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VI. Questions and Answers

A. What would be the impact of phasing out RMP grants in terms of projects and funding at sponsoring institutions, staff employed on operational projects, and staff employed on the RMP program (core) staffs?

B. Has any consideration been given to modifying RMP so that the mechanism which has been established may be used in a different way?

C. What is RMP doing in terms of Training and Manpower Utilization activities?

D. What is RMP doing in the area of kidney disease programs and regionalization?

E. What types of planning and feasibility studies are being done by the RMP program staffs?

F. What is the situation in terms of the use of State boundaries by the RMP's in defining their area of influence?

G. To what extent have the RMP's been successful in attracting other funds?

H. To what extent have the RMP's been able to assure continuation funding for operational projects without a continued reliance on Federal funds?

I. In the past there was some indication that the medical schools and providers dominated RMP. Is this still true?

J. Based on recent budgets, what percentage of RMP funds support activities of a categorical disease nature? How are these funds allocated among the various major diseases?

A. Q. What would be the impact of phasing out RMP grants in terms of projects and funding at sponsoring institutions, staff employed on operational projects, and staff employed on the RMP program (core) staffs?

A. Sponsoring Institutions of Operational Projects

As of June 30, 1972, some 1,007 operational projects were being carried out by the Regional Medical Programs at a level of $76,540,000. The phasing out of these projects would affect the following types of sponsoring institutions in terms of numbers of projects and grant funds:

Sponsor	No. of Operational Projects	Funding Level - FY 72 (in thousands)
Medical School	327	$ 27,772
University Health School	52	3,227
Other Educational Institution	61	3,561
University-Affiliated Hospital	52	3,670
Community or other Hospital	132	5,699
Voluntary Health Agency	49	3,044
Public Health Agency	74	5,049
Health Professional Society	18	2,919
Other	195	15,696
Multiple	47	5,902
TOTAL	1,007	$ 76,540

Staff Employed on Operational Projects

As of August 1972, staff employed on operational projects totaled 2,292 persons (full-time equivalents). This included:

Professional and Technical	1,654 FTE
Secretarial and Clerical	638 FTE
	2,292 FTE

This amounts to an average of 41 persons per Region, with a high in California of 184 operational project staff, and two to three Regions in the lower range of 7-10 operational staff.

Program (Core Staff)

Program staff in the RMP's for FY72 included 1,374 full-time equivalents. This includes:

Professional and Technical	805 FTE
Secretarial/Clerical	569 FTE
	1,374 FTE

Given 56 RMP's, this represents an average size staff of 24.5 full-time equivalents. Size of staff varies greatly with both the size of the region and its maturity. California, for example, with nine sub-regions, has a total staff of 206 FTE, while the Delaware RMP, which is a newly formed region, is just in the process of hiring staff.

B. Q. Has any consideration been given to modifying RMP so that the mechanism which has been established may be used in a different way?

A. A variety of options for modifying RMP were considered by the Office of the Assistant Secretary for Health before the final decision was made. Among these:

1. Implementation of Quality Control/Assurance Mechanisms

-- It is possible to look at quality assessment efforts comprised of three basic components: (1) development of the quality assessment system itself, including technical assistance to start it at the State or local level; (2) the actual operation of a quality monitoring system; and (3) corrective action which is taken as a result of areas of deficiency pointed out by the monitoring system.

To date, RMP has been mostly involved in corrective action to meet obvious problem areas. This has centered on patient care demonstrations involving new techniques and innovations in health care patterns, and educational efforts aimed at correcting identified areas of deficiency. During late FY72, RMP started to work in the area of raising the level of health care provider understanding and experience of the objectives and techniques of quality monitoring as rapidly as possible. RMPS plans development this year of an inter-regional program for development of quality of care consultative services. There has been little consideration so far in RMP of moving beyond the developmental and technical assistance role to having a direct monitoring responsibility for quality of care.

2. Local Implementation of CHP Plans and Priorities

--Depending on the nature of decisions made about the future role of the CHP agencies, there will probably be the need for some sort of implementing agency or agencies to take those actions and promote those activities necessary to accomplish projects and agreed upon plans. Such an implementing body would need to be responsive to the priorities and plans which had been developed by the CHP agencies.

Regional Medical Programs tend to fit rather naturally into the implementor role, although this has not been in conjunction with CHP plans or priorities in particular. Reasons for looking toward RMPs as implementing agencies include the linkage with the provider community, which will eventually be responsible for actual implementation; their current existence as viable, functioning organizations covering the entire country; and their past experience in this role in terms of patient care demonstration projects, emergency medical service systems, and program staff activities in promoting a range of new initiatives such as HMO's and quality assurance efforts.

3. Mechanism(s) for conducting pilot experiments, demonstrations, and reforms within the system. This includes community-based test beds for valid R&D efforts.

   --There has not been a particularly great emphasis on designing the products of health services research and development for widespread implementation at the local level. Much of what is locally developed does not take advantage of experiences elsewhere in the country. This area of widespread introduction of innovations into the health care delivery system is one in which RMP is already somewhat involved, but which could be expanded upon and made more explicit. This would be in keeping with one facet of the original RMP mandate which was to promote the latest advances, and it would also provide a needed compliment or "outlet" to HS' research and development efforts.

4. Promotion of/assistance to new Federal initiatives (e.g., HMO's, Emergency Medical Service Systems).

   --As new Federal initiatives are decided upon, their success depends a great deal on having agencies at the local level which can respond quickly and effectively to initiate new program activities. For a variety of reasons, including their linkage to the provider community, their operating experience, and the flexibility allowed by a grant structure which incorporates both operational project activity and program staff activities, the RMPs are able to function well in responding to a variety of new Federal initiatives.

5. Vehicle for large-scale implementation of community-based disease control programs, such as hypertension and end-stage renal disease.

   --Given recent Congressional action in terms of the National Cancer Act and the National Heart, Blood Vessel, Lung and Blood act of 1972, one possible area of focus was on community-based disease control programs. In part because of its legislative background, there are some proponents of having RMP give emphasis to large-scale implementation and support of disease control programs.

   Such disease control programs might best be carried out by a mechanism which has close ties to community health institutions, rather than by one of the national research institutes. Use of the RMP mechanism would help ensure that the disease control activities undertaken would be more nearly integrated with or linked to the larger health care delivery system and private provider sector at the local level, rather than leading to further fragmentation of the system.

6. Feedback loop from the service to the educational sector, and those institutions responsible for the production/training of health manpower.

   --There is currently a vary tenuous connection between the educational sector, more specifically the medical schools and other health personnel schools, and the patient services sector in the form of community hospitals and the practicing physicians. The educational sector tends to project its plans on the basis of shortages of specific personnel; the patient services sector, on the other hand, tends to look at gaps in health services, either in terms of specific population groups or geography. There is not a well-formed attempt to relate education to the health services delivery needs of an area.

   Regional Medical Programs in conjunction with the CHP agencies, would play a part in this effort by developing an improved feedback loop from the patient service sector to the educational sector, so that the focus of the latter is concentrated on gaps in health services, many of which might be filled by existing manpower.

7. Stimulation and support of greater sharing of resources and services among health institutions aimed at moderating cost increases.

   --There is a continuing need for the development of improved institutional linkages to increase the productivity of each of the participating institutions. Such linkages extend their capacity where limited services already exist, and provide for increased availability and accessibility where such services do not exist.

   Regionalization and new organizational arrangements are major themes of Regional Medical Programs. Working relationships and linkages among community hospitals and between such hospitals and medical centers are among the primary concerns of the program. The linking of less specialized health resources and facilities such as small community hospitals with more specialized ones is an important way of overcoming the maldistribution of certain resources, and thereby increasing their availability and enhancing their accessibility. Kidney disease is one area in particular in which the development of integrated regional systems can prevent the duplication which has so frequently wasted our limited resources.

C. Q. What is RMP doing in terms of Training and Manpower Utilization activities?

A. RMP support for training and manpower utilization activities is generally divided into three categories:

Activity	FY 1971			FY 1972		
	No. of Projects	* Amount (in thousands)	Percent of operational funds	No. of Projects	* Amount (in thousands)	Percent of operational funds
Training Existing Health personnel in New Skills	144	$10,154	22	200	$13,266	17
Training New Categories of Personnel	16	921	2	55	3,566	5
Continuing Education	149	9,578	21	186	12,031	16

Training Existing Health Personnel in New Skills - aimed at enabling the person trained to assume new responsibilities in his already chosen career field. The emphasis is on increasing the productivity of personnel and includes expanding the functions of registered nurses and career mobility for licensed practical nurses.

New Categories of Personnel - the establishment of training programs for new categories of personnel such as physicians' assistants, nurse practitioners, and community health workers. The primary objective here is to expand the manpower health pool through the development of these new categories of health and allied health professionals who can become part of an expanded health services delivery team.

*Total current funding level, which includes some funds obligated in prior years.

Continuing Education - courses aimed at maintaining or improving the level of practice of the health professional.

Most RMP training activities operate outside the general education process, and are of short-term duration. In FY71, through on-the-job training (involving release time), 85% of the training provided was five days or less, with 60% of that involving one day or less.

In RMP's approach to resolving manpower problems, the emphasis is on developing programs that more closely relate education to the health service delivery needs of an area. In terms of health professionals already recognized (e.g., MD's, nurses), the emphasis is on increasing their capabilities, knowledge and skills, and not on increasing the numbers of such recognized health professionals. Training is not supported which leads to licensure or registration.

On the other hand, training for new categories of personnel is devoted to creating new types of health paraprofessionals not yet recognized by the health care system as health professionals. The present curriculum structure of the health professional schools is not designed to create these new types of manpower (e.g., physician aide, home health aide).

In terms of the course registrations for each of the three major categories of training, the attached chart shows

naturally that the highest registration is in the shortest-term courses (i.e., continuing education, and new skills for existing personnel) while the training for new categories of personnel, which takes a longer period, shows a lower level of registrations.

COURSE REGISTRATIONS IN RMP-SPONSORED EDUCATION ACTIVITIES FY 72
(Listed by Type of Training Received and Discipline of Recipient)

DISCIPLINE	CONTINUING EDUCATION a/	NEW SKILLS FOR EXISTING PERSONNEL b/	NEW PERSONNEL c/	TOTAL No.	TOTAL Percent
Physicians (MD/DO)	46,328	10,140	-	56,468	29%
Dentists	1,442	197	-	1,639	1
Nursing Personnel	36,301	25,072	146	61,519	32
Allied Health Personnel	23,011	12,362	1,205	36,578	18
Hospital/Nursing Home Personnel	10,414	694		11,108	6
Medical, Dental and Nursing Students	6,106	1,139		7,245	4
Other	8,582	9,579	1,064	19,225	10
TOTALS	132,184	59,183	2,415	193,782	100%

a/ Continuing Education - courses aimed at maintaining or improving the level of practice of the health professional.

b/ New Skills for Existing Personnel - training aimed at enabling the person trained to assume new responsibilities in the already chosen career field or adding skills in a different but related health field (e.g., coronary care training for nurses, career mobility for licensed practical nurses).

c/ New Personnel - development of training programs for such new categories of personnel as physicians' assistants, nurse practitioners, and community health workers.

D. Q. What is RMP doing in the area of kidney disease programs and regionalization?

A. Kidney Disease Programs and Regionalization

Kidney disease is one disease area in which the development of integrated regional systems can prevent the duplication which has so frequently wasted our limited resources. RMP has worked to develop regional/national networks of dialysis and transplant centers, so as to maximize access to life-saving services enhancing quality and efficiency.

Between FY71 and FY72 there was a fourfold increase in the funding of operational projects concerned with kidney disease. By the end of FY72, 29 Regional Medical Programs were supporting end-stage renal activities at a funding level of approximately $6 million, in contrast to a level of $1.5 million in FY71. (This does not include over $2 million on contract activities, primarily related to home dialysis training, also being supported directly by RMPS).

The focus of the RMP effort has been on the development and implementation of regionalized, end-stage kidney disease programs. This was reflected at the national level by the development of a long-range, "life plan" approach for dealing with the major problem represented by the 8-10,000 new patients afflicted with end-stage kidney disease every year.

The principal aim of the "life plan" approach is the efficient linkage, and orderly growth of scarce resources throughout the United States. The program guidelines developed by RMPS and approved by the National Advisory Council seek to exploit the opportunities for regionalization of end-stage kidney disease programs without sacrificing quality and accountability. These guidelines require that in order to be eligible for grant support, RMP-proposed activities should include the following components:

1. Assurance of early identification of patients approaching renal failure

2. Rapid referral of such patients

3. Early classification of these patients regarding tissue-typing

4. Availability of the coordinated dialysis-transplantation facilities to assure treatment alternatives to both the patient and the physician

5. Effective cadaver kidney procurement and preservation operations, coupled with rapid kidney donor-recipient matching.

The advantages of such an approach include the fact that patients would have access to conservative treatment before kidney function

stops, an optimal organ in terms of tissue-typing would probably be found while the patient is still alive, and that almost all patients would be carrying out dialysis outside of the hospital.

Staff of the Regional Medical Programs Service have been working with the Social Security Administration to develop regulations implementing that portion of the Social Security Amendments of 1972 dealing with chronic renal disease. (Sec. 299I). This includes both the provisions for expanding eligibility for renal dialysis and transplantation, and for the development of quality standards and requirements for kidney disease treatment centers. This initial effort is expected to be completed by April 1973.

KIDNEY DISEASE

Grants and Contracts

	1972 Actual		1973 Estimated	
	No.	Amount	No.	Amount
Home training for Kidney Hemodialysis Centers.....	2	297,200	-0-	-0-
Kidney organ procurement project.....	4	1,097,707	-0-	-0-
Model regional integrated dialysis 1/.....	5	447,828	-0-	-0-
Limited care dialysis projects.....	3	204,552	-0-	-0-
Other major areas.....	3	58,925	-0-	-0-
Subtotal.....	17	2,106,212	-0-	-0-
Regional Medical Program Grants (Several project activities).....	74	6,246,000	N/A	2,461,000
Total.....	91	8,352,212	N/A	2,461,000

1/ Integrated systems include home dialysis training, organ procurement, and transplantation.

E. Q. What types of planning and feasibility studies are being done by the RMP program staffs?

Planning and Feasibility Studies of RMP Program Staffs

(In Thousands)

	FY71	FY72	12/31/71
Planning Studies and Inventories	$3,712	$4,792	$4,609
Feasibility Studies	2,362	3,049	2,933
	$6,074	$7,841	$7,542

Planning Studies and Inventories

A variety of planning and health data activity is carried out by the Regional Medical Programs to help determine specific objectives, needs and priorities within a region. The majority of RMP planning and health data activity centers around particular needs and problems, rather than being on-going, broad-based planning and data systems. Many of the planning and inventory studies are aimed at specific areas and are set up to lead to specific operational proposals which deal with such issues as the manpower and facilities resources in a region, the adequacy of and need for specialized clinical facilities, disease and patient referral patterns, and unmet educational needs. Among examples:

> The Research and Evaluation Unit of the Kansas RMP carried out a Physician's Assistant Survey. The study was designed to determine whether or not Kansas practitioners would use a physician's assistant. Seventy-five percent of the physicians surveyed indicated they would be willing to use such assistants and felt the need for employing them. The results of this survey played a major role in the development of the nurse clinician project which was initiated in July of 1971, the purpose of which is to train nurses to serve as physician's assistants.
>
> A survey by the Texas RMP showed that 19 counties in the State had no practicing physicians and that the 1970 physician-to-population in Southwestern Texas was 1:1,017. This past year the University of Texas Medical School at San Antonio announced establishment of the State's first bachelor degree program to train physician's assistants.

The table below shows the types of planning studies and data collection activities carried out during 1970 and 1971, in order to determine the extent of regional problems and the resources available for use in their solutions.

Area of Planning Study of Data Collection	Number of Studies
Manpower distribution and availability	50
Services and facilities	98
Health conditions	95
Categorical diseases	29
Screening	23
Continuing education	42
Data Banks	38
TOTAL	375

In addition, the Regional Medical Programs are involved in a variety of joint planning and data system efforts which involve cooperation with other agencies, particularly the Comprehensive Health Planning agencies. According to a program analysis memorandum completed in 1971 on RMP relationships with CHP agencies, some 45 State CHP agencies cooperated with RMP's on joint surveys, studies, or exchange of services in data collection or analysis. Of the 50 Regional Medical Programs having Federally-funded Areawide CHP agencies in their region, 46 reported having data sharing or other types of joint data activity with at least one Areawide agency in their region.

In Arkansas, for example, Areawide CHP agency staff and committees are utilized to provide subregional data to RMP in the development of subregional plans. The Arkansas RMP and the State CHP agency are also cooperating on the development of a regional hospital plan for health service delivery, and both were closely involved in the planning for the Experimental Health Services Delivery System.

RMP, with its strong linkage to the provider community, has served as an important technical, professional and data resource for the State and Areawide CHP agencies. The RMP's, in turn, have looked to the planning agencies for expression of broad-based community health needs and priorities.

Although the amount of funds being used for planning activities was large in the early years of the program, it has declined recently as most of the programs have become operational, and has ranged from approximately $4-5 million in the past two years.

Feasibility Studies.- Pilot projects which frequently provide necessary seed money. If the initial results warrant, implementation on a larger scale, either as a RMP-supported operational project or with funds from other sources, can generally proceed.

A project to screen Pittsburgh students for sickle cell anemia was initiated last year by the Western Pennsylvania RMP. Testing will provide an indication of the problem in school age groups, with the data to be analyzed by the Allegheny County Health Department and the University of Pittsburgh Health Center.

The American Indian Free Clinic opened this spring in a remodeled wing of the Grace Baptist Church in Compton, California, which is part of the greater Los Angeles area. With seed money from the California RMP, an OEO grant, and much volunteer help, the clinic handles 35-40 patients every Tuesday and Thrusday evening. All equipment for the clinic was donated and almost all the volunteer help are Indians.

F. Q. What is the situation in terms of the use of State boundaries by the RMP's in defining their area of influence?

A. Geographic boundaries: Number of programs which primarily:

Encompass single States	34
Encompass two or more States (e.g., Washington-Alaska RMP)	4
Are parts of single States (mainly in N.Y., Pa., Ohio)	11
Are parts of two or more States (e.g., Bi-State: St. Louis and southern Illinois)	7

There are both pluses and minuses to the use of State boundaries by the majority of the Regional Medical Programs.

Points Favoring the Use of State Boundaries

- There is a greater congruency with State CHP agencies, allowing greater consistency of RMP priorities to community and State established priorities.
- The increasing politicalization of health at the State level is more consistent with those RMP's that match State boundaries.
- Many emerging and important practical issues are or will be dealt with in a State frame of reference, including production of manpower, licensure, HMO regulation, and other tax-supported activities.

Points Against the Use of State Boundaries

- In those cases in which the RMP does not match a State boundary, there is generally strong justification in terms of the natural medical trade area. These include the metropolitan areas of St. Louis (and southern Illinois), Memphis, and Metropolitan Washington, D.C., with others in Ohio Valley (Kentucky plus Cincinatti and other parts of southern Ohio) and Intermountain RMP (Utah, and portions of surrounding States). State boundaries could harm making maximum use of these natural trade patterns.
- State boundaries can lead to creation of unnecessary or redundant specialized services and facilities, such as kidney disease and specialized heart disease resources. There might be less incentive to make optimum use of nearby resources of another State through regional planning and patient referrals.
- Use of a State boundary for an RMP should in no way inhibit it from reaching beyond State boundaries in its activities where the logic of the situation has so dictated. Most regions have followed this logic in developing their programs and activities.

G. Q. To what extent have the RMP's been successful in attracting other funds?

A. With a small initial input of program staff time or operational project funds, the RMP's have often been able to generate health care activities on a larger scale which brought in funds from a multiplicity of sources. In FY72, for example, approximately $8.4 million in other sources of funds was combined with $76.5 million in RMP funds to carry out operational projects. Other sources of funding included:

State funds:	$1.33M
Local funds:	3.51
Other Federal:	2.20
Other non-Federal:	1.40
	$8.44M

Among examples:

- Maine's Regional Medical Program has been primarily responsible for $400,000 of additional financial support from other agencies and organizations during this past year. This includes:

  * $75,000 from the Maine State Legislature and $40,000 from the New England Regional Commission working toward development of a College of Physicians

  * $29,000 from various voluntary health agencies for public education in health

  * $4,300 from a variety of drug corporations for a coronary care project

  * $40,000 from the Veterans Administration for Area Health Education Planning

  * $9,500 from the Commonwealth Fund for evaluation of the Inter-active Television Project

  * $43,000 from OEO - New England Regional Commission for a healthmobile project.

. New Jersey RMP's four-year old Urban Health Component, funded at $160,000, provides health planners to that state's eight Federally-designated Model Cities Programs. Begun in 1968 when urban health coordinators were assigned to New Jersey's first three Model Cities, it proved so successful that in April 1970 this project was expanded to include the other Model Cities in the state. To date, the staff has secured more than $8.4 million from sources other than RMP to fund health programs in these cities. (This Urban Health Component was expanded again in 1971 when the New Jersey RMP signed a contract with the New Jersey Department of Community Affairs to provide health planning assistance to the 16 cities in the state's ten Community Development Programs.)

H. Q. To what extent have the RMP's been able to assure continuation funding for operational projects without a continued reliance on Federal funds?

A. The concept of time-limited support has always been central to Regional Medical Programs. Furthermore, incorporation within the regular health care financing system of RMP-funded operational projects and activities has been an important measure of their success (or failure). This concept of time-limited support initially was given explicit policy expression several years ago. The National Advisory Council in November 1970 considered and approved a policy to the effect that RMP funding of operational projects generally should not be for more than three years. Additional emphasis was given to this policy by the RMP review criteria implemented in June 1971.

Based on data available from recent reports from about one-third of the Regions (19 of the 56), it is estimated that RMP support, in dollar terms, is being phased out within three years in some 75-80% of all operational projects. These same data indicate, again in terms of dollars, that roughly 60% of those projects from which RMP grant support is being withdrawn, will be continued from other sources, albeit at a reduced level of funding.

The increasing success of RMPs in turning over their grant funds within a reasonably short time, which in turn permits them to reinvest those same funds in new activities, and in attracting continuation support for activities they have helped initiate, is due to a number of factors. The major one seems to be that activities that are problem-oriented tend to elicit community or local support. They are able to attract other sources of funds (or services in-kind) from the very outset. Another reason is that planning for decremental funding is built into many RMP-initiated operational projects.

I.Q. In the past there was some indication that the medical schools and providers dominated RMP. Is this still true?

A. During the initial organizational stages of Regional Medical Programs, the medical schools functioned as one of the significant resources for the RMPs' development. Commonly the center of the medical trade areas along whose boundaries the 56 regions were formed, the schools provided a natural resource for the establishment of the RMPs and for the conduct of their activities. In addition, many of the medical schools served as the initial grantee for the locally-developing RMP.

As the Regional Advisory Groups began to mature, with their composition of a broad range of provider and public groups, the influence of the medical schools fell more into line with their normal influence in the community health structure. This shift is reflected in changes in the composition of the Regional Advisory Group, which is responsible for approving applications and setting overall RMP policy. Between 1967 and 1972, medical center officials have decreased from 16% to 9% of the representation while consumers have increased from 15% to 25% and practicing physicians from 23% to 27%.

RMPS has also recently clarified the relationship between Regional Advisory Groups and grantees. The basic point was that the RAG, as the broadly-based group representative of community health interests, has the responsibility for setting the general direction of the RMP and formulating program policies, objectives, and priorities.

With regard to the statement that Regional Medical Programs is dominated by providers, this is certainly true and is considered one of the strengths of the program. RMP provides an acceptable mechanism through which providers can work together with considerable flexibility to meet health needs that cannot be met by individual practitioners, health professionals, hospitals and other institutions acting alone. It provides one of the major links between both the Federal government and providers of care, and between consumer-oriented CHP agencies and the major provider groups.

J.Q. Based on their most recent budgets, what percentage of RMP funds support activities of a categorical disease nature? How are these funds allocated among the various major diseases?

A. FY72 saw an acceleration of the longer-term trend towards the support of more comprehensive and multi-categorical operational activities by the RMP's. In FY71, for example, only about one-third of the nearly 600 RMP-supported operational projects were multi-categorical or comprehensive in nature. The other two-thirds had essentially a single disease focus (e.g., heart disease, cancer, stroke). By the end of FY72, however, well over one-half of some 1,000 RMP operational projects were of a multi-categorical or comprehensive nature. The number of projects and funding levels for both categorical and comprehensive efforts is summarized below:

	FY71			FY72		
	No. of Projects	Amt.	%	No. of Projects	Amt.	%
Single, categorical disease focus	373	$28.5M	63	430	$29.6M	39
Multi-categorical or comprehensive	221	16.8M	37	574	46.7M	61

In terms of individual disease categories, there have been some significant shifts within the past year, as the summary table below shows:

	FY71		FY72		
	No. of Projects	Amt.	No. of Projects	Amt.	Net Change
Heart	147	$10.8M	116	$ 6.6M	-$4.2M
Cancer	89	6.2M	98	6.5M	+ .3M
Stroke & Hypertension	74	6.4M	65	5.0M	- 1.4M
Kidney	22	1.5M	74	6.2M	+ 4.7M
Pulmonary disease	22	2.5M	35	2.9M	+ .4M
Other related (e.g., diabetes)	19	1.0M	42	2.3M	+ .8M

The fourfold increase in the funding of operational projects concerned with kidney disease largely reflects the response of the RMPs to the Congressional priority on end-stage renal disease programs. The significant decrease, nearly 40 percent in the funding of operational projects focused exclusively on heart disease is directly related to the continuing disengagement of RMPs from coronary care demonstration and training

activities. This had, until recently, constituted the single largest discrete area of RMP activity.

In sum, there has been a large increase in the funding of comprehensive as opposed to categorical-type efforts. Among the categorical efforts themselves, there is an increasing balance among the several categorical diseases specified in title IX (i.e., heart disease, cancer, stroke, kidney disease, and other related diseases).