it says, "Whereas the Congress has earmarked in connection with PL 93-192 certain RMP funds for planning and development of pilot arthritis programs, be it resolved that the National Advisory Council on Regional Medical Programs recommends that activities in the field of arthritis be recognized for support under Title 9 of the Public Health Service Act to the

Authority resolution

extent that funds have been appropriated for this function."

CHAIRMAN PAHL: Any further discussion? Judy?

MRS. SILSBEE: Mr. Ogden, would the motion that you're making preclude a regional medical program whose RAG wanted to put some money into arthritis from doing that?

MR. OGDEN: I think it would. I think we've got four and a half million we can use for that purpose, as I understand it. They would have to make an application for that particular four and a half million or part of it.

CHAIRMAN PAHL: These are for the pilot arthritis centers. This apart from putting dollars into those kinds of studies and acativities, I should think, that may lead to that. But this is a pilot arthritis center program, and my interpetation is that they would have to come under the four and a half million dollars, using fiscal '74 funds.

MR. OGDEN: Do you want to call it pilot arthritis center program and put the word "center" in there?

MR. BAUM: This resolution came out of the Saturday meeting that we had last week, and it really came out of a suggestion that was made by one of the participants, and nobody was certain of the exact circumstance. But somewhere back in the beginning of RMP, either administratively or as the result of council action or something which no one really recalls right now, it was apparently determined that arthritis was not one of the related diseases under the RMP

legislation which speaks of heart disease, cancer, stroke, and related diseases. And that since the Congress had now specifically appropriated funds for arthritis, we felt--the group thought, I shouldn't say we--that it might be appropriate to recognize arthritis formally as a related disease. That was the intent originally of writing it this way.

CHAIRMAN PAHL: Thank you.

Bob?

MR. CHAMBLISS: I think the substantive part of your question, Mr. Ogden, as I see it, is that can a region engage in pre-existing arthritis activities separate from this particular legislative language, and the answer to that to me would seem to be yes, it can. It cannot engage in the development and planning of pilot arthritis centers, but it could engage if there are pre-existing--there may be pre-existing applications or proposals already in the RMP's for arthritis. Are you suggesting that those could not come in in a package beyond--

MR. OGDEN: I think we've got to separate it out of this, because we're talking apparently about a particular piece of legislation, and this relates to planning and development of pilot arthritis center programs, as I understand it. So, I'm willing to have that come before this council to the extent that funds have been appropriated for that

function. But I don't think we want to take other RMP funds and use them for the planning and development of pilot arthritis center programs. That's all I'm saying.

We've had programs at some point or another, as I can recall, that have involved arthritis one way or another from regions.

CHAIRMAN PAHL: This is a very specific label--

MR. OGDEN: This is a very specific thing.

CHAIRMAN PAHL: --pilot arthritis center program.

MR. OGDEN: And I think we ought to restrict it to the money that's in that bill and not make it sound like we're going to look at a wider range of things.

CHAIRMAN PAHL: Is there further discussion?

Mr. Lemke?

MR. LEMKE: Do I understand correctly that if there is no center existing in a region, that we could not begin any work?

CHAIRMAN PAHL: Not under this particular program, no.

MR. CHAMBLISS: Let me see if we are together here. Your question was, If there are no centers existing in a region, could you begin work under this provision? And my answer is that yes, you could begin to develop proposals and they would have to compete with all the others.

MR. OGDEN: That's different from the comment you

made before.

CHAIRMAN PAHL: I'd like to view this activity as we had the AHECS and the emergency medical services applications before. There was an allotment of funds set aside to develop a special program, and this was an earmarked level of funds requiring special guidelines and special review procedures. And I see this as an analogous situation in which we have up to $4.5 million this fiscal year to award through RMP's for the establishment of these pilot arthritis centers, and this will require applications from the regions following receipt of guidelines and establishing criteria for review, et cetera. All of this has to be done back here before we can announce the conditions of the program. There just hasn't been sufficient time to do this. But we will have a four and a half million dollar pilot arthritis center program this year which will be duly announced, special applications will have to come in either as part of the regular application or as an earlier deadline. It will have a special review panel made up of experts in the arthritis field and their preliminary review recommendations will come before this council and be acted upon and then funds awarded. So, I see it very parallel to the kind of activity we've had before.

This does mean that if you intend to apply for some of these funds that work should go along in considering what

goes into an application and so forth. But it doesn't mean that existing RMP funds would be used to establish a pilot arthritis center outside the parameters of this program.

We have a motion on the table that has been seconded. Is there any further discussion?

If not, all in favor of the motion, please say aye. [Response]

ARTHRITIS VOTE

Opposed? [No response]

It is carried.

Now we have one more piece of business, and then I think we might break for lunch.

We have in this program the unusual opportunity of doing good in various parts of the country, and we have another opportunity this time. In the Supplemental Appropriations Act of 1974, Congress saw fit to appropriate $9.5 million to be available until expended for the construction of the Children's Hospital of Philadelphia, and there has been a resolution drafted by staff for your consideration, and the wording of this is parallel or along the same lines as we had for some earlier construction projects, and it should look quite familiar to you, except we are now talking about the Children's Hospital of Philadelphia. Because it should appear familiar, I am not sure that extensive discussion is needed.

These funds are available until expended. We will

work through the Hill-Burton program. The mechanics of this now are well worked out. Everyone has great experience in this. And unless there is a need for discussion on the resolution, we would like to take action.

However, if you would like to consider it over the lunch hour or discuss it further now, why of course that's quite appropriate.

These monies are above and beyond the fiscal '74 appropriation for the RMP's. They will not detract from what we have been telling you so far about the kinds of support which we intend to provide to the RMP's for program activities, and we're not restricted to this fiscal year, since the money is available until expended.

MR. OGDEN: I move the adoption of the resolution.

MRS. MARS: I second it. PHILA Construction Resolution

CHAIRMAN PAHL: It has been moved and seconded to adopt the resolution as submitted. Is there discussion?

If not, all in favor say aye. [Response]

Opposed? [No response]

It is carried.

Thank you for your patience, sitting through these rather lengthy sessions on reports, but much has been happening, as you see.

I think we should break for lunch, and let me indicate that we have now gotten through our business this

morning. What we would like to do is reconvene. Let's see, it's a quarter of 1:00. I'm not sure what your schedules of departure are. We have the important business this afternoon of going over the recommendations of the site visitors and review groups on the three applications that were deferred from the last council meeting.

We also have the appearance of Mr. Rubel, who will have an important role to play, as you see, in the further development of this program and so forth, and I expect him to appear at 1:30 or thereabouts, and we have a short report on the Arizona RMP from one of our staff, and we have to accept or modify the minutes of the last meeting, which are in your folder and which perhaps you could glance over during the lunch hour and see if there is any amendments or changes you wish to make and take up that after lunch.

So, I would suggest that we try to reconvene at 1:30 and no later than twenty of 2:00, if you feel you can get through the cafeteria lines and have lunch at that time. Is that satisfactory? Let's try to make it 1:30, then, as close to that as we can get through our lunch. Thank you.

[A luncheon recess was taken at 12:45 o'clock p.m.]

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AFTERNOON SESSION - 1:50 o'clock

CHAIRMAN PAHL: Now that we have just about simultaneously both all of ourselves back and Mr. Rubel, I'd like to reconvene the council for the afternoon session and just merely say we are pleased to have Mr. Rubel here, who, as you know, has been asked to coordinate the activities of the RMP, CHP, and health facilities programs in the Bureau of Health Resources Development, and this is the first meeting that Mr. Rubel has had with this council, and I think he'd be willing not only to make a statement but perhaps answer any questions you might have. And then following this we can move on into our executive session with the business of specific applications.

Gene?

MR. EUGENE RUBEL: I'm delighted to be here. I'm sorry I couldn't be here this morning, but I had another commitment that I had to race away from. Ind I didn't have the opportunity to hear Dr. Margulies, Dr. Endicott, and Dr. Dunn. And I certainly don't want to reiterate, go over, some of the ground that they already covered.

This is a challenging time for all of us, and frankly I'm, as some of you in the room know, very excited about the directions that I think we're moving in.

We've got a lot of uncertainty. We have legislative proposals, some already on the table and others about to be

put on the table. We have a Congress that has other matters it has to deal with, and we're not quite sure when our turn in line--where we are in terms of the line.

Amidst that, we have to somehow make operational decisions today and plan for where we are trying to go in the months and years ahead. That makes for growing lots of grey hair.

I thought I knew what comprehensive health planning was all about or was beginning to get the glimmerings of that several weeks ago, having been here for six months now. And suddenly in these last two weeks I've had to suddenly learn a whole new--learn about all kinds of things that I didn't know about, and it has been a rather difficult time for me, and both the RMP and Hill-Burton people have been just wonderful in helping.

As you've already discussed, we know that there are some operational decisions that have to be made very shortly here. We have money seemingly at our disposal but not quite in our hands. We have an order from a federal judge. And I am convinced that in a matter of perhaps even days, we are going to have some definitive decision, and I think we can get over this very, very long period of uncertainty.

The challenge, as I see it, is to use the resources we have today to help us move in the direction it appears we are going, whether it's next January or next June or someplace

like that.

You have already had discussion of the one bill that is in the hopper already, HR 12053, and I won't go over it except to say that I see very much of a consensus on the major points between the Administration and the Congress. And so the job that I have is to try to help us move towards implementing that legislation.

We don't have a very good track record as to our ability to pick something up and run with it, once the Congress does act. Unlike other programs where we are starting something from scratch, I just don't think we have the--even if we wanted to, we don't have the luxury of being able to take six months or a year here to try to untangle bureaucratic snarls and try to get started.

The problems in the health care system require us to do something. We can't just stop everything and wait until we can get ourselves nicely organized, that's number one. And, number two, we've got organizations and institutions that are counting on us for support, and we can't say, "Well, you guys just please keep going until we can get our selves together."

And so we are starting now to figure out what could we do to prepare ourselves for administering the new program, even though we don't know exactly what the new program is all about.

We have had a series of task forces already within the Health Resources Administration, and we are going to have a lot more in the coming weeks and months, trying to eal with some very tough polixy questions and some very pedestrian operational problems of a new kind of operation.

Let me just say a word as to what I see the new thing as being, and then I'd be delighted to chat with you about it.

The Congress and the Administration are grappling right now with a notion of somehow health planning--control in the health care industry, regulation in the health care industry. And certainly with the big push that national health insurance is getting, it becomes even greater of a problem.

We know that the President has requested that economic stabilization controls be continued for the health care industry and for the petroleum industry; there is a very strong feeling on the part of the Administration that the usual market forces aren't there and we need something.

Also a recognition, a very strong recognition, on the part of the federal government that to the maximum extent possible it would like the states to take on this job, and that's one of the reasons that the Phase 4 regs allow for a state to come in with its own program and to be completely exempt from federal regulation.

There is also a recognition, howefer, that health care is not primarily a governmental kind of program, that somehow we need different kinds of mechanisms to deal with health than we do with sewer planning or with welfare, with social services, transportation and a whole realm of other things that are primarily in the public sector. And there has been this recognition that we need to view the planning kind of role, not so much at an arbitrary state level, but much more in a medical service area, whatever that means.

In many cases overlapping state boundaries and certainly overlapping other kinds of boundaries, and we have a tough time describing what a medical servixe area is.

In many places the state is the natural unit, but in many places it isn't. And we somehow need to involve all the sectors, providers, hospital administrators, the physicians, other professionals in health care, the educators, the third party payers, government, and just plain consumers, somehow to s it around a table and grapple with the problems of a community.

We certainly don't want to sit here in Washington and decide how many hospital beds St. Louis needs or how many hospital beds Topeka needs. But yet we recognize that somebody has got to do that.

I tried to say on many occasions that what started out in 1966, 1965, '67, as attempts at somehow organizing a

little bit has now grown up, and the government is very deeply concerned with how the health care system works, doesn't want to take it over but does want to exert some control.

The challenge we have is how do you carry that out, how do you do that. And we're all starting from very little knowledge base, despite the fact that we've had facility planning under the Hill-Burton program ever since it started in 1946. We don't know all that much about how you plan for a facility development. We certainly have no common place here somebody can go and try to find out.

An example I use now, we had some beautiful pictures in Time Magazine about a month ago, the results of something called a brain scanner. It's a nice little machine that costs $350,000. We have every institution in this country, health care institution in this country, trying to figure out how to get one. And there is no place that anybody can go centrally and say, "Well, what is the thing? How much is it used and what should it be used for and what's the incidence you need in order to use it and the like?"

And so we've got every institution in the country and damn near every planning institution in the country trying to figure out what do you do with these things. And we need obviously, it seems to me, an awful lot more of central focus to--not to dictate, "You shall have one of

these for every 500,000 population," but to say this is what it's like, this is what it's used for, and here's some suggestions about how you might--some criteria you might use in deciding where they should go in your geographic area.

We recognize that the decisions that have to be made here and the process is very much a political one, and so it should be. I think we have learned an awful lot about how you organize these kinds of institutions or how you set up this kind of organization. But the public spotlight is very much on us. Where once upon a time the kinds of activities that we're engaged in now were viewed as marginal, suddenly they are in the forefront; with enactment of section 1122 which allows for review of capital expenditures, health planning agencies have become in many communities right in the middle of great big fights. In many places they haven't been able to deal with it very effectively.

Others have had to deal with these kinds of problems for years already and they're a lot more mature.

I kind of skipped all over the place. Our job here over the next month is going to be to try to figure out how to get this new thing implemented while at the same time we use the resources we have today under current legislation, and one statement that I will make is that as long as I'm involved with this, we'll be following both what the original law

intended and what the courts tell us with respect to their interpretation of the law, what the kind of authorities we have are to be used for.

Hopefully we can force some people to work together that perhaps up till now have not worked together. There is no question in my mind but what I see coming is one single planning organization and having one organization that covers every part of this United States. Perhaps there will be others that survive, but they won't be getting federal funding.

The challenge we have is to get from here to there with a minimum amount of bloodshed and with a minimum amount of organizational chaos, trying to keep our eye on the problems of the health care scene rather than on our own organizational problems. But we are going to have a tough time.

I was in Philadelphia this morning. We have essentially a health facility group whose start was in the old Hill-Burton 618--

MR. BAUM: 318.

MR. RUBEL: 318 agency that we set up. We have a health management corporation, which is one of the experimental health service delivery system units which we set up. We have a regional medical program which we set up, and we have a comprehensive health planning B agency which we set up. And exactly where one ends and the other begins nobody knows.

And we've got a fair amount of organizational chaos, and we caused it. Now the challenge is to somehow unravel all of that, and it's not going to be very simple to do.

I'd be delighted to chat with you about what we're up to and try to respond to whatever questions or comments you have of what Drs. Endicott and Margulies and Dunn said as well.

MRS. MARS: In this reorganization you do then not anticipate changing the original mission of RMP, so to speak, and the programming and projects?

MR. RUBEL: I have spent many, many hours attempting to discover what the original mission of RMP was, and I'm sure you've discussed this at great length. I've gone back and tried to read the history, what the original commission contemplated and the shell that came out of the Congress as a compromise. We have this great mixture of categorical programs--

MRS. MARS: Let's say 1973.

MR. RUBEL: There's no question in my mind that we will be following very much both the word and the spirit of the law, at the same time trying to use the resources that we have to move towards where we think we're going now. I think we can do that. I think we have done that.

I am amazed by the amount of cooperation that has occurred in the past, some of it despite the federal

government. In many ways local people have a much better way of dealing with each other than we do sitting in this building.

That there's perhaps going to be differences in emphasis and attitude I think so. There is--it should be pointed out, I don't know in the discussion of the legal situation this morning--there is a section 910 of the Public Health Service Act duly enacted by the Congress which does authorize the secretary to make grants and contracts for some specific purposes, not necessarily through regional medical programs. To what extent that authority is going to be used or not, I don't know. But it was certainly within the intent of the Congress in enacting it that it be used or else they wouldn't have enacted it. But these are questions that are being decided right now.

MRS. MARS: Otherwise you are saying it's going to take a completely new direction?

MR. RUBEL: Now is it going to take a completely new direction?

MRS. MARS: After it is integrated.

MR. RUBEL: I would say when the Congress passes new legislation, I would think it's going to take a rather different direction.

MRS. MARS: What do you anticipate this to be?

MR. RUBEL: As I tried to say, a mechanism to allow

for all the sectors of the health care scene at the local level to get together and look at what is being provided in health care and what they think is necessary, where the excesses are and where the gaps are, and then scheming to figure out how to fill the gaps and to curb the excesses in cooperation very much with state regulatory kinds of mechanisms that either exist already or are going to exist in the future.

DR. MERRILL: Do you visualize as far as the staff in Washington goes that eventually this group will be merged as are the groups at the lower level and direction for the groups now amalgamated in the region will be directed by a group similarly merged in Washington?

MR. RUBEL: I don't visualize that right now. I don't visualize that happening until new legislation is enacted. We have three separate divisions today, and they will remain so. The great bulk of our efforts over the coming months have to be to administer our current programs, while we're going to try to draw as best we can in working with small task forces and trying to plan for the future.

Once we have new legislation, I think it inevitable that we will have one organization. Whatever it is, I would say pretty clearly it is going to be administered as most other departmental programs are in a decentralized fashion through our regional offices.

MR. OGDEN: If we as a group wanted to suggest that some sort of pilot operation be attempted or some sort of demonstration be tried of consolidating say a CHP "B" agency with a subregional advisory group with the regional medical program and perhaps that group working with the 1122 people on certification for Hill-Burton in a particular area of a state, would we be able to seek funding for this and get it?

MR. RUBEL: There are some very specific statutory requirements in current law and Title 9 and in section 314 that have to be met. We can't just throw them out. But this kind of thing, I think, is very much worth exploring and we can do it, and in many places it is almost happening already.

MR. OGDEN: This is the point. It is occurring in some places, and if we could formalize this in some sort of pilot activity in a few places or perhaps even in one or two states.

MR. RUBEL: You have a problem with demonstrations. I spent several years on the periphery of welfare reform, and we had lots of people saying we should demonstrate something. Well, the time it takes to demonstrate whether something is successful or not is not the time that the politicians will wait until they make a decision. They're going to be going ahead, whatever we do.

I would say where it makes sense in a community to do it, I think it's something that I would encourage tomorrow. But again we've got statutory things that we just have to meet. We can't waive them. We can't throw them away. We can't make believe they're not there. In terms of dollars, we've got plenty of dollars. That's not the problem. Frankly I think we have too many dollars. That's going to cause us a lot of--all of us collecitvely--a lot of heartache with so many dollars coming in all at once and then with changes coming after that.

MR. OGDEN: I think we as an advisory council need not only keep of course in close track with you as to what your thinking is, but you need to keep us advised of what is developing so that perhaps some of these things can be done as soon as possible. Whether we can use Title 9 funds or 314(e) money or something of this nature, whether we fund it, CHP funds it. I'm sure Hill-Burton can't. But somehow money from either the CHP or RMP areas perhaps could be found to put something like this together.

MR. RUBEL: I don't think in most places it's a question of money. It's a question of separate organizations, contrasting styles, and people seeing themselves as having different purposes, more than the dollars. I don't think the dollars will be an obstacle at all.

CHAIRMAN PAHL: I think that these are appropriate

issues to discuss, bit I think that it is all too new internally to give you a definitive answer. But I think this is the responsibility that we all have under this new bureaucratic arragnement.

MR. OGDEN: I think you see what we have in mind.

CHAIRMAN PAHL: Absolutely.

MR. OGDEN: These things have occurred. We have had, for example, right in my home town the local CHP "B" agency is not operating. The RMP man who is there and our Eastern Washington Advisory Committee is doing CHP "B's" work right now on an organized basis. And they hire him to do this. And as far as any work that goes on, the certification under section 1122 is concerned, he is very much involved. So, we've got that little thing sort of growing right now.

MR. RUBEL: We have given a great deal of thought to try to figure out how on an organized basis we can force some collaboration--

MR. OGDEN: It's when you get to the state levels that you begin to run into the problems of the existing structures that are there.

CHAIRMAN PAHL: Also the National Association of Regional Medical Programs of course went to court to free the money for certain designated purposes, and I'm sure there will be differences of opinion, depending on how those funds

are used, if it's not in keeping with what they feel is the right direction. And so there are problems in doing this on a visible level as an announced programmatic activity with these released funds.

MR. RUBEL: Let me just say that I have spent virtually evwry hour of the last two weeks, with the exception of this morning, attempting to get some operational decisions here so that we can start moving.

once we get some commitments from the department, which I think is going to happen very soon, I would be not only happy, but we've got to work very closely together and work very closely together with the National Association of RMP Coordinators. There is no point in trying to do something here in isolation or in secrecy, and that's not my style. There may well be some differences of opinion, and we've got to try to figure out how to resolve them as best we can. It's going to be--you know, we've got a tough time ahead of us. We've got three or four months, something like that, left in the fiscal year, and we are going to have to be making a lot of awards during that time period, and you all have to be involved in that.

And one other point that I guess I should make, I am making whatever efforts I can to make sure that within the very near future the full complement of this council will be sitting around this table. It's going to take a little

bigger table than we have here today. The council has a statutory role and we try to use it. And you can't do it very well with five people sitting here instead of the 20 that should be here.

We recognize that as a problem, and we're trying to deal with it.

CHAIRMAN PAHL: Are therr other questions, either from council or public?

DR. GAYE: I'm Dr. Gaye from the Regional Medical Program in New Mexico. Mr. Rubel, we have had a number of experiences out in the field where it's intended for one or more programs to work together, work in concert, and it would be extremely helpful to us if word of the desirability of programs working together would come down through the channels at approximately the same rate; and so it would be very helpful to us, if you want things to happen out in the field, and of course for all the three agencies that you're involved in to hear about it.

MR. RUBEL: No question that there is going to be a lot of communication. That's what I've tried to do and what I've done up till now with our CHP agencies, and communication is going to be the essence of what is going to be coming here in the future. There is only so much the printed word can do, but there certainly is going to be an awful lot of it coming. And I hope it can come back too. We need all kinds of feedback.

CHAIRMAN PAHL: Is there another question?

Yes, Mr. Lemke?

MR. LEMKE: This is more in the nature of a comment than a question. But I see this from an entirely different viewpoint than you do. And I think that RMP and CHP are working fairly well together, at least in my experience; and urthef that there is really a crying need for both organizations, one to represent the public and one to represent the professional side. I think that in my experience you may very well ruin the credibility of both of them if you jam them together in too big a hurry.

MR. RUBEL: We will not be jamming organizations together under current legislation. I think that it's, you know, to the extent that there is a feeling that there is a need for a kind of implementing agency, as has been used to describe RMP, the place to try to present that is before the Congress.

I was trying to reflect before on the feeling that I get on the part of those in control in the Congress and in the Administration that such an institution is felt not to be necessary. The only place where--first of all, we believe or I believe that there are matters of mutual concern to the existing agencies today where they can very profitably be working together. But we have no intention under current law of attempting to merge these organizations or to merge

the federal agencies that are administering these organizations. Once we have new legislation, that becomes a very different situation, and all that we'll be doing until we have new legislation is contingency planning, which I think is what any organization has to do. Or else we'll be sitting with our mouth open and have to take six months or a year to try to figure out how to put it together again. I don't think that's in anybody's interest.

CHAIRMAN PAHL: As you can see, Mr. Rubel has a particularly difficult job during this coming period, and I want to say publicly we are going to do everything we can to cooperate and assist in whatever forward direction the Administration is taking, and we certainly expect to have you participate in not only the meetings of the council but hopefully, as your schedule permits, the meetings of the coordinators and others so there can be this kind of dialogue both from Washington to those who are responsible for participating in our program as well as vice versa.

So, we thank you for coming today, and stay as long as you can.

MR. RUBEL: Let me add one more point. It's not just here. In the six months that I've been responsible for CHP, I have--I was adding it up yesterday--I have traveled some 60,000 miles. I have visited some 35 areawide agencies and almost a dozen state agencies in CHP. And I will continue

to do that as much as I possibly can. We do some important things here, but the real important stuff is being done out in the communities out there, and I try to maintain some kind of contact with reality. Sometimes it's what you need in order to survive some of the kind of stuff you've got to take around here.

I am encouraged by what I see. I see a maturing. I can recall--Mr. Gaye, I don't know if you remember this--but I came to visit you when I didn't have the foggiest idea of what RMP was about. It must be two and a half years ago, and it's a very different world today than it was then. And, recognizing that there can be some very substantial philosophical differences in terms of what our system should look like and what kinds of governmental and private roles we need, I am very optimistic. I think while, you know, I've read a fair amount about seventy-five million dollar budget, an enormous decrease from past years, the amount of money that we are going to spend on this is not the critical item, remember. What we buy primarily is staff, people's time. We buy their emotions and their willingness to get in and--you can buy a fair amount of that with $75 million. We're not buying medical services and we're not giving people money. And looking at that one budget item and saying, "This is obviously a tiny, minor little thing"--if that's what you do, you're making a big mistake. This is terribly important. I would guess that

the new legislation that's passed here is going to be the most important piece of health legislation passed this year. And I would rank it next to national health insurance in terms of what we of the federal government are doing in the way of working our will on the health care system.

CHAIRMAN PAHL: Thank you again very, very much. And I'm sure we will have some more questions as we go along with this.

We asked Mrs. Silsbee to come up and assist us in our review of applications. As the last item of open meeting business, I would like to request adoption of the minutes either as submitted to you or with any corrections, changes, that you feel are appropriate. I hope you have had a chance to perhaps glance at these over the lunch hour, and if there are no changes, we'd be glad to accept a motion for adoption.

MR. OGDEN: I move the adoption of the minutes as they are.

Adoption of Minutes

MR. MARS: I second.

CHAIRMAN PAHL: It has been moved and seconded. All in favor say aye. [Response]

Opposed? [No response]

The minutes are adopted as submitted.

Now, this terminates the open session of the meeting, and we will ask all those who are not members of the council or the government please to absent themselves.

We appreciate your participation in the meeting, and in just a moment we will turn to Mrs. Silsbee and the review of the applications and findings of the site visits to the three RMP's.

[Time noted: 2:23 o'clock p.m.]

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