ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

January 25, 1974

M E M O R A N D U M

TO: CAS Administrative Board

FROM: Connie Choate, Secretary to August G. Swanson, M.D.

SUBJECT: Next Meeting

The next meeting of the Administrative Board will be on March 6, 1974, the day preceding the CAS Spring Meeting. The meeting will begin at 10:00 a.m. and end at 9:30 p.m. That evening, Dr. Lionel Bernstein, of the Office of the Assistant Secretary for Health, will join the Board for cocktails and dinner followed by a discussion period. The meeting will be held at the Mayflower Hotel. The meeting on March 6 will replace the meeting previously scheduled for March 21.

Enclosed is the material on the Spring Meeting that has been sent to the entire CAS mailing list. Please be sure and fill out your hotel reservation forms and mail them directly to the Mayflower Hotel. I would appreciate your also filling out the attendance form and returning it to me as soon as possible. Please note that the AAMC will reimburse your expenses (coach airfare) to cover the Administrative Board (March 6) but not the CAS Spring Meeting (March 7-8).

Ronald W. Estabrook, Ph.D.
Jack W. Cole, M.D.
Carmine D. Clemente, Ph.D.
Robert M. Blizzard, M.D.
A. Jay Bollet, M.D.
David R. Challoner, M.D.
D. Kay Clawson, M.D.
Rolla B. Hill, Jr., M.D.
Leslie T. Webster, M.D.
Ernst Knobil, Ph.D.
Robert G. Petersdorf, M.D.

cc: Daniel C. Tosteson, M.D.
Sherman M. Mellinkoff, M.D.
AAMC Executive Staff
DAA Division Directors
Mary H. Littlemeyer

Enclosures

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

JANUARY 25, 1974 CAS BRIEFS NO. 23

ATTACHED IS THE PROGRAM FOR THE CAS SPRING MEETING TO BE HELD MARCH 7 & 8, 1974, AT THE MAYFLOWER HOTEL IN WASHINGTON, D.C. ALL CAS REPRESENTATIVES AND OFFICERS OF MEMBER SOCIETIES ARE INVITED TO ATTEND.

ENCLOSED IS A HOTEL RESERVATION FORM WHICH IS TO BE SENT DIRECTLY TO THE MAYFLOWER HOTEL. PLEASE SEND IN YOUR RESERVATION CARD AS SOON AS POSSIBLE. THE HOTEL WILL NOT GUARANTEE SPACE AFTER FEBRUARY 22, 1974.

THERE WILL BE A $20.00 REGISTRATION FEE TO COVER THE COST OF THE TWO LUNCHEONS AND THE RECEPTION AT THE AAMC. PLEASE SEND YOUR CHECK WITH THE ENCLOSED FORM INDICATING WHETHER OR NOT YOU WILL ATTEND BY FEBRUARY 15, 1974. A SELF-ADDRESSED ENVELOPE IS ENCLOSED FOR YOUR CONVENIENCE.

MS. CONNIE CHOATE
SECRETARY TO
AUGUST G. SWANSON, M.D.
DIRECTOR OF ACADEMIC AFFAIRS

ENCLOSURES - HOTEL RESERVATION CARD (TO BE SENT DIRECTLY TO THE MAYFLOWER HOTEL)

ATTENDANCE FORM (TO BE SENT TO CONNIE CHOATE AT AAMC WITH $20.00 IF ATTENDING)

CAS SPRING MEETING PROGRAM

COUNCIL OF ACADEMIC SOCIETIES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

COUNCIL OF ACADEMIC SOCIETIES SPRING MEETING
March 7 - 8, 1974
Mayflower Hotel, Washington, D.C.

THURSDAY, MARCH 7, 1974

9:00 a.m. - 12:30 p.m.

CAS BUSINESS MEETING

12:30 p.m. - 2:00 p.m.

CAS LUNCHEON - Guest speaker to be announced

2:00 p.m. - 5:00 p.m.

CAS GENERAL SESSION

Biomedical Research & Health Legislation, 1974:

Mr. Harley M. Dirks, Professional Staff Member
Senate Appropriations Committee

Mr. Lee Goldman, Staff Director
Senate Health Subcommittee of the
Committee on Labor & Public Welfare

Mr. Stephan Lawton, Counsel
Subcommittee on Public Health & Environment of the
Committee on Interstate & Foreign Commerce

John A. D. Cooper, M.D., President
Association of American Medical Colleges

5:30 p.m. - 7:30 p.m.

Reception at AAMC offices, 1 Dupont Circle

FRIDAY, MARCH 8, 1974

9:00 a.m. - 12 Noon

Debate on Tenure Policies - See attached page

12 Noon - 1:30 p.m.

CAS LUNCHEON - Guest speaker to be announced

2:00 p.m. - 4:00 p.m.

Debate on Collective Bargaining - See attached page

COUNCIL OF ACADEMIC SOCIETIES
SPRING PROGRAM
March 8, 1974
9:00 a.m. - 4:00 p.m.
Mayflower Hotel
Washington, D. C.

THE EFFECT OF TENURE POLICIES & COLLECTIVE BARGAINING ON FACULTY DEVELOPMENT

Debate on Tenure Policies:

RESOLVED, THAT ACADEMIC TENURE IS OUTMODED AND SHOULD BE ABOLISHED

MODERATOR & DISCUSSION LEADER:

Sherman M. Mellinkoff, M.D.
Dean
The UCLA School of Medicine

SPEAKER FOR THE MOTION (20 min.):

Cheves McC. Smythe, M.D., Dean
The University of Texas
Medical School at Houston

SPEAKER AGAINST THE MOTION (20 min.):

Mr. William Van Alstyne
Professor of Law
Duke University School of Law

REBUTTAL (10 min.): Dr. Smythe

REBUTTAL (10 min.): Mr. Van Alstyne

DISCUSSION FROM FLOOR (60 min.)

* * *

Debate on Collective Bargaining:

RESOLVED, THAT COLLECTIVE BARGAINING BY THE FACULTY WILL STRENGTHEN BOTH RESEARCH AND EDUCATIONAL PROGRAMS IN UNIVERSITIES

MODERATOR & DISCUSSION LEADER:

Ludwig Eichna, M.D.
Professor & Chairman
Department of Medicine
SUNY, Downstate Medical Center

SPEAKER FOR THE MOTION (20 min.):

Otto M. Lilien, M.D.
Professor and Chairman
Department of Urology
State University of New York
Upstate Medical Center

SPEAKER AGAINST THE MOTION (20 min.):

John N. Lein, M.D.
Associate Dean for
Continuing Education & Development
University of Washington
School of Medicine

REBUTTAL (10 min.): Dr. Lilien

REBUTTAL (10 min.): Dr. Lein

DISCUSSION FROM FLOOR (60 min.)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

ATTENDANCE FORM

PLEASE FILL OUT AND RETURN TO CONNIE CHOATE BY FEBRUARY 15, 1974

I WILL _____ WILL NOT _____ ATTEND THE CAS SPRING MEETING ON MARCH 7 & 8, 1974, AT THE MAYFLOWER HOTEL IN WASHINGTON, D.C.

ENCLOSED IS MY CHECK FOR $20.00 _____

NAME (PLEASE PRINT) _____

ADDRESS _____

_____

SOCIETY _____

DATE _____

FEB 25 1974

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

TO: Officers and Representatives of CAS Member Societies

FROM: Connie Choate, Secretary to August G. Swanson, M.D.

SUBJECT: CAS Spring Meeting

Attached is the final program for the CAS Spring Meeting to be held March 7-8, 1974, at the Mayflower Hotel here in Washington, D.C.

If you have not already done so, please fill out the enclosed attendance form, indicating whether or not you will attend, and return it to me immediately. If you desire hotel reservations at the Mayflower, please contact the hotel directly at (202) 347-3000.

Attachments

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

PROGRAM
FOR
COUNCIL OF ACADEMIC SOCIETIES SPRING MEETING

March 7 - 8, 1974
Mayflower Hotel, Washington, D.C.

THURSDAY, MARCH 7, 1974

9:00 a.m. - 12:30 p.m.

CAS BUSINESS MEETING
Colonial Room
(Lower Level)

12:30 p.m. - 2:00 p.m.

CAS LUNCHEON - Guest speaker:
Chinese Room The Honorable William Roy
(Main Level) United States House of Representatives

2:00 p.m. - 5:00 p.m.

CAS GENERAL SESSION
Colonial Room
(Lower Level)

Biomedical Research & Health Legislation, 1974:

Mr. Harley M. Dirks, Professional Staff Member
Senate Appropriations Committee

Mr. Lee Goldman, Staff Director
Senate Health Subcommittee of the
Committee on Labor & Public Welfare

Mr. Stephan Lawton, Counsel
Subcommittee on Public Health & Environment of the
Committee on Interstate & Foreign Commerce

John A. D. Cooper, M.D., President
Association of American Medical Colleges

5:30 p.m. - 7:30 p.m.

Reception at AAMC offices, 1 Dupont Circle

continued . . .

COUNCIL OF ACADEMIC SOCIETIES
SPRING PROGRAM
March 8, 1974
9:00 a.m. - 4:00 p.m.
Colonial Room
Mayflower Hotel
Washington, D.C.

THE EFFECT OF TENURE POLICIES & COLLECTIVE BARGAINING ON FACULTY DEVELOPMENT

Debate on Tenure Policies:

RESOLVED, THAT ACADEMIC TENURE IS OUTMODED AND SHOULD BE ABOLISHED

MODERATOR & DISCUSSION LEADER:

Sherman M. Mellinkoff, M.D.
Dean
The UCLA School of Medicine

SPEAKER FOR THE MOTION (20 min.):

Cheves McC. Smythe, M.D., Dean
The University of Texas
Medical School at Houston

SPEAKER AGAINST THE MOTION (20 min.):

Mr. William Van Alstyne
Professor of Law
Duke University School of Law

REBUTTAL (10 min.): Dr. Smythe

REBUTTAL (10 min.): Mr. Van Alstyne

DISCUSSION FROM FLOOR (60 min.)

* * *

Debate on Collective Bargaining:

RESOLVED, THAT COLLECTIVE BARGAINING BY THE FACULTY WILL STRENGTHEN BOTH RESEARCH AND EDUCATIONAL PROGRAMS IN UNIVERSITIES

MODERATOR & DISCUSSION LEADER:

Ludwig Eichna, M.D.
Professor & Chairman
Department of Medicine
SUNY, Downstate Medical Center

SPEAKER FOR THE MOTION (20 min.):

Otto M. Lilien, M.D.
Professor and Chairman
Department of Urology
State University of New York
Upstate Medical Center

SPEAKER AGAINST THE MOTION (20 min.):

John N. Lein, M.D.
Associate Dean for
Continuing Education & Development
University of Washington
School of Medicine

REBUTTAL (10 min.): Dr. Lilien

REBUTTAL (10 min.): Dr. Lein

DISCUSSION FROM FLOOR (60 min.)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

ATTENDANCE FORM

PLEASE FILL OUT AND RETURN TO CONNIE CHOATE IMMEDIATELY

I WILL _____ WILL NOT _____ ATTEND THE CAS SPRING MEETING ON MARCH 7 & 8, 1974, AT THE MAYFLOWER HOTEL IN WASHINGTON, D.C.

ENCLOSED IS MY CHECK FOR $20.00 _____

NAME (PLEASE PRINT) _____

ADDRESS _____

_____

SOCIETY _____

DATE _____

CAS Business meeting
March 7, 1974
Mayflower Hotel
Wash D.C.

COUNCIL OF ACADEMIC SOCIETIES

ROLL CALL

ALLERGY
American Academy of Allergy

Oscar L. Frick

Association of Anatomy Chairmen

D. Curtis Worthington

ANESTHESIOLOGY
Association of University Anesthetists

Douglas Eastwood
Robert Epstein

Society of Academic Anesthesia Chairmen, Inc.

John Steinhaus

BIOLOGICAL CHEMISTS
American Society of Biological Chemists

Robert Hill William Rutter
Robert Harte

CLINICAL RESEARCH
Academic Clinical Laboratory Physicians & Scientists

CLINICAL RESEARCH - continued
American Federation for Clinical Research

David R. Challoner, MD

American Association for the Study of Liver Diseases

American Society for Clinical Investigation, Inc.

Central Society for Clinical Research

John Eckotein

Southern Society for Clinical Investigation

Sowell Harbison

DERMATOLOGY
Association of Professors of Dermatology

David Ramsay

ENDOCRINOLOGY
Endocrine Society

Robert M. Blizzard

Jack Oppenheimer

GASTROENTEROLOGY
American Gastroenterological Association

MEDICINE
American College of Chest Physicians

American College of Physicians

Association of American Physicians

Association of Professors of Medicine

Association of Teachers of Preventive Medicine

Society of Teachers of Family Medicine
F. Marian Bishop

MICROBIOLOGY
Assn. of Medical School Microbiology Chairmen

NEUROLOGY
American Academy of Neurology

Association of University Professors of Neurology
T. R. Johns

American Neurological Association
Hal Jennings

OBSTETRICS AND GYNECOLOGY
American College of Obstetrics and Gynecology

Association of Professors of Gynecology and Obstetrics

OPTHALMOLOGY AND OTOLARYNGOLOGY
American Academy of Ophthalmology and Otolaryngology

Society of University Otolaryngologists
Roger Boles
F. L. Putney

Association of University Professors of Ophthalmology
James Elliott

ORTHOPAEDICS
American Academy of Orthopaedic Surgeons

Charles Heck

Association of Orthopaedic Chairmen

D. Kay Clawson

PATHOLOGY
American Association of Neuropathologists

American Association of Pathologists & Bacteriologists

Rolla B. Hill

Association of Pathology Chairmen, Inc.

Rolla B. Hill

PEDIATRICS
American Pediatric Society

Ralph Wedgwood

Association of Medical School Pediatric Department Chairmen, Inc.

Samuel Katz

Marvin Cornblath

Society for Pediatric Research

Lawrence Frenkel

PHARMACOLOGY

Association for Medical School Pharmacology

William S. West

Frank Standert

PHYSIATRY

Association of Academic Physiatrists

Alicia Hastings

PHYSIOLOGY

American Physiological Society

Dr. Robert Berne

Assn. of Chairmen of Depts. of Physiology

~~Edmund~~ Ewald Sel Kurt

Biophysical Society

PSYCHIATRY

American Assn. of Chairmen of Depts. of Psychiatry

David Hawkins

American College of Psychiatrists

RADIOLOGY
American College of Radiology

American Society of Therapeutic Radiologists

Association of University Radiologists
James Scatliff

Society of Chmn. of Academic Radiology Depts.
Harold Jacobson

SURGERY
American College of Surgeons

American Assn. of Neurological Surgeons
W. Eugene Stern

American Assn. of Plastic Surgeons
Edward Bennett

American Assn. for Thoracic Surgery
Edward Beattie

American Surgical Association

Jack Cole

Association for Academic Surgery

Hiram Polk

Francis Nance

Plastic Surgery Research Council

Thomas J. Krizek

Society of Surgical Chairmen

Society of University Surgeons

Gerald Austen

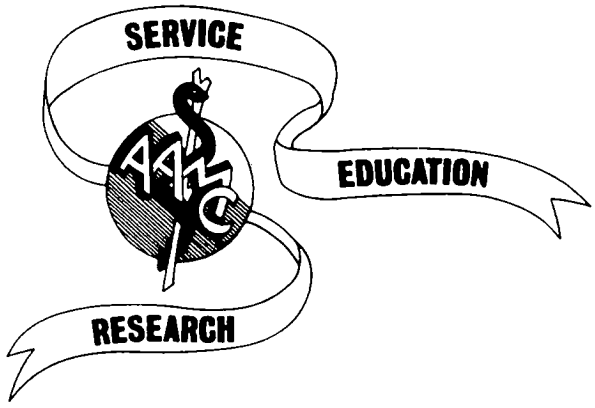
UROLOGY

American Urological Association

Dr. Walter Kerr

Society of University Urologists

William Parry



AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

Thursday, March 7, 1974

9:00 a.m. - 12:30 p.m.

Mayflower Hotel
Colonial Room, Lower Level
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

AGENDA

COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING
Thursday, March 7, 1974
9:00 a.m. - 12:30 p.m.
Mayflower Hotel
Colonial Room, Lower Level
Washington, D. C.

File Nov 4 1973
CHS Minutes

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

March 19, 1974

James E. Youker, M.D.
Professor and Chairman
Division of Radiology
Medical College of Wisconsin
Milwaukee County General Hospital
8700 West Wisconsin Avenue
Milwaukee, Wisconsin 53226

Dear Dr. Youker:

Miss Choate has referred to me your March 4 letter regarding the minutes of the November 4, 1973 meeting of the Council of Academic Societies.

Thank you for correcting the information about the representation of the Society of Chairmen of Academic Radiology Departments. I am appending your letter to the official minutes held in the AAMC Archives to reflect this change.

We are sorry for the inconvenience this may have caused you. Thank you for writing.

Sincerely,

Mary H. Littlemeyer
Senior Staff Associate

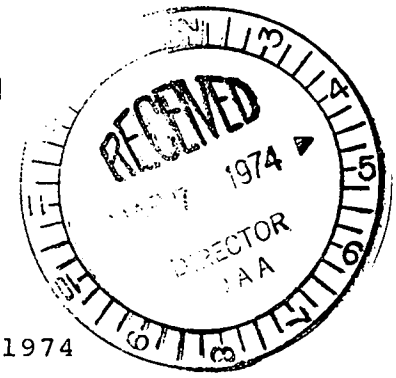
cc: Ronald W. Estabrook, Ph.D.
Chairman, Council of Academic Societies

MHL:mj

THE MEDICAL COLLEGE OF WISCONSIN
MILWAUKEE COUNTY GENERAL HOSPITAL
8700 WEST WISCONSIN AVENUE
MILWAUKEE, WISCONSIN 53226

DIVISION OF RADIOLOGY

DIAGNOSTIC RADIOLOGY SECTION
NUCLEAR MEDICINE SECTION
RADIATION THERAPY SECTION



March 4, 1974

MHL — Pls Note Sorry —

Ms. Connie Choate
Secretary to August G. Swanson, M.D.
Director of Academic Affairs
Council of Academic Societies
The Association of American Medical Colleges
One Dupont Circle, Suite 200
Washington, D.C. 20036

Dear Ms. Choate:

In reading over the minutes of the November 4, 1973, Meeting, I note that the Society of Chairmen of Academic Radiology Departments is listed as not being present at the Washington Meeting. Since I was there personally for the visit, this must have been an oversight. I believe that I had stepped out of the room at the time of the roll call, but otherwise I was there for the entire business meeting and cast my vote on all of the issues raised.

I stopped back at your table and notified you of my presence. Therefore, I would appreciate if if you would correct the minutes to indicate that the Society of Chairmen of Academic Radiology Departments' representative was, indeed, at the business meeting.

Sincerely yours,

J. E. Youker

James E. Youker, M.D.
Professor and Chairman

JEY/rc

cc: Harold Jacobsen, M.D.

MINUTES

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

November 4, 1973

Washington Hilton Hotel
Washington, D.C.

I. Call to Order

The meeting was called to order at 10:00 a.m. Dr. Robert G. Petersdorf, Chairman, presided. Forty-seven constituent societies were represented. Societies not represented were:

American Association of Neuropathologists
American Association of Pathologists and Bacteriologists
American College of Obstetrics and Gynecology
American Society for Clinical Investigation, Inc.
Association of Medical School Microbiology Chairmen
Association of Professors of Gynecology and Obstetrics
Association of Teachers of Preventive Medicine
~~Society of Chairmen of Academic Radiology Departments~~ See correspondence across
Society of Surgical Chairmen
Society of University Surgeons

II. Approval of Minutes

The minutes of the meeting held March 28, 1973 were approved as circulated.

III. Chairman's Report

The report presented by the Chairman, Dr. Robert G. Petersdorf, was distributed on November 21 to the Officers and Representatives of each of the CAS constituent societies as CAS Brief No. 21. This was done in response to requests by many who attended the session.

IV. Chairman-Elect's Report

The report of the Chairman-Elect, Dr. Ronald W. Estabrook, highlighted a number of areas in which he would expect the CAS to focus in the coming year, a number of which were major issues during this past year. These include education for primary care, cost of medical education, H.R. 1, research and research training, faculty tenure, responsibility of the

health science center for training biomedical scientists, accreditation, institutional responsibility for graduate medical education, strengthening relationships with other organizations, such as FASEB, and improving involvement of CAS constituents in its programs.

V. Department of Academic Affairs, Director's Report

The report of the Director, Department of Academic Affairs, Dr. August G. Swanson, cited major areas of increasing need in the institution to which AAMC service programs are responding.

Since 1968 applicant activity to medical school has increased 90% with enrollment increased by 42%. A centralized application service, envisaged by AAMC seven years ago, processed the applications of 37,000 out of the 40,000 applicants last year. This service permits a current monitoring of applicant activity. Other service programs in admissions are the Early Decision opportunity and experimental admissions matching programs being tried by medical schools in California and Michigan.

A complete revision of the Medical College Admission Test currently underway will alleviate pressures in the selection process and enable advisers to counsel better those who may ultimately pursue health careers other than medicine.

A Division of Educational Resources established in July is now working in liaison with the National Library of Medicine to access, review, index, and develop a retrieval system to permit the identification of multimedia learning materials. Another resource in the pilot stage is a National Test Item Library. With the anticipated increase in faculty teaching load, these programs are designed to make broadly available from institution to institution effective educational materials.

An integrated data system instituted by the AAMC will reduce demands on the institutions for data and will maximize the access to institutional, faculty, and student data.

VI. Action Items

1. AAMC Bylaw Revision on Assembly Representation

ACTION: On motion, seconded and carried, the CAS unanimously approved the proposed AAMC Bylaw revision (as set forth in the Agenda Book on page 12) to increase representation in the Assembly of the Council of Academic Societies and the Council of Teaching Hospitals.

2. AAMC Bylaw Revision on Distinguished Service Members

ACTION: On motion, seconded and carried, the CAS approved the proposed AAMC Bylaw revision (as set forth in the Agenda Book

on page 12) to create a category of member to be called Distinguished Service Member. The vote was 29 in favor and 11 opposed to this proposal.

The Council chose not to implement its option to recommend Distinguished Service Members to the Executive Council at this time.

3. Revision in CAS Rules and Regulations - CAS Nominating Committee

ACTION: On motion, seconded and carried, the CAS voted unanimously to adopt the proposed revision in the CAS Rules and Regulations (as set forth in the Agenda Book on page 23) to permit the selection of the Nominating Committee from among the representatives present at the Annual Fall Meeting of the Council by a majority vote.

4. Election of 1974 Nominating Committee

ACTION: In accordance with the newly adopted provision above described, the following were chosen by written ballot to comprise the CAS 1974 Nominating Committee:

Chairman
Ronald W. Estabrook, Ph.D. - American Society of Biological Chemists

Basic Science Representatives
Carmine D. Clemente, Ph.D. - American Association of Anatomists
Sam L. Clark, Jr., M.D. - Association of Anatomy Chairmen
Ernst Knobil, Ph.D. - Association of Chairmen of Departments of Physiology

Clinical Science Representatives
F. Marion Bishop, Ph.D. - Society of Teachers of Family Medicine
Charles F. Gregory, M.D. - Association of Orthopaedic Chairmen
William O. Dobbins III, M.D. - American Federation for Clinical Research

A list of the 1974 Nominating Committee with their complete addresses appears as Appendix A.

5. Election of members of 1973-1974 CAS Administrative Board

ACTION: The following were elected to the CAS Administrative Board:

Chairman-Elect: Jack W. Cole, M.D.

Administrative Board

Basic Scientists: Carmine D. Clemente, Ph.D.
Leslie T. Webster, Jr., M.D.

Clinical Scientists: A. Jay Bollet, M.D.
D. Kay Clawson, M.D.

A list of the Administrative Board for 1973-1974 appears as Appendix B.

VII. Information Items

1. Report of Cost Study from the Committee on Financing Medical Education

Dr. Charles Sprague met with the Council to discuss the Report of the Cost Study which had been circulated by mail prior to the meeting. This first effort has defined costs in undergraduate medical education. The next step will be to make recommendations as to how these costs should be financed.

2. Seattle Research Manpower Meeting

Dr. Michael Ball reported on this activity. Representatives from 20 medical schools, several voluntary health agencies, private foundations, the Office of the Assistant Secretary for Health and Scientific Affairs, and the NIH met October 1-3, 1973 in Seattle. The principal focus of the meeting was to develop ideas and plans for the assumption of increased responsibility by non-governmental agencies for planning and monitoring the development of the Nation's biomedical research manpower. This meeting was under the aegis of the AAMC, through the CAS, and the University of Washington.

3. Coordinating Council on Medical Education (CCME) and Liaison Committee on Graduate Medical Education (LCGME)

During the past year, the CCME and the LCGME have each held four meetings, primarily devoted to organizational activities.

The CCME is comprised of the AAMC, American Medical Association, American Board of Medical Specialties, American Hospital Association, and the Council of Medical Specialty Societies. Each of these parent organizations has three representatives to the CCME.

The LCGME also consists of representation from the same five organizations, but in this instance the AAMC, AMA, and ABMS each have four representatives, whereas two members each represent the AHA and the CMSS.

Two major issues that the CCME has undertaken are: (a) the problem of distribution of medical specialists and its role in modifying this distribution; and (b) the financing of graduate medical education. The CCME met in September with Dr. Edwards and his staff to discuss how to develop an appropriate interface between the CCME and the Secretary's office and will meet again with Dr. Edwards in November and January.

4. CAS Annual Meeting Sessions

In addition to the CAS Business Meeting, two special programs are planned in conjunction with the AAMC Annual Meeting. Member societies holding meetings at this time received special requests to invite their members to these CAS functions. Additionally, Presidents of the Professorial Societies will meet with members of the CAS Administrative Board and staff at breakfast on November 5. The main purpose of this meeting is to promote a dialogue between the CAS Administrative Board and staff and the constituent societies in an attempt to more successfully represent these interests.

5. Availability of Weekly Activities Report

As announced in CAS Brief No. 19 dated October 1, 1973, the AAMC Weekly Activities Report has been made available to medical school faculty at an annual individual subscription rate of $10.00. Group rates are also available.

VIII. New Business

In response to a question raised with regard to the status of the dues increase for CAS societies, Dr. Swanson reminded the Council that the dues increase would become effective in 1974, assuming that the Assembly would approve the increase at its meeting on November 6.

NOTE: The Assembly did approve the revised schedule of annual dues for CAS members.

IX. Adjournment

The meeting was adjourned at 12:15 p.m.

MHL:efl
12/5/73 (rev.)

Atts.: 2

06668

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

January 25, 1974

TO: All Council of Academic Societies Representatives

FROM: August G. Swanson, M.D.

SUBJECT: Change in CAS Rules and Regulations

The Administrative Board has proposed a change in the composition and length of term of members of the Administrative Board. It is proposed that the Administrative Board be increased from six to nine members and that the immediate Past-Chairman, as well as the Chairman and Chairman-Elect, be members of the Board. This will increase the total Board to 12 members and will eliminate the position of Secretary.

It is also recommended that the term of office of Board members be increased from two to three years. This change is recommended because the By-Laws of the AAMC provide for a three-year term for members of the Executive Council. The noncordance between Administrative Board terms of two years and Executive Council terms of three years has meant that individuals elected to the Executive Council during their terms of office on the Administrative Board continue to serve on the Executive Council after their Administrative Board terms have expired. The noncordance has been dealt with in the past by having these individuals serve ex officio on the Administrative Board while they continue on the Executive Council. This has meant that two individuals are serving ex officio on the Executive Council at all times and has in effect increased the size of the Executive Council from its authorized level of 9 to 11.

Because on occasions the Administrative Board members may be elected to the Executive Council part way through their terms on the Administrative Board, this problem of noncordance between Administrative Board tenure and Executive Council tenure will not be completely resolved, but will be improved. This will be particularly the case for the Chairman-Elect, who by the Rules & Regulations in Paragraph 3 of Section III, is automatically a CAS nominee for membership on the Executive Council. By virtue of including the immediate Past-Chairman as a member of the Administrative Board, the three-year term of this individual as Chairman-Elect, Chairman and immediate Past-Chairman, will be concordant with the three-year term of other members of the Board.

The Office of Secretary has been eliminated because functionally those responsibilities are carried out by the full-time staff.

This announcement of a change in the Rules & Regulations is promulgated in advance of the Business Meeting agenda in order to meet the requirement of at least 30 days notice for a change in Rules and Regulations.

The following is the present CAS Rules & Regulations as adopted October 29, 1971.

Section III. Administrative Board

1. The Council of Academic Societies shall be governed by an Administrative Board which shall be composed of a Chairman, Chairman-Elect, a Secretary and six other representatives of member Academic Societies. Three of said six representatives shall be elected by written ballot at each annual meeting of the Council of Academic Societies, and each such representative shall serve for a term of two years or until his successor is elected and installed. Representatives to the Administrative Board may succeed themselves for two additional terms.

2. The Administrative Board shall meet at least twice each year at the time and place of the meetings of the Council of Academic Societies. The Administrative Board may meet at any other time and place upon call of the Chairman, provided ten (10) days written notice thereof has been given.

3. The Administrative Board shall recommend to the Nominating Committee of the Association nominees for positions on the Executive Council of the Association. The Chairman-Elect shall be one (1) nominee, and the remainder shall be chosen from members of the Administrative Board, chosen so as to present a balanced representation between societies primarily concerned with preclinical disciplines and societies primarily concerned with clinical disciplines.

Proposed change in CAS Rules & Regulations re size and terms of Administrative Board

Section III. Administrative Board

1. The Council of Academic Societies shall be governed by an Administrative Board which shall be composed of a Chairman, Chairman-Elect, *immediate Past-Chairman* and *9* other members. Three of said *9 members* shall be elected by written ballot at each annual meeting of the Council of Academic Societies, and each such *member* shall serve for a term of *3* years or until his successor is elected and installed. *Members elected to serve on the Executive Council of the Association shall continue to hold membership on the Administrative Board until their terms on the Executive Council expire.*

NOTE: The above was approved by the CAS Administrative Board on December 13, 1973.

III. Action Items:

2. Distinguished Service Membership

At its December 13, 1973, meeting, the CAS Administrative Board nominated for AAMC Distinguished Service Membership the following former Board members, all of whom served on the Board for more than one year, providing each indicates that he wishes to take an active role in the AAMC and will attend its meetings.

Thomas Kinney
Jonathan Rhoads
Daniel Tosteson
Harry Feldman
Sam Clark, Jr.
Patrick Fitzgerald
John Nurnberger
Robert G. Petersdorf
Ralph Wedgwood
James Warren
Charles Gregory
William Weil
Robert Forster
Ludwig Eichna
Ernst Knobil

Association of American Medical Colleges

GRADUATES OF FOREIGN MEDICAL SCHOOLS IN THE UNITED STATES A CHALLENGE TO MEDICAL EDUCATION

Report to the EXECUTIVE COUNCIL from the Task Force on Foreign Medical Graduates

February 15, 1974

FOREWORD

In August of 1973 a Task Force on Foreign Medical Graduates was appointed by the Executive Council with the following membership:

Kenneth R. Crispell - Chairman, University of Virginia
Martin S. Begun - New York University School of Medicine
George E. Cartmill - Administrator, Harper Hospital and Wayne State University
Merlin K. DuVal - University of Arizona
Rolla B. Hill, Jr. - Jacksonville Hospitals Educational Program and University of Florida
Robert J. Weiss - Harvard University
Joseph M. White - University of Missouri at Columbia

The Task Force met on four occasions, namely October 5, November 30, December 27, 1973 and January 28-29, 1974. In its deliberations the Task Force was assisted through the participation of Dr. Emanuel Papper, Chairman of the Council of Deans. It also wishes to thank Dr. Betty Lockett of the Health Resources Administration for her contributions and particularly for providing background documentation for the work of the group. Representatives of AHA (Dr. John G. Freymann), AMA (Dr. Raymond Holden) and HRA (Dr. Harold Margulies) provided helpful comments and criticism at a crucial stage in the deliberations of the Task Force.

Statistical data contained in the text and tables were obtained from the following sources:

- "The Foreign Medical Graduate and Physician Manpower in the United States", BHRD/DMI/OIHMS, Report No. 74 - 47, prepared by Betty A. Lockett and Kathleen N. Williams, Washington, D. C., DHEW - HRA, BHRD, August 1973.

- The American Medical Association and its published statistics.

- Annual reports and other communications of the Educational Council for Foreign Medical Graduates.

- The National Board of Medical Examiners.

As outlined in the terms of reference for the Task Force, the group restricted its concern to those problem areas of the FMG which fall within the sphere of responsibility and authority of the membership of the Association. For this reason the report of the Task Force intentionally is limited to issues of education and quality of medical services, two areas of particular concern to the AAMC.

BACKGROUND AND INTRODUCTION

Throughout the history of the United States immigration has contributed towards the overall development of the work force in the country. The medical profession has been no exception. The arrival of physicians educated abroad, however, and their integration in the United States systems of medical education and service has reached unusual proportions in recent years. Furthermore, many American college graduates have sought medical education abroad and are now beginning to return home with a medical degree earned in a foreign country. These students add a domestic dimension to problems which stem from the rapidly increasing number of foreign medical graduates (FMG)[1] entering the country and being licensed to practice. The complexity of education, accreditation and licensure in medicine further complicates the situation.

The Phenomenon

The basic trend of admitting FMGs into the United States is represented in table 1. It shows that in a little over a decade the number of FMGs in the United States has increased four times more rapidly than has the total physician supply. FMGs are approaching 20 percent of all physicians and one-third of all hospital and residency training posts are filled by them. In 1972 more graduates of foreign medical schools entered the United States than physicians were graduated by our own schools, and 46 percent of all newly licensed physicians in that year were FMGs.

The Immigration and Naturalization Act Amendments of 1965 have had a major impact on the migration of FMGs to the United States. Termination of the national quota system previously in effect opened avenues of entry to the United States for physicians trained in countries where, even in the face of major unmet health needs, the available physician supply appeared to exceed effective economic demand. In addition, preferential immigration status was assigned to professional and occupational skills presumed to be in short supply nationwide, including medicine and other health skills. The result was that physicians from developing countries began to take advantage of the opportunity to immigrate to the United States regardless of their ability to meet licensure requirements in this country.

Foreign-born FMGs are admitted to the United States both as immigrants (permanent residents) and as nonimmigrants (primarily exchange visitors). In the eleven years ending June 1972, over 50,700 physicians entered this country as exchange visitors, the great majority for graduate medical education. Since 1967 about 44 percent of all physicians entering the United States have been immigrants and 52 percent exchange visitors. This has begun to change, however.

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1) For the purpose of this document a foreign medical graduate is a physician who has completed the requirements for graduation from medical school and for practice in a country outside the United States, Canada, and Puerto Rico

In 1971 and 1972 more physicians were admitted as immigrants (53 and 63 percent respectively) than as exchange visitors. A major portion of these admitted immigrants, however, were FMGs who converted from nonimmigrant status while residing in this country. Legislation in 1970 facilitated this trend by eliminating the requirement that exchange visitors be absent from the United States for a period of two years after ending their studies, provided they were from countries where their special skills are not in short supply.

There is an emerging group of American-born FMGs who seek medical education abroad after failing to gain admission to a medical school in the United States. They request entry into the American medical education system at various stages of their training. Accurate figures regarding these students are not available, but it is estimated that as many as 6,000 students are currently enrolled in medical schools abroad compared with 50,716 students in American medical schools in September of 1973. According to a recent survey carried out by the Division of Manpower Intelligence of the Bureau of Health Resources Development, in 1971-1972 medical schools of Latin American universities had 2,045 American students enrolled, 91 percent of whom were at the Universidad Autonoma de Guadalajara in Mexico. In 1970 AAMC initiated the Coordinated Transfer Application System (COTRANS) which arranges for qualified American students to take Part I of the National Board Examination and apply for transfer into a United States medical school. As of May 1973 a total of 442 American students had been admitted through this mechanism to domestic medical schools for advanced standing.

Evaluation of FMGs for Admission

Admission to graduate medical education programs and to state licensure examinations generally is predicated on the fact that the graduate has met the education requirements of an accredited medical school in the United States or Canada. Before 1955 the Council on Medical Education of AMA attempted to approximate the system of evaluating medical education in the United States by preparing a list of foreign medical schools considered of sufficient quality for graduates to be admitted into domestic graduate medical education programs. Because this practice proved unsatisfactory, the Educational Council for Foreign Medical Graduates (ECFMG) was established as an independent agency sponsored by AAMC, AHA, AHME, AMA, and FSMB to develop a system of certifying minimal educational accomplishments of FMGs. For certification the ECFMG uses two criteria-proof that the candidate has fulfilled all requirements of a medical school listed in the World Directory of Medical Schools published by the World Health Organization, and a satisfactory score on an examination furnished by the National Board of Medical Examiners. The examination is prepared by a test committee from questions provided by the NBME. Eighty percent of the questions are taken from Part II of the National Board Examination.

Since its inception in 1958 the ECFMG has organized a worldwide network of 178 examination centers in which a cumulative total of 313,885 examinations has been given to 178,325 candidates. The overall pass rate including all repeaters through 1972 is 67 percent. Upon the first try 45 percent obtain a passing score, while a decreasing percentage of those who fail in the first attempt pass in subsequent tries. There is great variation in performance of FMGs from different countries and from different schools within some countries.

Some Characteristics of FMGs

Country of Origin - Until recently the majority of FMGs came from European or other countries with standards of medical education similar to those in this country. As a consequence of the amendments to the Immigration and Naturalization Act passed by Congress in 1965, the number of physician immigrants from Asian and other developing countries increased rapidly. As table 2 shows, 27 and 12 percent of the 2,093 physician immigrants came from Europe and Asia respectively in 1963, while the corresponding figures for 1972 were 13 and 70 percent out of a total 7,143 FMGs. This represents a major shift in nationality of physicians coming to the United States and also in the nature and quality of their medical education because one should not expect medical education offered in developing countries to be the same as that of economically and technically developed nations.

Performance - In objective-type examinations FMGs perform at a lower level than do graduates from American medical schools. Thus, in the past few years the failure rate in the ECFMG examination (score below 75) has varied from 67.4 to 56.9 percent, while students or graduates of American schools have had a failure rate of 14 percent on Part I and 2.5 percent on Part II of the National Board Examination. In FLEX (Federation Licensure Examination) 50 percent of FMGs have passed versus 85 percent of graduates from American schools. In Specialty Board Examinations the failure rate in 1972 was 63 percent for FMGs and 27 percent for domestic graduates. It must be emphasized that there is a much wider spread of performance with FMGs and that some perform as well as domestic graduates. It is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality than that rendered by graduates from domestic schools. American FMGs have a similar if not greater failure rate in the ECFMG examination than foreign-born FMGs. This suggests that language difficulties do not significantly influence performance in standardized examinations of this kind.

Specialty and Geographic Distribution - As shown in table 3, FMGs are distributed by specialty in much the same way as physicians educated in the United States. They are concentrated largely in the five major specialties and general practice chosen by United States graduates. Approximately 52 percent of FMGs versus 57 percent of graduates from domestic medical schools select internal medicine, pediatrics, general surgery, obstetrics and gynecology, psychiatry, and general practice.

Proportionally more FMGs are in specialties such as anesthesiology and physical medicine, while fewer FMGs are in dermatology, and orthopedic surgery. In addition, FMGs are disproportionately found in some residency programs. For example, residencies in general practice, physical medicine, colon and rectal surgery, anesthesiology, and pathology are more than 50 percent filled by FMGs. This may imply in the future a smaller supply of physicians born and educated in the United States for these specialties.

Therefore, in the aggregate FMGs are distributed along the same lines as our own graduates, although for certain specialties there is a differential distribution between FMGs and graduates from domestic medical schools. It remains to be seen whether this differential in enrollment in residency programs will have any impact on specialty distribution in practice at a later time.

The participation of FMGs in the practice of medicine has further distorted the geographic distribution of physician manpower in this country. It has been shown that they follow a similar pattern as that of physicians educated in the United States and tend to concentrate in cities.

State Institutions - In many states the demand of public institutions for physicians is accommodated by special licensure provisions for FMGs not fully qualified to practice. The extent to which these FMGs are employed and the impact of their activities on medical care are not known. However, anecdotal evidence suggests that much health care delivery in the public sector depends on physicians not fully qualified but willing to accept working conditions and income levels qualified physicians will not accept.

Academic Medicine - Many FMGs have entered careers in academic medicine in this country. Usually these are physicians who either already have established a reputation in their home country and found the working conditions more attractive in an American institution or have demonstrated unusual capabilities within an American graduate program and entered into an academic career in this country. In 1970 there were 4291[1)] FMGs in academic positions (including medical education and research) representing 7.5 percent of all FMGs in the United States at that time. This percentage is slightly greater than that of United States medical graduates (about 5 percent). Today our medical schools have 4,165 FMGs out of a total of 34,658 salaried physicians on their full-time and part-time academic staff. The contribution of FMG scientists to American medical science has been substantial.

Dual Standards

The present policy for certifying FMGs has led to a system of dual standards for admission to graduate medical education in this country. To illustrate, figure 1 gives a graphic representation of the three programs in the continuum of medical education offered in the United States. It shows that the quality of the student's educational experience and performance is ascertained by the following:

- Accreditation on a national or regional basis of the three required education programs offered consecutively by a college or university, a medical school, and a teaching hospital.

- Selection of students for each program on the basis of performance in the previous program, or scores obtained in national entrance examinations, and broader judgement by a selection committee of the institution.

- Internal evaluation of the student by the faculty in a continuing fashion and final certification by the faculty for awarding the degree.

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1) This figure includes U.S. born FMGs.

- External evaluation of the student by Parts I and II of the National Board Examination (83 of 116 medical schools require the student to take the National Board Examination, while 26 of these schools make a passing score a requirement for promotion or graduation).

- External evaluation for licensure through FLEX (unless the candidate has already received a passing score on the National Board Examination) and for specialty certification by specialty board examination.

The majority of FMGs now applying for admission to graduate medical education has not been screened by equivalent selective internal and external evaluation processes. Furthermore, with notable exceptions, in most countries there is no accreditation system similar to our system. In general, the intensity and quality of the learning experience in the United States is attained by a high faculty student ratio, adequate educational and clinical resources, a competitive situation, and the exposure of the student to the institution's research atmosphere. Finally, by incorporating the student into the medical care programs of the teaching hospital United States medical schools guarantee the American student a participatory role in clinical medicine, while in most schools abroad the clinical student is an onlooker. It may be concluded that while many medical schools abroad are outstanding and excel in many of these same features, the United States medical school provides a more intensive learning experience to the student than those institutions from which a large proportion of the FMGs have graduated. Beginning with the extensive premedical education in colleges, the United States educational continuum results in a physician-graduate of considerable personal maturity and professional sophistication in the art and science of medicine.

The present mechanism by which FMGs are admitted into graduate medical education programs implies that the ECFMG examination is a substitute for assessing the quality of the educational process over a period of four to six years and for selecting and evaluating the student for admission and promotion during this period. In reality, there is no examination available for measuring professional competence. Hence we are faced with dual standards for admission and are condoning the evolution of a dual system of graduate medical education. Currently, a little over one-half of the physicians entering the American system are products of accredited United States medical schools, while the balance for the most part represents products of unaccredited education systems. This double standard results in wide disparity in the quality of the physicians admitted to deliver care in the United States. It undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people.

The FMG's Advocate

The notion that American medical education is rendering a service to foreign doctors by permitting them to enter our system in large numbers must be challenged on several counts. The FMG coming to this country faces difficult and disadvantageous conditions which in many instances offset the potential benefits to be gained from entering the education system. Some of these problem areas are:

- Differences in culture and daily life resulting in isolation.

- Learning of a new language.

- Acceptance into a setting which imposes excessive responsibility for patient care without adequate supervision and educational content.

- General stigma associated with the status of being an FMG and therefore lack of full acceptance on a professional basis.

- Need to accept positions under unfavorable working conditions and with relatively low salary.

- Acceptance of lower performance level.

- Fear and threat of failure.

The present system of accepting FMGs into the United States and incorporating them into our medical education and care systems has created a category of second-class physicians. From an educational and ethical point of view, this is undesirable.

The Task Force's Response

In reviewing the benefits and problems which accompany the admission of FMGs to the United States the Task Force considered many approaches. Although the prohibition of medical practice by FMGs could be considered a possible solution, the long history and ideals of the United States regarding immigration policy make this unacceptable. It was agreed that any recommendations should be in accord with two major considerations, namely that:

- Medical schools in the United States presently are able to identify outstanding candidates for educational programs which prepare physicians, provide programs of quality medical education to students of medicine, and deliver highly qualified physicians in sufficient numbers into the medical care system of this country. With the rapid increase of enrollment by students in our medical schools (15,000 by September 1975), it is anticipated that our basic need for physicians in the 1980's presumably can be satisfied from domestic sources. If the anticipated number of graduates is insufficient to meet our nationally conceived need for physicians, adequately planned and financed programs should be initiated to increase further the class size of domestic medical schools. It seems inappropriate that the United States with its existing resources should depend to any significant degree on physicians supplied by education systems of other countries.

- The dual standards in admission of United States and foreign medical graduates must be reduced in the interest of quality of medical education and care, as well as for the benefit of foreign graduates who come to this country to achieve medical excellence. Ultimately nobody can gain from the continued existence of two classes of physicians.

The Task Force is aware of the consequences that corrective measures may have on the number of FMGs gaining admission to graduate medical education in the United States. Because the implications of the present trend are so vast, it recommends that steps be taken to minimize the difference in admission standards between graduates of domestic and foreign medical schools, in spite of the fact that complete equality cannot be achieved rapidly and that some hospitals will be faced with a shortage of housestaff during an intermediary period of time. The recommendations do not address themselves to the licensing process except for the loopholes which permit unqualified FMGs institutional medical practice without adequate supervision.

The Task Force recognizes the similarity between these recommendations and those made by the National Advisory Commission on Health Manpower in 1967 (pp. 71-81 of volume 2 of the Commission Report). For their implementation close collaboration among concerned government and private agencies is required. The Task Force urges the AAMC to initiate such concerted action.

RECOMMENDATIONS

The Task Force recommends the following policies to the AAMC for adoption and implementation by the constituency in collaboration with related agencies:

1. Physician Manpower - Medical schools of the United States must become the major source for educating physicians to satisfy the need for physician services to the American people. This country should not depend for its supply of physicians to any significant extent on the immigration of FMGs or on the training of its own citizens in foreign medical schools. If the anticipated need for physicians exceeds present or future enrollment in our medical schools, appropriate measures including adequate funding must be taken to enlarge the student body accordingly. Since there is a delay of seven to ten years until a corrective increase in first year medical school admissions first becomes manifest in terms of physician manpower, a continuing analysis of our physician needs is called for.

2. Admission Criteria - The process of certifying FMGs for admission to graduate medical education programs in the United States is inequitable and inadequate. In order to apply the same standards to all medical graduates, it is recommended that a generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until another such examination may become available, Parts I and II of the National Board Examination should be employed for this purpose. FMGs can register for this examination only after having demonstrated an acceptable command of spoken and written English. Part III of the National Board Examination or some other method for determining clinical competence should be required for continuation beyond the first year of graduate medical studies or for direct admission to advanced standing in graduate medical programs.

3. Approval of Programs of Graduate Medical Education - In order to ensure all medical graduates of a continuing exposure to quality education, regulations for the approval of programs of graduate medical education must be strictly enforced. The regulations should emphasize the educational function of these programs. In addition, the relative number of FMGs permitted in any program should be limited and geared to the educational resources of the program. Effective adaptation and enculturation cannot be expected unless special efforts are made and there is a balance between American and foreign graduates in the program. Since undergraduate and graduate medical education are considered integral parts of an educational continuum, it is also recommended that the number of first year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools, but provide sufficient opportunities to highly qualified FMGs.

4. Pilot Project - Because examinations to determine the professional competence of the physician are still in a developing stage it is recommended that a pilot project be initiated for the enrollment of a limited number of FMGs as students in modified undergraduate medical education programs in United States institutions. The objectives of this project to be undertaken by AAMC and interested medical schools, are to identify the educational deficiencies of FMGs and provide supervised learning experiences to correct these deficits with the goal of bringing the FMG to a level of professional competence similar to that reached by graduates of domestic schools. In this project preference should be given to United States citizens and may include American students enrolled in foreign medical schools qualified for participation in the COTRANS program.

5. Loopholes - On the basis of temporary licenses or exemptions from licensure provisions, a large but unknown number of FMGs is delivering medical services in institutional settings such as state institutions and other medical service organizations. They are active in this capacity without having qualified either for graduate medical education or licensure. The indefinite continuation of unsupervised medical practice on this basis without minimal involvement in approved graduate medical education should be discontinued. It is recommended that AAMC join with the American Hospital Association, the American Medical Association and other agencies to bring this problem to the attention of the Federation of State Medical Boards in a concerted effort to seek and implement appropriate solutions.

6. Hospital Patient Care Services - These recommendations when implemented undoubtedly will reduce the number of FMGs qualified for appointment to positions in graduate medical education. Therefore, new methods must be developed to ensure patient care services in many hospitals. The Task Force believes that other health care personnel can be trained to provide under physician supervision many of the services now required to be rendered by physicians. Projects to study and demonstrate the engagement of such personnel in institutional care settings should be undertaken immediately. Ultimately, the efficient utilization of such personnel depends on appropriate education of the health care team, particularly physicians, and thus is a conjoint responsibility of medical and other health profession faculties.

7. Special Categories - The Task Force recognizes two groups of FMGs who require special consideration. The first group is represented by those physicians who seek a temporary educational experience with the intent of returning to their home country. These physicians should be admitted to graduate medical education programs without having to pass Parts I and II of the National Board Examination in those instances when the FMG enters with a visitor exchange visa and has a statement describing the proposed program of study. This program should have the concurrence of the American institution accepting the physician, the FMG's home institution, and the governmental or private agency interested in the FMG's education and continuing employment. Furthermore, the American institution should not plan to continue the FMG's engagement beyond the training period, which usually should be limited to two years.

The second group encompasses FMGs who have established reputations as medical academicians and are appointed by medical schools as visiting scholars. Unless the respective state licensing boards prescribe differently, temporary exemptions from the requirement specified under recommendation two should be accorded these FMGs provided they are visiting members of a medical faculty and their involvement in the practice of medicine is limited to patient care related to their teaching obligations. The granting of these exemptions should be based on a policy agreed upon nationally and should cover a delimited period of time. FMGs who serve on medical faculties as teachers and scientists without patient obligations including supervision of those who render patient care do not fall within the purview of these recommendations.

8. Time Table - A realistic time table should be established for implementation of these recommendations.

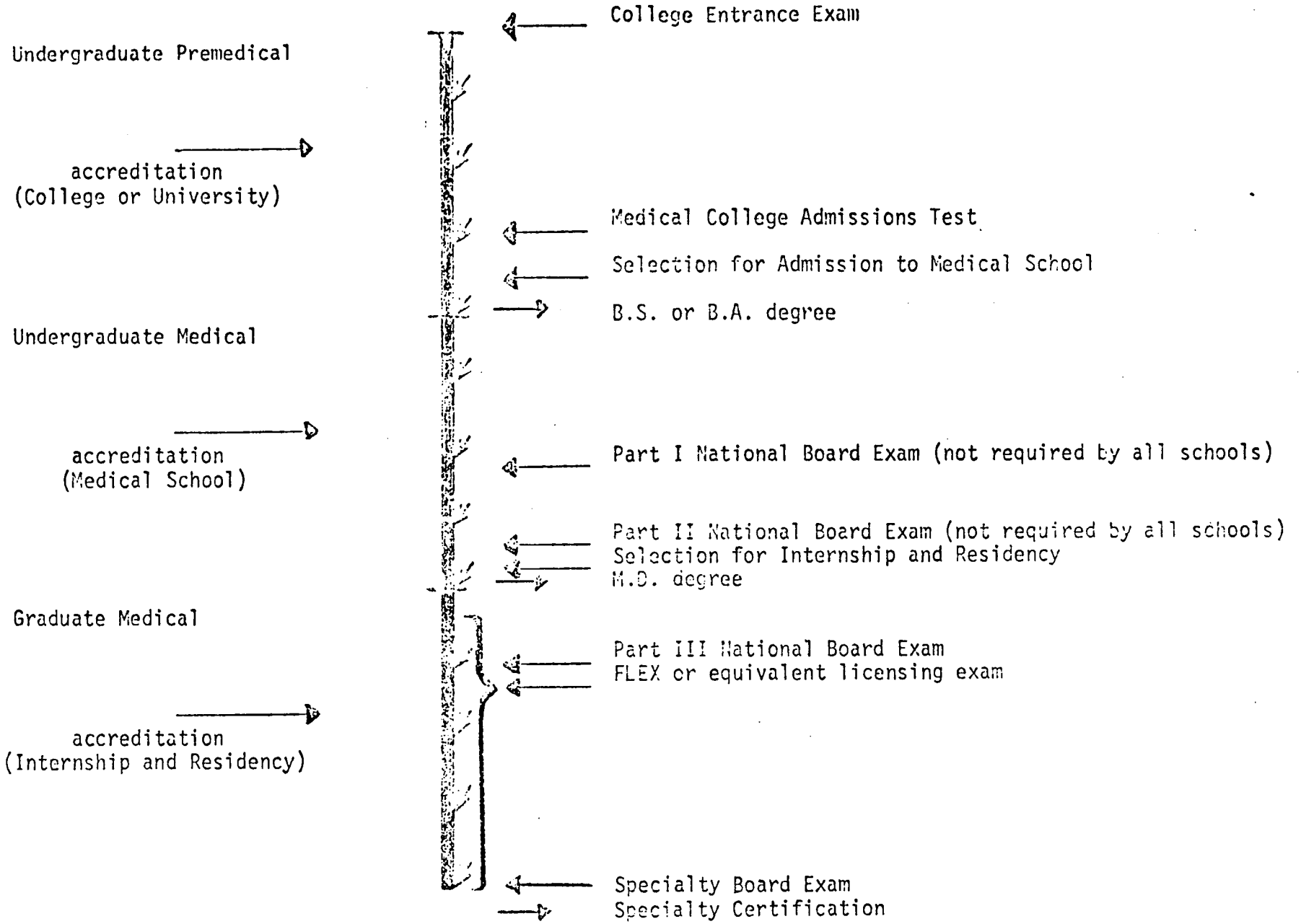

Figure 1: Continuum of medical education - Included are the points at which selection and internal and external evaluation of the student occurs (at right of graph). At the left accreditation of the programs is indicated. (↙ indicates internal evaluation)

TABLE 1

Ten Years Trend in Admission, Employment and Licensure of FMGs and Graduates of Domestic Medical Schools

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
ECFMG												
No. Exams Administered	14,535	19,130	18,511	18,337	18,988	19,188	19,548	22,598	29,950	31,033	32,072	37,623
No. Candidates Passed	6,054	6,043	6,820	7,724	7,842	8,770	7,774	8,127	11,916	9,693	12,837	12,289
No. FMGs Certified	not available before 1966 --				6,699	5,364	6,142	4,686	5,436	6,886	8,712	6,727
Admission to U.S.												
Exchange Visa	3,970	4,637	4,518	4,160	4,370	5,204	5,701	4,460	5,008	4,784	3,939	4,613
Immigrants	1,297	2,093	2,249	2,012	2,552	3,326	3,128	2,756	3,158	5,756	7,143	7,119
Total*	5,767	6,730	6,767	6,172	6,922	8,897	9,125	7,515	8,523	10,947	11,410	12,265
U.S. Graduates	7,168	7,264	7,336	7,409	7,574	7,743	7,973	8,059	8,367	8,974	9,551	10,391
Graduate Medical Education												
Interns:												
U.S.	6,900	7,136	7,070	7,296	7,309	7,573	7,506	7,194	7,869	8,213	8,120	8,239
FMG	1,273	1,669	2,566	2,821	2,361	2,793	2,913	3,270	2,939	3,339	3,946	4,924
Total	8,173	8,805	9,636	10,097	9,670	10,366	10,419	10,464	10,808	11,552	12,066	13,163
Residents:												
U.S.	21,914	22,177	22,433	22,852	22,765	22,548	23,116	23,816	25,013	26,495	28,970	30,610
FMG	7,723	7,062	7,052	8,153	9,133	9,502	10,627	11,231	12,126	12,908	13,543	14,471
Total	29,637	29,239	29,485	31,005	31,898	32,050	33,743	35,047	37,139	39,403	42,512	45,081
Liscensed to Practice												
U.S. Graduates	6,648	6,832	6,605	7,619	7,217	7,267	7,581	7,671	8,016	7,943	7,815	not yet
FMGs	1,357	1,451	1,306	1,528	1,634	2,157	2,185	2,307	3,016	4,314	6,661	avail-
Total	8,005	8,283	7,911	9,147	8,851	9,424	9,766	9,978	11,032	12,257	14,476	able
Physicians in U.S.												
U.S. Graduates		245,550						271,390	276,811	282,609	288,525	not yet
FMGs		30,925						53,552	57,217	62,214	68,009	avail-
Total	268,000	276,475	284,224	292,088	303 375	308,630	317,032	324,942	334,028	344,823	356,534	able

* Beginning in 1967 the total includes other categories of non-immigrant physicians.

TABLE 2

Country or Region of Emigration of FMGs for 1963 and 1972

Year	Europe		Canada		Latin America *		Asia		Other °		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	No.
1963	575	27.5	467	22.3	580	27.7	260	12.4	211	10.1	2093
1972	911	12.7	439	6.4	372	5.1	4996	69.9	425	5.9	7143

* Includes South America, Mexico and Cuba.
° Includes Africa, Oceania, and selected countries of the Americas.

TABLE 3

Selected Specialty Distribution of FMG's and U.S. Medical Graduates as of 1970

Specialty	All Physicians		Foreign Medical Graduates *		U.S. Medical Graduates	
	Number	Percent	Number	Percent	Number	Percent
Internal Medicine	41,872	12.5	6,894	10.9	34,978	12.9
Pediatrics	17,941	5.4	3,787	6.0	14,154	5.2
General Surgery	29,761	8.9	5,748	9.1	24,013	8.9
Ob-Gyn	18,876	5.6	3,403	5.4	15,473	5.7
Psychiatry	21,146	6.3	5,588	8.7	15,558	5.8
Subtotal 1	129,596	38.8	25,420	40.1	104,176	38.5
General Practice	57,948	17.3	7,512	11.9	50,436	18.6
Subtotal 2	187,544	56.1	32,932	52.0	154,612	57.1
Other	146,484	43.9	30,459	48.0	116,025	42.9
Grand Total	334,028	100.0	63,391	100.0	270,637	100.0

* Including graduates from Canadian medical schools.

February 22, 1974

The NIRMP Program

The 1974 NIRMP matching process was completed on February 20; results are to be mailed to hospitals and students about the first of March thus advancing the notification date six weeks ahead of the 1973 program. This improvement in operation was achieved by the NIRMP Board and Staff with the assistance of a private consulting group and is significant in maintaining the credibility of an essential mechanism in the continuum of medical education. Operational improvements, however, are only one side of the present concerns for the NIRMP.

The occurence of violations involving some students and some program directors, especially in certain first-year residency programs, have resulted in the establishment of an NIRMP Monitoring Program within the AAMC. The Group on Student Affairs and the Organization of Student Representatives of the AAMC were responsible for developing this program announced by Dr. John A.D. Cooper on February 22. The program is essentially a means for committees in the medical schools to report incidents of non-compliance to the AAMC President for communication to the program director and the school involved. It is hoped that this program will serve as a potential deterrent to many violations. The occurence of some violations may be also traced to problems resulting from basic changes in the process of medical education, this is particularly so in psychiatry.

The AAMC has responded to a request from the members of a Task Force on the Internship and Residency of the American Association of Chairmen of Departments of Psychiatry to assist them in assessing the concerns of members of this specialty group about problems relating to the NIRMP. The AAMC has identified

two projects in which staff can give direct assistance. The first is to gather information about the numbers and characteristics of the applicant pool for residency programs in psychiatry. The second is a review of the NIRMP to determine whether this program or one similar to it can function satisfactorily as a logical entry point for medical school graduates into the second phase of the continuum of medical education.

The AAMC suggests that information of this nature would be useful to other specialty groups whose applicants and program directors are finding the NIRMP to be less than satisfactory.

Robert Thompson, Ed.D.
Director of Student Programs and Services
Department of Academic Affairs

STATUS REPORT ON MCAAP PROJECTS

Subsequent to the publication of the Final Report of the Task Force on the Medical College Admissions Assessment Program (MCAAP), staff of the Division of Educational Measurement and Research have been studying the ways AAMC resources and talent may be optimally mobilized to respond to the recommendations of that report. At this point it appears that the recommendations might be best grouped according to the following project areas:

I. The Cognitive Assessment Battery - The activity is expected to focus immediately upon the development of new subtests in reading, comprehension and analysis, quantitative reasoning, and specific subtests with a strong achievement orientation in chemistry, biology, and physics.

II. Formalized Assessment of Personal Qualities - This activity of necessity will be research oriented at the outset and will attempt to identify predictors/correlates of clinical performance, practice characteristics, etc.

III. Problem Solving - This project is expected to focus on the assessment of general problem solving behavior and its relationship to later performance measures, e.g. diagnosis.

IV. Pre-enrollment Guidance and Advising - This effort would involve the expansion of current acitivities as needed and appropriate

V. Letters of Evaluation

VI. The Interview

(these last two efforts will attempt to improve these as devices for data collection).

VII. Medical Student Information System - This project will attempt to extend established programs to provide for better feedback to the schools.

VIII. Evaluation of Clinical Performance of Students

IX. Physician Performance

(these last two areas are essential for purposes of short and long term validation respectively. The latter interest initially is expected to be contained in the proposed AAMC Longitudinal Study Follow-Up).

Further specification and implementation of these projects will be accomplished through the combined efforts of the MCAAP Committee and AAMC staff.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

add to info. p. 33

February 15, 1971

A Policy Statement of the Association of American Medical Colleges on National Health Care

Position on National Health Plans

The Association of American Medical Colleges supports the concept that adequate health care and maintenance is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system. The system must be a national one, with adequate provision for varying regional requirements. Financing should be based on prepayment, both public and private. Control of the system and fixing of national health goals and priorities requires appropriate balance between public and provider inputs.

Any such system must assure access to primary care and prompt referral, in accordance with individual patients' needs, to progressively more sophisticated facilities and personnel. It must also provide for, and emphasize, preventive as well as curative care on an ambulatory basis.

The system should optimize quality of care and economy; and should utilize incentives as an aid in cost-control and in developing a more effective and responsive national mechanism for delivery of health services. It must include a continuing and dynamic method for evaluating overall operation and performance of providers.

Position on the Special Role of Academic Health Centers

The education of health manpower must take place within the system for providing health services. In those settings where both health services and education are provided, costs will be greater than in those settings in which care alone is provided. This fact should be reflected in reimbursement policies under any health care plan.

Because of their special and essential role in educating health professionals, conducting research, and in developing new methods, academic health centers must be recognized as national resources. Within the Centers, biomedical research and those elements of educational cost not directly related to provisions of patient services should be separately funded from multiple sources, including the Federal Government.

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Congressional Record

PROCEEDINGS AND DEBATES OF THE 93d CONGRESS, FIRST SESSION

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Senate

S. 2513

CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE ACT OF 1973

By Mr. LONG (for himself, Mr. RIBICOFF, Mr. TALMADGE, Mr. NELSON, Mr. ABOUREZK, Mr. BENTSEN, Mr. HANSEN, Mr. DOLE, Mr. ROTH, Mr. MONTOYA, Mr. PERCY, Mr. MCGOVERN, Mr. SAXBE, and Mr. HUGH SCOTT:

S. 2513. A bill to amend the Social Security Act by adding a new title thereto which will provide insurance against the costs of catastrophic illness, by replacing the medicaid program with a Federal medical assistance plan for low-income people, and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic health insurance at reasonable premium charges, and for other purposes. Referred to the Committee on Finance.

Mr. LONG. Mr. President, on behalf of myself and Senator RIBICOFF, as well as Senators TALMADGE, NELSON, BENTSEN, HANSEN, DOLE, ROTH, ABOUREZK, MONTOYA, PERCY, SAXBE, MCGOVERN, and HUGH SCOTT, I am proud to introduce today proposed legislation which we believe represents a major step forward in the provision of adequate protection agaist the high costs of necessary health care.

The Catastrophic Health Insurance and Medical Assistance Reform Act of 1973 represents many months of effort designed to develop a means of assuring virtually all Americans that they will not be bankrupted by the devastating effects of serious illness, as well as a definitive approach toward eliminating the widespread inequities of the medicaid program by replacing it with a program providing equal benefits to all Americans at the lower end of the income scale. Additionally, the proposal contains provisions designed to stimulate, on a voluntary basis, the actual availability of adequate basic private health insurance to those many millions of hard-working, middle-income Americans as a floor of protection above which they would be covered by catastrophic health insurance.

These are the people who can often afford good private health insurance at reasonable premium rates, but to whom such coverage is not always available and often, when available, incorporates various underwriting restrictions designed to limit the insurer's liability rather than protect the person insured.

The thrust of these latter provisions is to assign a vast area of responsibility to the private health insurance industry of this country, giving them benchmarks against which the success of their efforts will be measured. Obviously, to the extent private health insurance effectively meets the basic needs of a large segment of our population, to that extent further expansion of governmental programs would not be necessary.

The Long-Ribicoff health insurance proposal has three essential parts:

The first part consists of catastrophic insurance coverage for virtually all Americans. Each year hundreds of thousands of Americans are stricken by catastrophic illnesses or accidents. In addition to suffering the terrible physical consequences of these events, these individuals and their families also suffer the often devastating financial effects of these illnesses.

I have long thought that the Federal Government should play a part in mitigating the financial effects of these illnesses through the use of the established social insurance mechanisms.

This plan, like medicare, would be financed by social security payroll taxes and administered by the time-tested Social Security Administration. The plan, effective July 1, 1974, would cover nearly all employees covered under social security and their dependents, and all social security beneficiaries. It would make payment for the types of services covered by medicare, after an individual had been hospitalized for sixty days or a family had incurred expenses of $2,000. The payments would cover expenses beyond those deductibles.

Again, the catastrophic plan is not designed to replace basic private health insurance but rather to supplement that protection.

The second part of the bill consists of an entirely new basic health benefits program for low-income individuals and families. While most middle-income families can afford and can obtain reasonably adequate private health insurance coverage toward the costs of their first 60 days of hospitalization and first $2,000 of medical expenses, many millions of low-income individuals and

families cannot afford or do not have such basic private health insurance protection available to them.

The present Federal-State program providing health benefits to the poor—medicaid does not generally cover low-income workers who are not on welfare. It is basically provided only to welfare families and, even then, benefit and eligibility levels vary all over the lot from State to State. In most States medicaid is limited to poor aged, blind, and disabled persons or fatherless families.

Today, for example, in one State a disabled person with $1,800 annual income might not be eligible for medicaid whereas, in another State, he would be. Further, that same disabled person might be covered for only 15 days of hospitalization under medicaid in one State while, in another, he would be eligible for unlimited hospitalization. Now, that just does not make sense, does it?

Aside from those obvious inequities in treatment of the poor, there is another inequity developing with implementation of the new supplemental security income plan for aged, blind, and disabled persons, where thousands of people in a State would be eligible for medicaid and other thousands in the same State, and with the same income, would not. And in no State is medicaid coverage available to a hard-working couple or small intact family with low income.

These general problems with the existing medicaid program are best illustrated by specific cases, such as the man in Florida who recently had to divorce his wife of many years in an attempt to qualify her under medicaid and thus obtain the necessary medical care for her chronic illness.

The major new program which Senator RIBICOFF and I propose, would provide, effective July 1, 1975, basic health benefits coverage with uniform national eligibility standards for all low-income individuals and families. It would be administered, as would catastrophic health insurance, by the Social Security Administration.

The basic benefits provided under the low-income plan are designed to mesh with the deductibles under the catastrophic program. This new proposal is directed primarily at providing necessary health benefits protection to the millions of working low-income families in the United States who receive no coverage at the present time. The program would also eliminate the inequities and much of the redtape in the present medicaid program.

Coverage under the new program would be available to all individuals and families with annual incomes at or below the following levels: First, an individual with income at or under $2,400; second, a two-person family with income at or under $3,600; and third, a family of four with an income at or under $4,800. For each family member above the first four, the eligibility limit is increased by $400. In addition, families with incomes slightly above the eligibility levels would be eligible for benefits if their medical expenses reduced their income to these levels. For example, a family of four with an income of $5,200 would become eligible after they had expended $400 for medical expenses, including any health insurance premiums. Of course, no person presently eligible for medicaid would lose entitlement to benefits, because of the new program.

The benefits covered by the plan would include 60 days of hospital care and all medically necessary physicians' services, laboratory and X-ray services, home health services and care in skilled nursing homes and intermediate care facilities. A copayment of $3 would be required on patient-initiated services, such as visits to a doctor's office, but copayments could not exceed $30 per individual or family during a year. These copayments would not apply to well-baby care or with respect to family planning services.

The plan would also afford catastrophic insurance coverage to those low-income families who are not covered under the catastrophic plan and would also pay for low-income families and coinsurance required under the catastrophic plan.

States would be free to provide additional benefits—such as drugs and dental services—with the Federal Government assuming one-half of the cost.

For millions of older Americans with low incomes, the Long-Ribicoff bill would pick up their part B medicare premiums—presently $6.30 per month—as well as paying their medicare deductibles and coinsurance amounts. In addition, it would provide them with all medically necessary hospital, skilled nursing facility, and intermediate care facility services. Home health care would also be available without limitation.

With respect to mental illness, the program would cover all medically necessary care in an accredited medical institution and care in qualified mental health centers.

The plan would also cover up to five visits to a psychiatrist for "crisis intervention," as well as any additional visits or care approved by a professional standards review organization as medically appropriate and, in the absence of which, the patient would reasonably be expected to be institutionalized or suffer serious dysfunction.

Additionally, the bill also includes coverage of appropriate routine immunization and pap smears on a scheduled allowance basis. This provision is written in such a way so as to also make this coverage of immunizations and pap smears applicable to medicare beneficiaries generally.

The benefits under the low-income plan are residual—that is, they are available only after whatever private health insurance or similar coverage which the person may have has paid first. Under

the bill, no employer insurance plan could exclude an otherwise eligible employee solely because that employee could be covered under the low-income plan. Additionally, if an employed, low-income plan eligible refuses to participate in an employer-sponsored health insurance program where the employer pays 75 percent or more of the cost, that individual would have to pay the first $250 of his hospital or medical costs before being eligible for benefits under the low-income plan.

Mr. President, coverage under the low-income plan would virtually eliminate hospital bad-debts problems. The plan would pay physicians' services at medicare levels—rather than at the often substandard medicaid rates. It would provide necessary long-term care for many millions of low-income older people—long-term care not now provided under medicare.

Of great importance, the plan would afford very substantial fiscal relief to State and local governments. States would make a fixed contribution toward the cost of the low-income plan based upon each State's level of spending for medicaid and general assistance health care in the year prior to the effective date of the plan, July 1, 1975. For example, if a State spent $100 million of its own funds under medicaid for the types of care covered under the new low-income plan, it would contribute that $100 million to the low-income fund during the first and in each succeeding year. Additionally, the State would contribute 50 percent of the estimated amount of State and local expenditures in the year before the low-income plan effective date for health care services to people ineligible for medicaid, but who would be eligible for those types of services under the new low-income plan.

The estimated annual cost of the low-income plan is $5.3 billion in general revenues above present Federal-State expenditures for medicaid. The catastrophic illness plan, financed from social security payroll taxes, would cost an estimated $3.6 billion in the first full year of operation.

The total new Federal cost of $8.9 billion for the catastrophic health insurance and low-income plan compares with the estimated cost of over $70 billion for the national health insurance plan proposed by Senator KENNEDY. The Long-Ribicoff proposal would also cost about $6 billion less annually than legislation endorsed by the American Medical Association.

Mr. President, the third part of our bill consists of a new and voluntary certification program for private basic health insurance policies. With this new program, private insurers could, of their own volition, submit any or all of their basic health insurance policies to the Secretary for certification. This certification would be based upon certain minimum criteria specified in the bill relating to adequacy of coverage, ratio of benefits paid to premium income and conditions of eligibility.

Insurers could advertise the certification in promoting their policies. Three years after enactment of this bill, carriers and intermediaries under the medicare program would be expected to offer one or more certified policies to the general public in areas where they sold policies.

In addition, the bill contains provisions designed to facilitate arrangements whereby basic health insurance policies meeting minimum standards could be offered through private insurance "pools" established by groups of private insurers.

The bill also directs the Secretary of Health, Education, and Welfare to report to Congress after 3 years as to the extent to which private health insurance meeting the criteria established in the bill is actually and generally available in each State.

Mr. President, this bill does not constitute a "be all—end all" approach, but it does provide an opportunity to provide significant assistance to many millions by closing major gaps in the financing of necessary health care. We believe that careful building and improving upon the present system through this major initiative is the only feasible alternative to the potentially disruptive and bankrupting effects involved in proposals which would radically alter and almost scrap existing structures and mechanisms. The variables are too uncontrollable and the chances of error too great for us to risk the magnitude of any mistakes in the total takeover approach. What Senator RIBICOFF and I propose to do is what we know needs to be done and can be done.

We firmly believe that the thrust of the catastrophic health insurance and the Medical Assistance Reform Act is the direction in which we should proceed. Both Senator RIBICOFF and I expect that our proposal will certainly benefit from additional constructive efforts during the course of legislative consideration.

Mr. President, I believe that those who have joined in cosponsoring this measure with us have made a significant and impressive contribution. These are Senators who, through the years, have made their suggestions and sponsored their own bills, indicating ways that they believed we could solve the problem of providing better health care for America. Having worked in this area, we were proud that some of them saw fit to join our efforts and coalesce on a bill which we believe the Senate could pass.

We are extremely proud to have them in this effort. We believe that by moving in this fashion, trying to take the suggestions of each Senator on the Finance Committee as well as each Senator who has worked in this area through the years up to this point, we can contribute to shaping a bill in the best na-

tional interests, and a bill that can be passed, and one which we believe will serve the Nation.

Mr. President, I now send the Catastrophic Health Insurance and Medical Assistance Reform Act to the desk and ask that it be appropriately referred.

The ACTING PRESIDENT pro tempore. The bill will be received and appropriately referred.

Mr. LONG. I also request unanimous consent that a summary of each of the three titles of the bill appear in the CONGRESSIONAL RECORD following these remarks, and a letter I received today from Congressman DOWNING, which illustrates one of the problems with private health insurance which will be dealt with by title III of our bill.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Description of Catastrophic Health Insurance Plan—Title I of the Bill

ELIGIBILITY

The bill would establish, effective July 1, 1974, a new Catastrophic Health Insurance Program (CHIP) as part of the Social Security Act financed by payroll contributions from employees, employers and the self-employed. Under the plan all persons who are fully or currently insured under the Social Security program; their spouses and dependents (and all Social Security beneficiaries) would be eligible for CHIP protection. All persons who are entitled to retirement, survivors, or disability benefits under Social Security, as well as their spouses and dependent children, would thereby be eligible for CHIP. This constitutes about 95 percent of the population.

The largest noncovered groups are Federal employees, employees covered by the Railroad Retirement Act, and State and local governmental employees who are eligible for Social Security but not covered due to the lack of an agreement with the State. (There are a small number of people who are still not covered by Social Security or other retirement programs; the majority of these are domestic or agricultural workers who have not met the necessary Social Security coverage requirements.)

Federal employees are, however, eligible for both basic and major medical catastrophic health insurance protection under the Federal Employees Health Benefits Act, with the Federal Government paying 40 percent of the costs of such coverage.

BUY-IN FOR STATE AND LOCAL EMPLOYEES

Under the plan, State and local employees who are not covered by Social Security could receive coverage under CHIP if the State and local governments exercise an option to buy into the program to cover them on a group basis. When purchasing this protection, States would ordinarily be expected to include all employees and eligible annuitants under a single agreement with the Secretary. A determination by the State as to whether an individual is an annuitant or member of a retirement system or is otherwise eligible to have such coverage purchased on his behalf would, for purposes of the agreement to provide CHIP protection, be final and binding upon the Secretary.

Each State which enters into an agreement with the Secretary of Health, Education and Welfare to purchase CHIP protection will be required to reimburse the Federal Catastrophic Health Insurance Trust Fund for the payments made from the fund for the services furnished to those persons covered under CHIP through the State's agreement with the Secretary, plus the administrative expenses incurred by the Department of Health, Education and Welfare in carrying out the agreement.

Payments will be made from the fund to providers of services for covered services furnished to these persons on the same basis as for other persons entitled to benefits under CHIP. Conditions are also specified under which the Secretary or the State could, after due notice, terminate the agreement.

BENEFITS

The benefits that would be provided under CHIP would be the same as those currently provided under Parts A and B of Medicare, except that there would be no upper limitations on hospital days, or home health visits. Present Medicare coverage under Part A includes 90 days of hospital care and 100 days of post-hospital extended care in a benefit period, plus an additional life-time reserve of 60 hospital days; and 100 home health visits during the year following discharge from a hospital or extended care facility. Part B coverage includes physicians' services, 100 home health visits annually, outpatient physical therapy services, laboratory and X-ray services and other medical and health items and services such as durable medical equipment.

The major benefits excluded from Medicare, and consequently excluded from this proposal, are nursing home care, prescription drugs, hearing aids, eyeglasses, false teeth and dental care. Medicare's limitations on extended care, on inpatient care in psychiatric hospitals, which limit payment to active treatment subject to a 190-day lifetime maximum, and the program's annual limitation on outpatient services in connection with mental, psychoneurotic and personality disorders are also retained. An additional exclusion would be for items or services which the Secretary of Health, Education and Welfare rules to be experimental in nature.

DEDUCTIBLES AND COINSURANCE

In keeping with the intent of this program to protect against health costs so severe that they usually have a catastrophic impact on a family's finances, a deductible of substantial size would be required. The proposed has two entirely separate deductibles which would parallel the inpatient hospital deductible under Part A and the $50 deductible under Part B of Medicare.

The separate deductibles are intended to enhance the mesh of the program with private insurance coverage. In order to receive both hospital and medical benefits, both deductibles must be met. If a person were to meet the hospital deductible alone, he would become eligible only for the hospital and extended care benefits.

Similarly, if a family were to meet the $2,000 medical deductible, they would become eligible only for the medical benefits. There would be hospital and medical coinsurance requirements (as described below) but these would rise to a maximum of $1,000.

HOSPITAL DEDUCTIBLE AND COINSURANCE

There would be a hospital deductible of 60 days hospitalization per year per individual.

After an individual has been hospitalized for a total of 60 days in one year, he would become eligible for payments toward hospital expenses associated with continued hospitalization. The program would thus begin payment with the 61st day of his hospitalization in that year. Only those post-hospital extended care services which he receives subsequent to having met the 60-day deductible would be eligible for payment.

After the hospital deductible has been met, the program would pay hospitals substantially as they are presently paid under Medicare, with the individual being responsible for a coinsurance amount equal to one-fourth of the Medicare inpatient hospital deductible applicable at that time. Extended care services which are eligible for payment would be subject to a daily coinsurance amount equal to one-eighth of the Medicare inpatient hospital deductible. In 1973, this coinsurance amounts to $17.50 a day for inpatient hospital services and $8.75 a day for extended care services. Thus, the coinsurance could rise yearly in proportion to any increase in hospital costs.

MEDICAL DEDUCTIBLE AND COINSURANCE

There would be a supplemental medical deductible initially established at $2,000 per year per family. The Secretary of Health, Education, and Welfare would, between July 1 and October 1 of each year (beginning in 1975) determine and announce the amount of the supplemental medical deductible for the following year.

The deductible would be the greater of $2,000 or $2,000 multiplied by the ratio of the physicians' services component of the Consumer Price Index for June of that year to the level of that component for December, 1974. Thus, the deductible could rise yearly in proportion to any increase in the price of physicians' services.

After a family has incurred expenses of $2,000 for physicians' bills, home health visits, physical therapy services, laboratory and X-ray services and other covered medical and health services, the family would become eligible for payment under the program toward these expenses. For purposes of determining the deductible, a family would be defined as a husband and wife and all dependents.

After the medical deductible had been met, the program would pay for 80 percent of eligible medical expenses, with the patient being responsible for coinsurance of 20 percent.

DEDUCTIBLE CARRYOVER

As in Part B of Medicare, the plan would have a deductible carryover feature—applicable to both the dollar deductible and the hospital-day deductible—under which expenses incurred (or hospital days used) but not reimbursed during the last calendar quarter of a year would also count toward the satisfaction of the deductibles for the ensuing year. For example, an individual admitted to the hospital with a cardiac condition on December 10, 1975, and continuously hospitalized through February 19, 1976, would not, in the absence of the carryover provision meet the hospital-day deductible unless he were to be hospitalized for at least another 10 days in 1976.

With a carryover provision, however, the individual described above would meet the hospital deductible on January 30, 1976. Similarly, if a family's first eligible medical expenses in 1975 amount to $1,200 and were incurred during the months of November and December, and an additional $3,000 in eligible medical expenses are incurred in 1976, the family would, in the absence of a carryover provision, be eligible for payment towards only $1,000 of their expenses in 1976. With a carryover provision, however, the family described above would be eligible for payment toward $2,200 of their expenses in 1976.

ADMINISTRATION

Payments made to patients, providers and practitioners under this program would be subject to the same reimbursement, quality, health and safety standards, and utilization controls as exist in the Medicare program. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners, and other suppliers.

The utilization of services would be subjected to review by present utilization review committees established in hospitals and extended care facilities and by the professional standards review organizations established under P. L. 92-603.

The proposal contemplates using the same administrative mechanisms used for the administration of Medicare, including, where appropriate, Medicare's carriers and intermediaries. The proposal also would encompass use of Medicare's statutory quality standards, in that the same conditions of participation which apply to institutions participating in Medicare would apply to those institutions participating in CHIP.

The Social Security Administration, utilizing its network of district offices, would determine the insured status of individuals and relationships within families which are necessary to establish entitlement to CHIP benefits. The determination of whether the deductible expenses had been met would also be handled by the Social Security Administration in cooperating with carriers and intermediaries. The proposed administrative plan envisions establishing a $2,000 minimum expense amount before individual bills would be accepted. This would protect the administrative agencies from being innundated with paperwork.

FINANCING

The amendment would finance the plan with the following contribution schedule: 1975–1977, 0.3 of one percent of taxable payroll on employees and 0.3 on employers; 1978–1981, 0.35; 1982 and after, 0.4. Rates for the self-employed would also be 0.3, 0.35 and 0.4 respectively.

The contributions would be placed in a separate Federal Catastrophic Health Insurance Trust Fund from which benefits and administrative expenses related to this program would be paid. The complete separation of catastrophic health insurance financing and benefit payments is intended to assure that the catastrophic health insurance program will in no way impinge upon the financial soundness of the retirement, survivors, or disability insurance trust funds or Medicare's hospital and supplementary medical insurance trust funds. Such separation will also focus public and congressional attention closely on the cost and the adequacy of the financing of the program.

To provide an operating fund at the beginning of the program (in recognition of the lag in time between the date on which the taxes are payable and their collection), and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis without interest) during the first 3 calendar years of the program. The amount which could be drawn in any such calendar year could not exceed the estimated amount of 6 months of benefit payments during that year.

CONCLUSION

More than one million families of the approximately 49 million families in the United States annually incur medical expenses which will qualify them to receive benefits under the program. Of course, nearly all American families will receive the benefit of insurance protection against the costs of catastrophic illness.

DESCRIPTION OF MEDICAL ASSISTANCE PLAN FOR LOW-INCOME INDIVIDUALS AND FAMILIES—TITLE II OF THE BILL

GENERAL APPROACH

The bill would establish a medical assistance plan, effective July 1, 1975, for low-income individuals and families. The plan would provide Federally-administered basic health benefits coverage with uniform national eligibility standards.

The basic benefits provided under the plan are designed to mesh with those under the catastrophic health insurance plan. The plan is aimed in large part at providing coverage to low-income working individuals and families, in addition to replacing the current Medicaid program. It would eliminate the present inequities in Medicaid whereby people with the same incomes and needs are eligible for Medicaid in one State but ineligible in another, as well as the extensive variations in benefits between States. The plan would also result in substantial fiscal relief to State and local governments.

ELIGIBILITY

Coverage would be available to all individuals and families having an annual income at or below the following levels: $2,400 for an individual; $3,600 for a two-person family; $4,200 for a three-person family; $4,800 for a four-person family; and $400 additional for each additional family member.

Eligibility would not be linked to eligibility for welfare payments and, consequently, there would be no requirement that an individual fit into one of the current welfare categories (such as aged, blind or disabled). This would mean that working low-income individuals and families presently ineligible for Medicaid (such as thousands of migrant families) would be eligible for benefits under this plan.

In view of the fact that the plan is not linked to the welfare program, and to simplify its administration, there would be no assets test applied in determining eligibility.

The program would contain a "spend-down" provision under which an individual or family's income would be reduced by their incurred health care expenses in determining their eligibility for benefits under the program. For example, a family of four with $5,000 of income would be covered under the program after they had incurred expenses of $200 for medical care.

To be eligible for benefits, persons would have to be either resident citizens of the United States or aliens lawfully admitted for permanent residence, or otherwise legally residing in the United States.

Eligible individuals would file an application (or have an application filed in their behalf). Upon approval of an application, each individual would be issued a health benefits eligibility card.

To enhance administrative simplicity, eligibility would be certified on an annual basis with a coverage year generally beginning on April 1, and with the income determinations generally being based upon the previous year's income. Provisions are included to allow entrance into the program, where appropriate, at any point during the year. In such cases, eligibility would be redetermined on the following April 1. In addition, the plan provides for prospective earnings estimates, where appropriate, in determination of eligibility.

Individuals' or families' eligibility would generally continue throughout the coverage year unless their income increased to more than 20 percent above the eligibility level. In determining eligibility, a family is defined as two or more individuals related by blood, marriage or adoption, and residing in a place maintained by one or more of them as their home. Also, in determining eligibility, income would include both earned and unearned income, including welfare payments, pension or Social Security payments, support and alimony payments, gifts, rents, dividends and interest. The plan includes lesser income limits for Puerto Rico, the Virgin Islands and Guam. Additionally, there would be special rules established by the Secretary to deal with cases where the gross income of an individual or family from a trade or business (including farming) would be considered sufficiently large to cause the family not to be regarded as "low income".

The plan contains a "grandfather" provision to guarantee that no current Medicaid recipient would be disadvantaged by this program.

BENEFITS

The plan would cover medically-necessary inpatient hospital services for up to 60 days during a benefit period, as well as all medically-neccessary skilled nursing facility care, intermediate facility care and home health services. Additionally, the plan would cover all medically-necessary medical and other health services (including physicians' services and laboratory and X-ray services), as well as prenatal and well-baby care, family planning counseling services and supplies and, for children under 18, periodic screening, diagnosis and treatment. Additionally, the plan would make payments for Part B Medicare premiums for eligible individuals.

Mental health care would be covered on an inpatient basis to the extent that it consisted of active care and treatment provided in an accredited medical institution, and outpatient mental health services would be covered without limitation if provided in a qualified community mental health center. Additionally, the plan would cover up to five visits to a psychiatrist, related to "crisis intervention", during any benefit period. Additional visits would be authorized upon a finding that the patient would require institutionalization in the absence of such care or that he would be severely dysfunctional.

For individuals who are also entitled to benefits under the catastrophic health insurance plan, the medical assistance plan would pay any coinsurance required under the catastrophic plan. For persons not eligible for benefits under the catastrophic plan, the medical assistance plan would make payments for benefits covered under the catastrophic plan. The plan would also cover routine immunizations.

DEDUCTIBLES AND COINSURANCE

In view of the fact that the medical assistance plan is aimed at providing benefits to individuals and families without adequate resources to purchase medical care, there would generally be no deductibles or coinsurance payments required.

However, to assist in controlling patient-initiated utilization, there would be a $3 per visit copayment for each of the first 10 outpatient physicians' visits per family, but no copayment would be applicable for visits for well-baby care and family planning services.

There would be one other circumstance in which a copayment would be required. This would be applicable in those situations where a person, without dependents, is in a long-term care facility for more than 60 days. In such cases, the individual (usually an elderly person in a nursing home) would retain $50 of his monthly income and any income in excess of $50 would be required as a copayment.

PAYMENTS AND ADMINISTRATION

Payments made to providers and practitioners under this program would be subject to the same reimbursement, quality, health and safety standards, and utilization controls as are applicable under the Medicare

program. Reimbursement controls would limit payments to not more than audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers.

Payments made under this program, along with any required copayment, would have to be accepted by providers and practitioners as payment in full for the services rendered, and no person accepting such payment could charge amounts in excess of the payment for the individual receiving the service.

Benefits under the program would be residual and amounts payable under this program would be reduced by amounts payable under any other public or private insurance plan under which the individual was covered, with the exception of a State program designed to supplement this program.

In addition, amounts otherwise payable under this program would be reduced by not more than $250 in a benefit period if an eligible employed individual failed to enroll in an employer-sponsored health insurance plan for which the employer paid 75 percent or more of the premium cost. No employer could exclude an otherwise eligible employee from participation in a health insurance plan solely on account of the employee's eligibility for benefits under the Medical Assistance Plan.

The utilization and quality of services would be reviewed by utilization review committees established in hospitals and skilled nursing facilities, and by the Professional Standards Review Organizations established under Public Law 92-603.

The program utilizes the same administrative mechanisms used for the administration of Medicare, including, where appropriate, Medicare's carriers, intermediaries and public health agencies. The program also would encompass use of Medicare's statutory quality standards, in that the same conditions of participation which apply to institutions participating in Medicare would apply to those institutions participating in this program.

Primary policy, operating and general administrative responsibility for the program is specifically assigned to the Social Security Administration, basically involving personnel and facilities employed in the Bureau of Health Insurance.

FINANCING

The low-income plan would be financed from general revenues, just as the Federal share of the current Medicaid program is now financed, and also with State funds. A medical assistance trust fund would be established to make payments for benefits under the program. The fund would receive appropriations from general revenues and State contributions.

States would contribute a fixed amount which would be equivalent to their total expenditures from State funds under Medicaid for the types of benefits covered under this plan during the year prior to the effective date of this program. Additionally, a State would also pay 50 percent of the estimated amount that the State and local governments had expended in that same base year for provision of these types of services to people not covered under Medicaid who would however, be covered under the new plan. State contributions in future years would be limited to the initial contribution amount.

The State contribution would be reduced by an amount equal to one-half the amount expended by the State from non-Federal funds in providing types of services not covered under this program, but which could have been matched under the Medicaid program. This provision would encourage States to offer or to continue providing optional services, such as drugs, dental services and eyeglasses.

The additional first full-year Federal cost above present Medicaid expenditures, is estimated at $5.3 billion.

CONCLUSION

An estimated 34 million people throughout the United States would be eligible for benefits under this program in any given year though, of course, not all of these people will receive services in a given year. The current Medicaid program covers some 22 million people. The additional people covered under this new program represent primarily the working poor who, until this time, have been ineligible for Federally-supported medical assistance.

Description of Private Basic Health Insurance Voluntary Certification Program—Title III of the Bill

GENERAL APPROACH

The bill would establish a voluntary certification program for private basic health insurance. Under this program, a private health insurer could, if it chose, submit one or more of its basic health insurance policies to the Secretary for certification. The Secretary's certification would be based upon the policies' meeting certain minimum criteria with respect to adequacy of coverage, conditions of eligibility, actual availability of the policy and reasonableness of pay-out ratio which are specified in the bill.

If a policy was certified by the Secretary, the private insurer could advertise such certification in promotion of the policy.

As a condition of eligibility for contracting as the Government's agents, beginning three years after enactment of the bill, carriers and intermediaries under the Medicare program would be expected to offer one or more certified policies to the general public in each service area where the carrier or intermediary sold health insurance policies.

Additionally, the bill would facilitate arrangements whereby basic health insurance policies meeting the minimum standards could be offered ahrough "pools" of private insurers.

The bill would direct the Secretary of Health, Education and Welfare to report to the Congress after three years on the extent to which private health insurance meeting the criteria established in the bill is actually and generally available.

CRITERIA FOR BASIC PRIVATE HEALTH INSURANCE

The bill contains a set of criteria for basic private health insurance policies. Private health insurance would not be required to meet these criteria but these yardsticks would be applied by the Secretary in certifying policies volnutarily submitted for certifiaction.

The criteria dealing with adequacy of coverage would basically call for benefits of at least 60 days of hospital care and coverage of medical bills up to $2,000. A policy meeting these criteria would mesh with the deductible amounts under the catastrophic health insurance program. The standards also limit the amount of deductible and copayments which could be charged with respect to the covered hospital and medical care.

Other criteria ban exclusions, waivers of liability and waiting periods in group policies and, with respect to individual policies, limit medical exclusion to preexeisting preg-

nancy and waiting periods for other preexisting conditions to not more than 90 days.

Additional requirements deal with opportunities for enrollment including at least an annual "open" enrollment period.

Reasonable ratios of benefit payments to premiums are defined in terms of average ratios for group policies generally underwritten by insurers.

USE OF CERTIFCATION

The Secretary would design an appropriate emblem which could be used by the private insurer in advertising the certified policy.

CARRIERS AND INTERMEDIARIES

Three years from the effective date no insurer could serve as a Medicare carrier or intermediary unless it offered one or more certified policies to the general public in each geographic or service area in which it did business.

FACILITATING INSURANCE "POOLS"

The bill contains an antitrust exemption under which insurers could enter into contracts or arrangements for the sole purpose of establishing insurance "pool" arrangements in order to offer to the general public certified health insurance policies. Such pools allow proportionate sharing of risks and rewards.

REPORT BY THE SECRETARY

The Secretary of Health, Education and Welfare would report to the Congress at the end of three years on the extent to which private health insurance meeting the criteria for certification contained in the bill was actually and generally available in States.

Hon. THOMAS N. DOWNING,
House of Representatives,
Washington, D.C.

DEAR MR. DOWNING: I have an insurance policy with National Preferred *Division* Globe Life and Accident Insurance Company, Box 18526, Oklahoma City, Oklahoma 73118.

It was issued in November 1960, and is a cash payment policy of $100 to $150 per week, payable after the third day of hospitalization. I have collected on this insurance on several occasions when I was hospitalized, the last time being in June 1973.

Since I have terminal cancer, a condition which did not exist when the policy was issued, the Company now advises me that they are cancelling the policy as of February 1974. They have this option as so stated in the policy.

My question is, since this policy was issued such a long time ago, has there been any insurance laws passed since then that prohibits a company from cancelling a policy at their option. It does not seem fair that a person pays all these years on a policy, and even though I have collected small amounts in the past, now when they feel there may be long term hospitalization they opt to cancel.

I would appreciate a reply with your comments and suggestions, if any, as to what can be done in this case. I know that my policy states at their option, and I will have to abide by it, but it seems to me that this is something that should be considered in future legislation to protect the consumer, and this is my reason for bringing it to your attention.

FACT SHEET—LONG-RIBICOFF CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT OF 1973

TITLE I—CATASTROPHIC HEALTH INSURANCE PLAN

Eligibility

All persons covered by the Social Security System and their spouses and dependents. This constitutes 95% of the population. Most of the rest of the uncovered population are government employees. State and local governmental employees not covered under Social Security could buy into the program. Federal employees who are eligible for basic and catastrophic protection under the Federal Employees Health Benefits Act would continue to be covered by that program.

Benefits

Social Security administered trust fund pays for medical bills after a family has incurred $2000 of medical bills in a year. Hospital costs would be paid for after a person has incurred 60 days of hopsital costs. The $2000 deductible and the 60 day deductible are entirely separate. If a person were to meet the hospital deductible alone it would be eligible only for the hospital benefits. Similarly, if a family were to meet only the $2000 deductible, it would be eligible only for medical benefits.

After the deductibles are met there would still be copayments required similar to the Medicare copayments ($17.50 a day for hospital and 20% of medical bills). But these copayments would stop once they reach $1000.

Cost

$3.6 billion payable by .3% increase in Social Securtiy tax on employee and employer.

Effective date

July 1, 1974.

TITLE II—MEDICAL ASSISTANCE PLAN

Replaces Medicaid with a uniform national program of medical benefits for low-income persons administered by Social Security Administration.

Eligibility—34 million people

All persons now receiving Medicaid benefits.

All individuals and families having an annual income at or below the following levels:

$2,400 for an individual;
$3,600 for a two-person family;
$4,200 for a three-person family;
$4,800 for a four-person family;

And $400 additional of each additional family member.

Families with incomes above these levels would become eligible if they spend enough on medical care to reduce their income to the eligibility levels. Thus, a family of four with $5000 would become eligible if it spent $200 for medical care.

Benefits

Provides hospital care for up to 60 days and all skilled nursing facility care, intermediate facility care and home health services.

Also covers physicians services, X-ray, laboratory, prenatal and well-baby care, family planning counselling services and supplies, periodic screening, diagnosis and treatment for children under 18, inpatient mental health care that consists of active care and treatment in a medically accredited institution and outpatient care in a qualified community health center. Outpatient psychiatric services would be limited to 5 visits related to "crisis" intervention and additional visits could be authorized upon finding that in their absence the patient would require institutionalization or be severely dysfunctional.

The plan would also pay the $6.30 monthly Part B Medicare premium for persons eligible for this Title.

Copayments and deductibles

Only copayment is $3 for each of first 10 visits to doctor per family (but no copayments for visits for well-baby care and family planning services).

Payments to health care providers and administration

Same as Medicare (reasonable costs for institutions, reasonable charges for physicians.

Payments made under the program would have to be accepted as payment in full and there could be no additional charges to patient.

Benefits reduced to patients by $250 if they have failed to enroll in an employer-employee plan in which employer pays 75% or more of the premium cost.

Cost

$5.3 billion in federal general revenues. States would have to pay no more than they did for Medicaid in the year prior to this Title's effective date plus one-half of what they paid for medical services for those not covered by Medicaid. Thus states would be held harmless against additional costs or caseloads.

Effective date

July 1, 1975.

TITLE III

Establishes a voluntary certification program for private basic health insurance to encourage the availability of adequate private health insurance.

Insurer could submit policy to HEW Secretary for certification. Certification is based on adequacy of coverage, conditions of eligibility, actual availability. Certified policies would be advertised as such.

Criteria for certification of policies

Must provide 60 days of hospital care and coverage of medical bills up to $2000. (This meshes with catastrophic plan.)

Limits on deductibles and copayments.

Ban on exclusions, waivers of liability and waiting periods in group policies, and with respect to individual policies, a limit on medical exclusion to pre-existing pregnancy and waiting periods for other pre-existing conditions to not more than 90 days.

At least one annual open enrollment period.

Reasonable ratios of benefit payments to premiums defined in terms of average ratios for group policies generally written by insurers.

Incentives to provide certified policies

For three years from effective date of act, Secretary of HEW studies progress of insurers in making certified policies actually and generally available to population.

After that time no insurer could serve as a Medicare carrier or intermediary unless it offered one or more certified policies to the general public in each geographic or service area in which it did business.

Insurance pooling

Contains an anti-trust exemption under which insurers could enter into contracts or arrangements for the sole purpose of establishing insurance "pool" arrangements in order to offer to the general public certified health insurance policies. Such pools allow proportionate sharing of risks and rewards.

NIXON'S HEALTH INSURANCE MESSAGE CALLS FOR ACTION THIS YEAR

TO THE CONGRESS OF THE UNITED STATES:

One of the most cherished goals of our democracy is to assure every American an equal opportunity to lead a full and productive life.

In the last quarter century, we have made remarkable progress toward that goal, opening the doors to millions of our fellow countrymen who were seeking equal opportunities in education, jobs and voting.

Now it is time that we move forward again in still another critical area: Health Care.

Without adequate health care, no one can make full use of his or her talents and opportunities. It is thus just as important that economic, racial and social barriers not stand in the way of good health care as it is to eliminate those barriers to a good education and a good job.

Three years ago, I proposed a major health insurance program to the Congress, seeking to guarantee adequate financing of health care on a nationwide basis. That proposal generated widespread discussion and useful debate. But no legislation reached my desk.

Today the need is even more pressing because of the higher costs of medical care. Efforts to control medical costs under the New Economic Policy have been met with encouraging success, sharply reducing the rate of inflation for health care. Nevertheless, the overall cost of health care has still risen by more than 20% in the last two and one-half years, so that more and more Americans face staggering bills when they receive medical help today:

Across the nation, the average cost of a day of hospital care now exceeds $110.

The average cost of delivering a baby and providing post-natal care approaches $1,000.

The average cost of health care for terminal cancer now exceeds $20,000.

For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a catastrophic illness can mean catastrophic debt.

Beyond the question of the prices of health care, our present system of health care insurance suffers from two major flaws:

First, even though more Americans carry health insurance than ever before, the 25 million Americans who remain uninsured often need it the most and are most unlikely to obtain it. They include many who work in seasonal or transient occupations, high-risk cases, and those who are ineligible for Medicaid despite low incomes.

Second, those Americans who do carry health insurance often lack coverage which is balanced, comprehensive and fully protective:

*Forty percent of those who are insured are not covered for visits to physicians on an out-patient basis, a gap that creates powerful incentives toward high-cost in hospitals;

*Few people have the option of selecting care through prepaid arrangements offered by Health Maintenance Organizations so the system at large does not benefit from the free choice and creative competition this would offer;

*Very few private policies cover preventive services;

*Most health plans do not contain built-in incentives to reduce waste and inefficiency. The extra costs of wasteful practices are passed on, of course, to consumers, and

*Fewer than half of our citizens under 65 - and almost none over 65 - have major medical coverage which pays for the cost of catastrophic illness.

These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills - or worse. Delays in treatment can end in death or lifelong disability.

Comprehensive Health Insurance Plan (CHIP)

Early last year, I directed the Secretary of HEW to prepare a new and improved plan for comprehensive health insurance. That plan, as I indicated in my State of the Union message, has been developed and I am presenting it to the Congress today. I urge its enactment as soon as possible.

The plan is organized around seven principles:

First, it offers every American an opportunity to obtain a balanced, comprehensive range of health insurance benefits;

Second, it will cost no American more than he can afford to pay;

Third, it builds on the strength and diversity of our existing public and private systems of health financing and harmonizes them into an overall system;

Fourth, it uses public funds only where needed and requires no new federal taxes;

Fifth, it would maintain freedom of choice by patients and ensure that doctors work for their patient, not for the federal government;

Sixth, it encourages more effective use of our health care resources;

And Finally, it is organized so that all parties would have a direct stake in making the system work - consumer, provider, insurer, state governments and the federal government.

Broad and Balanced Protection for All Americans

Upon adoption of appropriate federal and state legislation, the Comprehensive Health Insurance Plan would offer to every American the same broad and balanced health protection through one of three major programs:

1) *Employee Health Insurance*, covering most Americans and offered at their place of employment, with the cost to be shared by the employer and employee on a basis which would prevent excessive burdens on either;

2) *Assisted Health Insurance*, covering low-income persons, and persons who would be ineligible for the other two programs, with federal and state government paying these costs beyond the means of the individual who is insured; and,

3) *An improved Medicare Plan*, covering those 65 and over and offered through a Medicare system that is modified to include additional, needed benefits.

One of these three plans would be available to every American, but for everyone, participation in the program would be voluntary.

The benefits offered by the three plans would be identical for all Americans, regardless of age or income. Benefits would be provided for:

-hospital care;
-physicians' care in and out of the hospital;
-prescription and life-saving drugs;
-laboratory tests and X-rays;
-medical devices;
-ambulance services; and,
-other ancillary health care.

There would be no exclusions of coverage based on the nature of the illness. For example, a person with heart disease would qualify for benefits as would a person with kidney disease.

In addition, CHIP would cover treatment for mental illness, alcoholism and drug addiction, whether that treatment were provided in hospitals and physicians' offices or in community-based settings.

Certain nursing home services and other convalescent services would also be covered. For example, home health services would be covered so that long and costly stays in nursing homes could be averted where possible.

The health needs of children would come in for special attention, since many conditions, if detected in childhood, can be prevented from causing lifelong disability and learning handicaps. Included in these services for children would be:

-preventive care up to age six;
-eye examinations;
-hearing examinations; and
-regular dental care up to age 13.

Under the Comprehensive Health Insurance Plan, a doctor's decisions could be based on the health care needs of his patients, not on health insurance coverage. This difference is essential for quality care.

Every American participating in the program would be insured for catastrophic illnesses that can eat away savings and plunge individuals and families into hopeless debt for years. No family would ever have annual out-of-pocket expenses for covered health services in excess of $1,500, and low-income families would face substantially smaller expenses.

As part of this program, every American who participates in the program would receive a Healthcard when the plan goes into effect in his state. This card, similar to a credit card, would be honored by hospitals, nursing homes, emergency

rooms, doctors, and clinics across the country. This card could also be used to identify information on blood type and sensitivity to particular drugs - information which might be important in an emergency.

Bills for the services paid for with the Healthcard would be sent to the insurance carrier who would reimburse the provider of the care for covered services, then bill the patient for his share, if any.

The entire program would become effective in 1976, assuming that the plan is promptly enacted by the Congress.

How Employee Health Insurance Would Work

Every employer would be required to offer all full-time employees the Comprehensive Health Insurance Plan. Additional benefits could then be added by mutual agreement. The insurance plan would be jointly financed with employers paying 65% of the premium for the first three years of the plan, and 75% thereafter. Employees would pay the balance of the premiums. Temporary federal subsidies would be used to ease the initial burden on employers who face significant cost increases.

Individuals covered by the plan would pay the first $150 in annual medical expenses. A separate $50 deductible provision would apply for outpatient drugs. There would be a maximum of three medical deductibles per family.

After satisfying this deductible limit, an enrollee would then pay for 25% of additional bills. However, $1,500 per year would be the absolute dollar limit on any family's medical expenses for covered services in any one year.

How Assisted Health Insurance Would Work

The program of Assisted Health Insurance is designed to cover everyone not offered coverage under Employee Health Insurance or Medicare, including the unemployed, the disabled, the self-employed, and those with low incomes. In addition, persons with higher incomes could also obtain Assisted Health Insurance if they cannot otherwise get coverage at reasonable rates. Included in this latter group might be persons whose health status or type of work puts them in high-risk insurance categories.

Assisted Health Insurance would thus fill many of the gaps in our present health insurance system and would ensure that

for the first time in our nation's history, all Americans would have financial access to health protection regardless of income or circumstances.

A principal feature of Assisted Health Insurance is that it relates to premiums and out-of-pocket expenses to the income of the person or family enrolled. Working families with incomes of up to $5,000, for instance, would pay no premiums at all. Deductibles, co-insurance, and maximum liability would all be pegged to income levels.

Assisted Health Insurance would replace state-run Medicaid for most services. Unlike Medicaid, where benefits vary in each state, this plan would establish uniform benefit and eligibility standards for all low-income persons. It would also eliminate artificial barriers to enrollment or access to health care.

As an interim measure, the Medicaid program would be continued to meet certain needs, primarily long-term institutional care. I do not consider our current approach to long-term care desirable because it can lead to over-emphasis on institutional care as opposed to home care. The Secretary of HEW has undertaken a thorough study of the appropriate institutional services which should be included in health insurance and other programs and will report his findings to me.

Improving Medicare

The Medicare program now provides medical protection for over 23 million older Americans. Medicare, however, does not cover outpatient drugs, nor does it limit total out-of-pocket costs. It is still possible for an elderly person to be financially devastated by a lengthy illness even with Medicare coverage.

I therefore propose that Medicare's benefits be improved so that Medicare would provide the same benefits offered to other Americans under Employee Health Insurance and Assisted Health Insurance.

Any person 65 or over, eligible to receive Medicare payments, would ordinarily, under my modified Medicare plan, pay the first $100 for care received during a year, and the first $50 toward out-patient drugs. He or she would also pay 20% of any bills above the deductible limit. But in no case would any Medicare beneficiary have to pay more than $750 in out-of-pocket costs. The premiums and cost sharing for those with low incomes would be reduced, with public funds making up the difference.

The current program of Medicare for the disabled would be replaced. Those now in the Medicare for the disabled plan would be eligible for Assisted Health Insurance, which would provide better coverage for those with high medical costs and low incomes.

Premiums for most people under the new Medicare program would be roughly equal to that which is now payable under Part B of Medicare - the Supplementary Medical Insurance Program.

Costs of Comprehensive Health Insurance

When fully effective, the total new costs of CHIP to the federal and state governments would be about $6.9 billion with an additional small amount for transitional assistance for small and low wage employers:

*The federal government would add about $5.9 billion over the cost of continuing existing programs to finance health care for low-income or high risk persons.

*State governments would add about $1 billion over existing Medicaid spending for the same purpose, though these added costs would be largely, if not wholly, offset by reduced state and local budgets for direct provision of services.

*The federal government would provide assistance to small and low wage employers which would initially cost about $450 million but be phased out over five years.

For the average American family, what all of these figures reduce to is simply this:

*The national average family cost for health insurance premiums each year under Employee Health Insurance would be about $150; the employer would pay approximately $450 for each employee who participates in the plan.

*Additional family costs for medical care would vary according to need and use, but in no case would a family have to pay more than $1,500 in any one year for covered services.

*No additional taxes would be needed to pay for the cost of CHIP. The federal funds needed to pay for this plan could all be drawn from revenues that would be generated by the present tax structure. I am opposed to any comprehensive health plan which requires new taxes.

Making the Health Care System Work Better

Any program to finance health care for the nation must take close account of two critical and related problems - cost and quality.

When Medicare and Medicaid went into effect, medical prices jumped almost twice as fast as living costs in general in the next five years. These programs increased demand without increasing supply proportionately and higher costs resulted.

This escalation of medical prices must not recur when the Comprehensive Health Insurance Plan goes into effect. One way to prevent an escalation is to increase the supply of physicians, which is now taking place at a rapid rate. Since 1965, the number of first-year enrollments in medical schools has increased 55%. By 1980, the nation should have over 440,000 physicians, or roughly one-third more than today. We are also taking steps to train persons in allied health occupations, who can extend the services of the physician.

With these and other efforts already underway, the nation's health manpower supply will be able to meet the additional demands that will be placed on it.

Other measures have also been taken to contain medical prices. Under the New Economic Policy, hospital cost increases have been cut almost in half from their post-Medicare highs, and the rate of increase in physician fees has slowed substantially. It is extremely important that these successes be continued as we move toward our goal of comprehensive health insurance protection for all Americans. I will, therefore, recommend to the Congress that the Cost of Living Council's authority to control medical care costs be extended.

To contain medical costs effectively over the long haul, however, basic reforms in the financing and delivery of care are also needed. We need a system with built-in incentives that operates more efficiently and reduces the losses from waste and duplication of effort. Everyone pays for this inefficiency through their health premiums and medical bills.

The measure I am recommending today therefore contains a number of proposals designed to contain costs, improve the efficiency of the system and assure quality health care. These proposals include:

1) Health Maintenance Organizations (HMOs)

On Dec. 29, 1973, I signed into law legislation designed to stimulate, through federal aid, the establishment of prepaid comprehensive care

organizations. HMO's have proved an effective means for delivering health care and the CHIP plan requires that they be offered as an option for the individual and the family as soon as they become available. This would encourage more freedom of choice for both patients and providers, while fostering diversity in our medical care delivery system.

2) *Professional Standards Review Organizations (PSROs)*

I also contemplate in my proposal a provision that would place health services provided under CHIP under the review of Professional Standards Review Organizations. These PSRO's would be charged with maintaining high standards of care and reducing needless hospitalization. Operated by groups or private physicians, professional review organizations can do much to ensure quality care while helping to bring about significant savings in health costs.

3) *More Balanced Growth in Health Facilities*

Another provision of this legislation would call on the states to review building plans for hospitals, nursing homes and other health facilities. Existing health insurance has overemphasized the placement of patients in hospitals and nursing homes. Under this artificial stimulus, institutions have felt impelled to keep adding bed space. This has produced a growth of almost 75% in the number of hospital beds in the last 20 years, so that now we have a surplus of beds in many places and a poor mix of facilities in others. Under the legislation I am submitting, states can begin remedying this costly imbalance.

4) *State Role*

Another important provision of this legislation calls on the states to review the operation of health insurance carriers within their jurisdiction. The states would approve specific plans, oversee rates, ensure adequate disclosure, require an annual audit and take other appropriate measures. For health care providers, the states would assure fair reimbursement for physician services, drugs and institutional services, including a prospective reimbursement system for hospitals.

A number of states have shown that an effective job can be done in containing costs. Under my proposal all states would have an incentive to do the same. Only with effective cost control measures can states ensure that the citizens receive the increased health care they need and at rates they can afford. Failure on the part of the states to enact the necessary authorities would prevent them from receiving any federal support of their state-administered health assistance plan.

Maintaining a Private Enterprise Approach

My proposed plan differs sharply with several of the other health insurance plans which have been prominently discussed. The primary difference is that my proposal would rely extensively on private insurers.

Any insurance company which could offer those benefits would be a potential supplier. Because private employers would have to provide certain basic benefits to their employees, they would have an incentive to seek out the best insurance company proposals and insurance companies would have an incentive to offer their plans at the lowest possible prices. If, on the other hand, the government were to act as the insurer, there would be no competition and little incentive to hold down costs.

There is a huge reservoir of talent and skill in administering and designing health plans within the private sector. That pool of talent should be put to work.

It is also important to understand that the CHIP plan preserves basic freedoms for both the patient and doctor. The patient would continue to have a freedom of choice between doctors. The doctors would continue to work for their patients, not the federal government. By contrast, some of the national health plans that have been proposed in the Congress would place the entire health system under the heavy hand of the federal government, would add considerably to our tax burdens, and would threaten to destroy the entire system of medical care that has been so carefully built in America.

I firmly believe we should capitalize on the skills and facilities already in place, not replace them and start from scratch with a huge federal bureaucracy to add to the ones we already have.

Comprehensive Health Insurance Plan - A Partnership Effort

No program will work unless people want it to work. Everyone must have a stake in the process. This Comprehensive Health Insurance Plan has been designed so that everyone involved would have both a stake in making it work and a role to play in the process - consumer, provider, health insurance carrier, the states and the federal government. It is a partnership program in every sense.

By sharing costs, consumers would have a direct economic stake in choosing and using their community's health resources wisely and prudently. They would be assisted by requirements that physicians and other providers of care make available to patients full information on fees, hours of operation and other matters affecting the qualifications of providers.

But they would not have to go it alone either: doctors, hospitals and other providers of care would also have a direct stake in making the Comprehensive Health Insurance Plan work. This program has been designed to relieve them of much of the red tape, confusion and delays in reimbursement that plague them under the bewildering assortment of public and private financing systems that now exist. Healthcards would relieve them of troublesome bookkeeping. Hospitals could be hospitals, not bill collecting agencies.

Conclusion

Comprehensive health insurance is an idea whose time has come in America. There has long been a need to assure every American financial access to high quality health care. As medical costs go up, that need grows more pressing.

> *Now, for the first time, we have not just the need but the will to get this job done. There is widespread support in the Congress and in the nation for some form of comprehensive health insurance.*

Surely if we have the will, 1974 should also be the year that we find the way. The plan that I am proposing today is, I believe, the very best way. Improvements can be made in it, of course, and the Administration stands ready to work with the Congress, the medical profession, and others in making those changes.

But let us not be led to an extreme program that would place the entire health care system under the dominion of social planners in Washington. Let us continue to have doctors who work for their patients, not for the federal government. Let us build upon the strengths of the medical system we have now, not destroy it.

Indeed, let us act sensibly. And let us act now - in 1974 - to assure all Americans financial access to high quality medical care.

BIOMEDICAL RESEARCH MANPOWER CONFERENCE
BATTELLE SEATTLE RESEARCH CENTER
OCTOBER 1-3, 1973

In June of 1973, the inexorable elimination of the National Institutes of Health and National Institutes of Mental Health research training programs for developing young biomedical investigators had so clearly become the policy of the Federal government that a meeting of representatives from the major universities responsible for research training was called. These institutions recognized that their role must now extend beyond responding to requests for developing talented youth and become one of participating actively in the planning for preservation of research capability in the sciences basic to medicine. The two-and-one half day meeting was held in Seattle in October, 1973, and was attended by representatives from 20 university medical schools, several voluntary health agencies, private foundations, the Office of the Assistant Secretary for Health, Education and Welfare and the Director of the National Institutes of Health. The Association of American Medical Colleges, through its Council of Academic Societies, and the University of Washington School of Medicine arranged the meeting. The Battelle Memorial Institute kindly provided us with excellent conference facilities in Seattle.

For two-and-one half days the 62 participants met in plenary and small workshop sessions. The principal focus was on developing ideas and plans for the assumption of increased responsibility by non-governmental agencies for planning and monitoring the development of the Nation's biomedical research manpower. Three major groups were considered by the Con-

ference participants as inseparably interdependent in carrying forward research talent development. These are: the faculties of the Nation's colleges and universities; the informed laity, particularly those in the voluntary health agencies; and the legislative and administrative branches of the Federal government. Major supporting roles are expected from private foundations and the commercial-industrial sectors of society.

The recommendations emanating from the meeting placed great responsibility on the non-governmental sector for monitoring and planning the research training effort of the country in the future. This is not intended to imply that the Congress, the National Institutes of Health, the Department of Health, Education and Welfare and the National Science Foundation do not have principal responsibility for the Nation's biomedical research manpower policies. However, recent experience demonstrates that educational training policies can be radically changed by politically motivated decisions. A more stable element in policy development must be included if public expectations for improved health through research are to be met. This element must come from the responsible input of professional scientists and their academic institutions.

The appendix to this report contains the schedule of the Conference, a list of attendees, the letter to the participants regarding the purposes of the Conference, and an outline regarding the task forces that met and the report of each task force that formed the basis for developing the enclosed report. The individuals participating in each task force are also listed in this appendix.

RECOMMENDATIONS

Three principal recommendations were derived from the Biomedical Research Manpower Conference.

1. That the Congress establish a national commission, possibly under the auspices of the National Academy of Sciences, to help in determining the appropriate role for the federal government in the support of biomedical research and research training, with particular attention to the mission of its principal agency, the National Institutes of Health. Such a commission should have broad representation from business, labor, consumers, foundations, the scientific community, and other interested parties.

2. The Association of American Medical Colleges should take a leadership role in the evaluation of needs for manpower development and should call upon the assistance of the voluntary health agencies such as the American Heart Association, the American Cancer Society, the Muscular Dystrophy Society, Planned Parenthood and others. This program should also involve the biomedical scientific societies participating in the Council of Academic Societies of the AAMC in order to obtain a broad consensus of needs. The informed support of business, labor and individual citizens should be utilized to promote a rational, national biomedical research and research training policy. The academic medical community, the

professional biomedical scientific associations and the voluntary health agencies should also develop mechanisms to foster public education regarding the implications of biomedical research programs on the public and individual health of the American citizens.

3. A systems-analysis group should be established to evaluate biomedical research from the standpoint of optimizing contributions to health care and suggesting guidelines for the allocation of resources to basic and applied research. This group will require input of biomedical scientists and should include among its topics for consideration the factors which contribute to the career choice of students who enter biomedical research.

The task forces which met in Seattle to consider the issues related to biomedical research manpower training arrived at these recommendations based upon their evaluations of needs, priorities, evaluation mechanisms, the problems of finding public support and establishing new funding mechanisms. The workshop participants also considered that a high priority item must be the development for mechanisms for interaction between the institutions and universities associated with biomedical research and research training and the appropriate non-federal agencies, foundations, and voluntary health groups as well as the various arms of the federal government interested and involved in the support of biomedical research and research training.

The improvement of health as a stated national goal has received strong bipartisan support and major federal funding. Support for biomedical research grew sharply between 1950 and 1968. Throughout this entire period, approximately 15 percent of the extramural research budget of the NIH was assigned to support training in the biomedical sciences. During the late 1960's health care was supported through Medicare legislation and development of health care workers through health manpower legislation. The expanding cost of the latter two programs and shifts in policy have resulted in increased competition for federal dollars, reduced support for research and withdrawal of federal dollars for research training. Termination of support for research training was based upon two major arguments: 1) That the cost of training represents an equity for the individual leading to increased earning capacities; therefore, he should pay for the training himself; and 2) That the market forces should determine the entry of biomedical research workers into the various fields, rather than central planning.

The members of the conference take issue with both of these assumptions. The first premise ignores the very large costs involved in training for research, and the limited enhancement of earning power through attainment of research expertise. The argument that market forces will determine the entry of biomedical scientists ignores the long pipeline between entry and attainment of independence as a biomedical scientist.

Furthermore, in many of the more lucrative fields, such as anesthesiology, market forces have never drawn sufficient manpower to meet community or teaching needs.

Research and research training are national assets and not regional ones. They receive their funding from national agencies because only they can rise above the local constituencies and because they represent a partnership between the universities and institutions pursuing research and the sources of funding. Inasmuch as there is presently no dispassionate body to speak for either the Congress or the Executive Office relative to biomedical research needs, we propose the establishment of a national commission to help to determine the role of the federal government in the support of biomedical research and research training. This commission would have responsibility to propose public policy relative to research activity and manpower training. The commission should have broad representation including representatives from labor, industry, medical schools and other universities, and institutes pursuing biomedical research, consumers, voluntary health agencies, foundations, and other appropriate representatives of interested parties.

The necessity of bringing together the voluntary health agencies, the professional societies, the medical and non-medical institutions pursuing biomedical research and research training, and the National Institutes of Health and other national organizations associated with the support for biomedical research and research training to reach common goals in pursuit of support for these efforts to evaluate programs to produce biomed-

ical scientists, is clearly recognized. To accomplish this, a scientific registry of all programs to produce biomedical scientists should be developed by the commission suggested under recommendation No. 1, which will have university, state, federal and public input. Thus, the establishment of a mechanism for continuous monitoring of the optimal levels of biomedical support, of the entry of biomedical scientists by discipline and the outcome of training programs can be established. This mechanism should be responsive to the best advice of the scientific community as to directions of research so as to insure an adequate investment in non-categorical research as well as in special initiatives. It should be capable of influencing the flow of manpower into biomedical science in general, and specific disciplines in particular, based upon its best perception of scientific opportunities and of market forces. The latter are substantially influenced by the level of support for biomedical research by the federal government. Until such a mechanism can be established, we recommend that approximately 15 percent of the extramural NIH budget continue to be allocated to research training.

We recommend that the present mix of mechanisms of research training be maintained until further evaluation can assess its relative success; namely, the departmental training grants, direct fellowships for pre- and post-doctoral support and inclusion of research associates in research grants as well as the research career development award; and that within this mix the training grant be accorded a high priority. We also recommend that research training grants and fellowships which

tend to strengthen institutions with established reputations for research productivity be supplemented by continuation of capitation support of all medical schools, and of the Health Science Advancement Fellowship, that is offered only to trainees in departments that do not have training grants. These latter two mechanisms, therefore, offer an egalitarian balance between these programs. Loans should also be made available as an additional modality useful to a small percentage of students or research trainees who can't afford the increased costs of this mechanism. We suggest, however, that this mechanism is the least satisfactory for guaranteeing an adequate flow of biomedical research manpower in that it is unattractive to students from disadvantaged backgrounds who most need the help. Where the loan mechanism is employed, we recommend that payback be possible through service such as research, teaching, or activities in the health care system, rather than dollars.

In addition to the federal sources indicated above, every effort should be extended to recruit non-federal sources for supporting training in biomedical research. Generous programs are already in effect through several voluntary health agencies and foundations, but these need to be enlarged wherever possible. Thus, an association of the voluntary health agencies, together with the other parties recommended previously, should gather to review from time to time the status of research training funds, and research funds so that the most effective application of

these funds can be made to help meet the national health needs.

Money is potentially available through industry and other interested parties for biomedical research and research training. Therefore, we would encourage the development of a consortium in an effort to recruit increased funds from both general industry and those immediately concerned with biomedical sciences as well as foundations and voluntary health agencies not currently involved with funding biomedical research training. Such funds could be more economically administered by the central agency previously recommended, but yet could retain the advantage of identifying the recipient with the donor.

Needs can be assessed by the establishment of a data base that would include the present number of investigators as well as training opportunities funded by federal and non-federal sources. The funding of research grants and training grants, the distribution of investigators, training grants and trainees and the turnover of each of these individuals will be important to monitor. Areas in which there are deficiencies in the current supply of investigators and in which there are qualified, unemployed investigators need to be clearly established. The extent to which the presence or absence of stipends affects the access to research training for disadvantaged groups also needs to be monitored. Thus, a systems analysis group which will continue to investigate biomedical research from the standpoint of the optimization

of research contributions to health care and the allocation of these resources to basic and applied research can take into account factors derived from an adequate data-based analysis of the needs, appropriate means for evaluating the quality of the training and research programs, and the participation of the appropriate parties to determine priorities as needs change.

It is hoped that these recommendations can be implemented through the establishment of the appropriate groups with the help and support of the AAMC as the principal catalyzing body to permit their establishment.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MINUTES OF THE RESEARCH MANPOWER MEETING
AAMC CONFERENCE ROOM
WASHINGTON, D.C.
TUESDAY, FEBRUARY 12, 1974

The recent decisions by the Federal government to phase-out pre-doctoral support for graduate students in the basic medical sciences has prompted expressions of concern throughout the biomedical scientific community about the implications of these decisions on the supply of basic medical scientists in the years ahead. As a manifestation of this concern, staff of the AAMC was requested by its Executive Council to ascertain whether there was need to mount a new program of data collection and coordination to evaluate patterns of supply of basic medical scientists.

A meeting was held at the AAMC Headquarters, Tuesday afternoon, February 12, of a selected group of individuals interested in this problem. A listing of the participants is attached to these minutes.

It was the consensus of the participants that the basic information necessary to evaluate the number of students being trained by discipline, the pattern of doctorates being conferred by discipline and the career patterns of these students is currently being gathered by various agencies and associations. The participants strongly believe that there is no need to mount a major program of data collection.

However, it was felt that a coordinated effort should be made to apprise each of the organizations interested in this problem of the efforts currently under way or planned by other organizations.

As the next step in this coordination effort, each of the individuals present is asked to supply Dr. Michael F. Ball, at the AAMC, with the following.

1. The names of individuals not present at the initial meeting who should be advised of progress and included in any future meetings.
2. Ten copies of survey instruments, either in use at this time or in various stages of development.
3. A listing of current data accumulation programs regarding manpower assessment in the basic biomedical sciences.
4. Ten copies of current publications pertaining to manpower in the basic medical sciences and a listing of publications being planned.
5. Suggestions as to positive actions this ad hoc group might take to facilitate coordination of data being developed in the area of basic science manpower.

MFB:ms

February 19, 1974

RESEARCH MANPOWER MEETING PARTICIPANTS
February 12, 1974
AAMC

Michael F. Ball, M.D.	Association of American Medical Colleges
Dr. T.H. Curry	National Research Council
Carl D. Douglass, Ph.D.	National Institutes of Health
Greg Fawcett	Association of American Medical Colleges
Eugene L. Hess, Ph.D.	Federation of American Societies for Experimental Biology
Dr. Louise Marshall	National Research Council
J. Boyd Page, Ph.D.	Council of Graduate Schools
Roger Robertson	National Institutes of Mental Health
Dr. Herbert H. Rosenberg	National Institutes of Health
Dr. Solomon Schneyer	National Institutes of Health
Allen Singer	National Research Council
Richard D. Stephenson, M.D.	National Institutes of Health

cc: John A.D. Cooper, M.D., AAMC
Robert Caine, National Science Foundation
Robert Grant, FASEB
August G. Swanson, M.D., AAMC
D.C. Tosteson, M.D., Chairman, AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INSTITUTE ON PRIMARY CARE

Proposed October/November, 1974

Tentative Agenda

First Plenary Session

Issues in Primary Care Education

Presiding: Thomas E. Piemme, M.D., Institute Chairman

Welcome	John A. D. Cooper, M.D.
Issues in Primary Care: The Academic Perspective	Paul B. Beeson, M.D.
Issues in Primary Care: The Policy Perspective	Rashi Fein, Ph.D.

Second Plenary Session

Organization of Model Systems for Primary Care Practice

Presiding: Henry M. Seidel, M.D.

Introduction: Problems and Issues — Henry Seidel, M.D.

Use of Existing Institutional Resources — Thomas DelBanco, M.D.

delineation of examples of conversion of traditional "out-patient" departments to viable instruments and models for primary care practice - issues to be discussed include organization, staffing, recruitment of physician role models, involvement of specialty services, role of the student and graduate trainee, relationship to the medical school and/or hospital, and financing

Respondent — Gerald Perkoff, M.D.

to describe specific example of conversion of OPD to prepaid group practice model

Respondent — Roblieri, M.D.

to describe specific example of university affiliated hospital OPD to primary care practice model complementary to University Clinic

Use of Community/Private Sector Resources — Robert Evans, M.D.

discussion of the spectrum of solutions throughout the U.S. wherein community resources are used - examples to include use of public facility (Montefiore Hospital), use of family practitioner offices (Maryland), use of constellation of community hospitals (Rochester, Medical College of Virginia, Indiana), use of regional divisions (Michigan State), use of regional campuses (Illinois)

Respondent — Edward Kowalewski, M.D.

to describe specific example of use of network of practicing physicians and community hospital ambulatory facilities

Respondent — Harold Wise, M.D.

to describe specific example of use of urban low-income ambulatory facility (Martin Luther King Center)

Third Plenary Session

Graduate Physician Training in Primary Care

Presiding: Joel Alpert, M.D.

Introduction: Problems and Issues — Joel Alpert, M.D.

Training of Generalists in Medicine and Pediatrics — Evan Charney, M.D.

discussion of the development of primary care versus specialty tracks within medicine and pediatrics - description of specific programs developed for this purpose (Rochester) - discussion of implications for specialty boards - discussion of components of such training programs and degree of cross-training in sister specialties - discussion of expectation of behavior of trainee in practice setting

Respondent — Joseph Dorsey, M.D.

to describe specific example of such a training program in the context of prepaid group practice

Respondent — Robert Petersdorf, M.D.

to describe specific example for internal medicine and view of the American Board of Internal Medicine

Training of Family Practitioners — Robert Rakel, M.D.

discussion of the philosophy behind training for family practice - to include history of development since publication of Willard Report - to discuss essentials for training, and mechanisms for residency approval - to discuss component of training, settings in which training may take place, and expected practice behavior of products of such training programs

Respondent — Eugene Farley, M.D.

to describe specific example of training program in affiliated University Hospital

Respondent — Thomas Piemme, M.D.

to describe difficulties in governance and compromise model applicable to medical schools in urban locations

Fourth Plenary Session

Education of New Health Practitioners

Presiding: Alfred M. Sadler, M.D.

Introduction: Problems and Issues — Alfred M. Sadler, M.D.

Training the New Health Practitioner — Charles Lewis, M.D.

discussion of the development of the concept and outline of history of programs training physicians assistants, nurse practitioners, and MEDEX - discussion of issues of certification, accrediation, and legal status - discussion of objectives and components of training programs - discussion of resources necessary for program development - what institutions should/should not be engaged in such efforts - discussion of governance locus within academic health centers - discussion of fiscal implications

Respondent — David Lawrence, M.D.

to describe philosophy and structure of MEDEX model

Respondent — Robert Jewett, M.D.

to describe philosophy and structure of Physician Assistant

Training for Team Practice — David Kindig, M.D.

discussion of congruent training for the health professions - experience with the development of teams in the practice environment - definition of "core" curricula for health practitioners - fiscal implications for academic health centers - experience with teaching medical students and physician assistant students in the same classroom - who heads the team? - institutional governance of training

Respondent — Malcolm Peterson, M.D.

to describe a model (Hopkins) in which multiple resources have been placed in a new school

Respondent — John Ott, M.D.

to discuss development of performance objectives and methods by which skills and performance may be evaluated

Fifth Plenary Session

New Directions in Health Science Education

Presiding: Thomas E. Piemme, M.D., Institute Chairman

Priorities for Health Science Education
in the Next Decade

discussion of current experiments in health science education - results of significant innovations - fiscal incentives and limitations to innovation

Respondent — Hilliard Jason, M.D.

to discuss evaluation of training methodology - methods and preliminary conclusions

Respondent — August Swanson, M.D.

to discuss activities of the AAMC and the commitment of American Medical Colleges to training for primary care

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5127

Administrative Board
Memorandum No. 74-4AB
January 16, 1974

Subject: National Health Policy and Development Act of 1974

The attached legislation was introduced by Representative Rogers for himself, Representative Roy and Representative Hastings on December 20, 1973. The bill is intended to replace the CHP, RMP and Hill-Burton legislation. I believe this bill will be taken very seriously; its contents are most important, and I think warrants your attention. I would be interested in your views on any or all of the sections of the bill. A brief summary of the bill is as follows.

The proposed Act has four principal parts. Part A would establish a National Council for Health Policy. Part B would create a system of Health Service Agencies (HSAs) responsible for areawide health planning and development throughout the country. Part C would assist State governments in the creation of State Health Commissions (SHCs) responsible for State-level health planning and regulatory activities. Part D would create a new Federal program of construction assistance for health facilities based on loans, loan guarantees, and interest subsidies. The new programs would commence during the present fiscal year, thus overlapping with the authorities for CHP, RMP, and Hill-Burton. The Secretary would be responsible for assisting the existing agencies under the latter programs in their transition into the new programs, and then at the end of the present fiscal year the legislative authorities for CHP, RMP, and Hill-Burton would be terminated. The provisions of the new programs are based on the extensive experience now available with the existing programs and combine the most effective and successful features of each of them.

The National Council for Health Policy would be established in the Executive Office of the President. It would have five members appointed by the President with the advice and consent of the Senate, and suitable staff and support for performing its functions. It would be responsible for assessment of the nation's health; assessment of Federal and other health programs; assessment of the need for health resources, services, and financing; developing recommendations for a national health policy; issuing guidelines on the appropriate supply, distribution, and organization of health resources and services; and conducting studies and analyses concerning its recommendations for a national health policy. The Council would be required to submit an annual report to the public on the work it has done. In developing policy the Council would be required to give priority consideration to national health priorities specified in the legislation.

In creating a system of Health Service Agencies (HSAs) the Secretary would first be responsible for dividing the nation into health areas for planning and development purposes. He would then designate in each health area a private nonprofit corporation as the HSA responsible for planning and development in that area. The legislative proposal specifies minimum criteria for the legal structure, staff, governing body, and functioning of the HSAs. They would be broadly responsible for preparing and implementing plans designed to improve the health of the residents of their health areas; increasing the accessibility, acceptability, continuity, and quality of the health care provided the residents; and restraining increases in costs of such care. In performing these functions HSAs would be required to gather suitable data; prepare long-range goal plans and short-term priority plans; provide assistance of either a technical or financial nature to people seeking to implement provisions of the plans; coordinate activities with PSROs, SHCs, and other appropriate planning and regulatory entities; review and approve or disapprove proposed uses of Federal health funds within the area; assist States in the performance of capital expenditure reviews under the Social Security Act; and assist the SHCs in certifying as needed health services offered in the area. Procedures and criteria for use by HSAs and SHCs in their performing of reviews required by the legislation are detailed.

Authority is given to the Secretary for providing assistance to organizations seeking to be designated as HSAs during their development, for providing technical assistance of various kinds to HSAs and SHCs, for making planning grants to designated HSAs to fund part of the cost of their planning programs, and for making development grants for HSA use in implementation of their plans. The Secretary is required to perform annual and triannual reviews of the activities and quality of HSAs to assure that they perform their functions in a satisfactory fashion.

The Secretary would also be required to designate in each State a State Health Commission (SHC) meeting criteria for its composition, staffing, and functions which are specified in the legislation. In order to receive designation, a SHC would need to submit to the Secretary an approvable administrative program

for carrying out its functions. The SHCs would be responsible for annual review and approval or disapproval of the plans of the HSAs, annual review and comment on the budgets of the HSAs, review of applications submitted by HSAs for assistance from the Federal government, commenting on disapproved applications for Federal funds, performance of capital expenditure review functions under the Social Security Act, certification as needed of health services offered within the state, regulation of health care costs within the state, and (if they so desire) licensure and quality activities. Provision is made for the Secretary to provide financial assistance in the development and operating costs of SHCs. In addition the Secretary would be required after the expiration of the fourth fiscal year after enactment of the lesiglation to perform the functions of SHCs in any State in which one was not designated.

Attachment:

(Signed into law January 3, 1974)

PAYMENT FOR SERVICES OF PHYSICIANS RENDERED IN A TEACHING HOSPITAL

SEC. 15. (a)(1) Notwithstanding any other provision of law, the provisions of section 1861(b) of the Social Security Act, shall subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if paragraph (7) of such section read as follows:

"(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.".

(2) Notwithstanding any other provision of law, the provisions of section 1832(a)(2)(B)(i) of the Social Security Act, shall, subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if subclause II of such section read as follows:

"(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), where the conditions specified in paragraph (7) of such section are met, and".

(b) The provisions of subsection (a) shall not be deemed to render improper any determination of payment under title XVIII of the Social Security Act for any service provided prior to the enactment of this Act.

(c)(1) The Secretary of Health, Education, and Welfare shall arrange for the conduct of a study or studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in Section 1861(b)(6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861(b)(6) of such Act.

(2) The studies required by paragraph (1) shall be the subject of an interim report thereon submitted not later than December 1, 1974, and a final report not later than July 1, 1975. Such reports shall be submitted to the Secretary, the Committee on Finance of the Senate, and the Committee on Ways and Means of the House of Representatives, simultaneously.

(3) The Secretary shall request the National Academy of Sciences to conduct such studies under an arrangement under which the actual expenses incurred by such Academy in conducting such studies will be paid by the Secretary. If the National Academy of Sciences is willing to do so, the Secretary shall enter into such an arrangement with such Academy for the conduct of such studies.

(4) If the National Academy of Sciences is unwilling to conduct the studies required under this section, under such an arrangement with the Secretary, then the Secretary shall enter into a similar arrangement with other appropriate non-profit private groups or associations under which such groups or associations shall conduct such studies and prepare and submit the reports thereon as provided in paragraph (2).

(5) The Social Security Administration shall study the interim report called for in paragraph (2) and shall submit its analysis of such interim report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives not later than March 1, 1975. The Social Security Administration shall study and submit its analysis of the final report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives by October 1, 1975.

(d) The provisions of subsection (a) shall apply with respect to cost accounting periods beginning after June 30, 1973, and prior to January 1, 1975 except that if the Secretary of Health, Education, and Welfare determines that additional time is required to prepare the report required by subsection (c), he may by regulation, extend the applicability of the provisions of subsection (a) to cost accounting periods beginning after June 30, 1975.

AAMC/AADS/NLM EDUCATIONAL MATERIALS PROJECT

This project was developed during 1973 under a contract with the National Library of Medicine which permitted the establishment of a Division of Educational Resources within the Department of Academic Affairs of the AAMC. It is directed by William G. Cooper, Ph.D. and a staff based in both Washington, D.C. and Atlanta, Georgia.

The Advisory Committee for this Project is comprised of representatives of the academic communities of medicine and dentistry along with staff members of the National Library of Medicine, Health Resources Administration, Veterans Administration and the Armed Services. This group meets on a quarterly basis and provides guidance to staff directed toward the achievement of the project objectives.

The five basic programs to which this effort is dedicated includes: the development of a system for the appraisal of educational materials in non-traditional formats (audiovisual, computer-based instruction, simulations, etc.); the development and implementation of a clearinghouse system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by students and faculties; and

other areas of mutual concern regarding the use of educational technology in health science education.

One of the initial tasks undertaken was that of surveying the medical and dental school faculties in an attempt to ascertain what these individuals have identified as effective educational materials (either self-instructional or lecture support in format), whether they could be made available for peer review and whether they might be available for use by other institutions. The survey instrument was distributed by three pathways the latest one being as an insert for the February, 1974 issue of AAMC Education News which is currently mailed directly to 34,000 full-time members of medical school faculties.

The responses to these queries plus those obtained by the American Association of Dental Schools (AADS) and those already identified by professional groups and the National Medical Audiovisual Center (NMAC) provided a list of items that could be subjected to national peer review panels. The guidelines and check lists used to appraise these materials with regard to their information or content quality, instructional design and technical quality will be published separately in the near future.

Up to the present time six interdisciplinary panels have convened to review and assess educational materials (predominately audiovisuals) in anatomy, ophthalmology, neurosciences,

cardiovascular system, oral pathology and operative/restorative dentistry. The results of these reviews will be reported at a later date.

The items that are judged to be effective will be included in the National Medical Library's data base designated as "AVLINE" which will be available in a format similar to the MEDLINE system. It is anticipated that this data base will be available on a restricted test-mode basis by the summer of 1974 and on a wider systems basis by January, 1975.

It is important to note that members of the constituency (user population) have been involved in the development of the format for this clearinghouse system. The process of adding to and up-dating the AVLINE data base will be an ongoing process as we continue to seek to identify, evaluate and make available for use those educational materials that have been proven to be effective in medical and dental education.

The design, funding and production of new materials, the problems of distribution and retrieval of existing and new materials, the unique or similar characteristics of managing other formats of educational materials (test items, CAI, simulations, etc.) plus the important issues of need for faculty development in, and institutional support for, the utilization of these new forms of educational technology will continue to be major issues of concern for all of us.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #74-6

February 21, 1974

TO: The Assembly

FROM: John A. D. Cooper, M.D., President

SUBJECT: President Nixon's fiscal 1975 budget

This Memorandum reviews President Nixon's fiscal 1975 budget and analyzes the budgets of those federal health programs which particularly affect the interests of the Association. An index to the Memorandum is on page 5.

On February 4, President Nixon sent to Congress his fiscal 1975 budget which covers the 12 months beginning July 1, 1974. The budget proposes total federal spending of $304.4 billion against total federal revenue of $295 billion, resulting in a projected deficit of $9.4 billion. Comparable projections for fiscal 1974 in the President's fiscal 1974 budget were $268.7 billion in total federal spending, $256 billion in total federal revenue, and a $12.7-billion deficit. Revised fiscal 1974 projections (presented in the fiscal 1975 budget) show $274.4 billion in spending, $270 billion in revenue, and a $4.7-billion deficit.

In political terms, the fiscal 1975 budget is generally conciliatory. This is in sharp contrast with the harsh attacks in the fiscal 1974 budget directed at a Democrat-controlled Congress by a Republican President, fresh from a record-setting, landslide re-election victory. The difference is attributed to the rapid decline in Presidential popularity during a year of court and Congressional investigations into his re-election campaign practices and other matters. The budget proposes no major new initiatives. About 90 percent of the projected spending increase is the result of mandatory increases that are unavoidable under current laws.

Of the projected $304.4 billion in fiscal 1975 spending, $35.5 billion is for federal health programs, the vast majority of which ($26.6 billion) are accounted for by the Department of Health, Education and Welfare. Health-related programs of the Veterans' Administration account for an additional $3.4 billion; health-related programs in the Defense Department account for another $3 billion; and health-related programs in all other federal agencies account for the final $2.4 billion. Within the $26.6 billion of DHEW health spending, $20.9 billion is for Medicare and Medicaid, $2 billion is for the National Institutes of Health, $1.2 billion is for the Health Services Administration, $1.1 billion for the Health Resources Administration, and $823 million for the Alcoholism, Drug Abuse, and Mental Health Administration.

In highlight, the health budget proposes little new money for most programs, cutbacks in some continuing programs, and abandonment of other programs. Impounded

fiscal 1973 funds, which the President ordered released in December, are generally to be obligated in fiscal 1974, and to be spent in fiscal 1974 and 1975. The availability of fiscal 1973 funds is being used to maintain program levels while holding down requests for new funds. Some forward funding is likely to be used to reduce the impact of released fiscal 1973 funds. In most cases, the President has taken full advantage of the Congressionally provided authority to impound up to five percent of fiscal 1974 appropriations. NIH research activities are relatively unchanged; general research support grants are again proposed for elimination, and research training is to be supported largely through the fellowship program proposed by HEW Secretary Weinberger. Health manpower support is to be reduced and revised, stressing geographic distribution and equal access to the health professions for women and minorities. Separate support for allied health and public health personnel education is to be dropped. The Hill-Burton hospital construction program is again proposed for elimination. Community mental health center support is proposed again for phasing out. Regional medical programs and comprehensive health planning are to be consolidated in a new health resources planning program. Funding is proposed for the new health maintenance orgranization support program and for VA assistance to health manpower schools. No funds are included in the budget for the President's national health insurance program, sent to Congress on February 6.

Following are summary tables of the DHEW and VA health budgets:

DHEW HEALTH PROGRAMS

	(Budget authority in millions)		
	1973	1974	1975
Food and Drug Administration	$ 149	$ 165	$ 200
Health Services Administration[1]	1,082	1,176	1,177
Center for Disease Control[1]	160	136	138
National Institutes of Health[2]	1,758	1,781	1,835
Alcohol Drug Abuse and Mental Health Administration[1]	881	833	735
Health Resources Administration[1]	1,249	1,137	574
Assistant Secretary Health	76	74	97
Total	$5,355	$5,302	$4,756

1. Includes agencies formerly in the Health Services and Mental Health Administration
2. Health manpower shifted to Health Resources Administration.

VA HEALTH PROGRAMS

	(Budget authority in millions)		
	1973	1974	1975
Medical care	$2,606.1	$2,859.1	$3,175.0
Medical and prosthetic research	78.0	75.5	89.0
Assistance to health manpower training institutions	20.0	25.0	---
Medical administration and miscellaneous operating expenses	28.7	33.9	37.5
Total	$2,732.8	$2,993.5	$3,303.6

Assessing the fiscal 1975 budget for DHEW health programs is complicated by two factors: the injection into the budget process of the released fiscal 1973 funds and the July 1, 1974, expiration of most federal health authorities. None of the expiring authorities has been extended yet, and as a result there are no fiscal 1975 authorization levels against which to measure the President's budget request. Furthermore, some expiring programs are likely to be extended virtually without change while others are to be revised substantially. Thus straight-line extrapolation from fiscal 1974 authorization levels is not always possible. Nevertheless, some legislation is pending to extend and modify some of the expiring programs, and that legislation includes proposed authorization levels for fiscal 1975. These levels are almost certain to change as the legislative process continues, but at the moment they offer the only insight into possible fiscal 1975 levels of authorization. A table listing the expiring health programs, the status of pending legislation, and pending authorization levels compared to the President's budget requests is on pages 32-33.

The complex effect on the budget process of the released fiscal 1973 funds is demonstrated in the NIH research totals for budget authority, obligations and outlays. The effect is similar for other DHEW programs. The NIH data follow:

NIH Research Totals

	(Amounts in thousands)			
	1973	1974		1975
		PL 93-192	OMB	
Budget authority	$1,713,715	$1,813,900	$1,734,150	$1,785,922
Obligations	1,484,043		1,964,612	1,786,814
Outlays	1,446,587		1,837,451	1,980,641

Approximately $230 million in fiscal 1973 NIH budget authority for research, appropriated by Congress, was impounded by the Office of Management and Budget and was not released for obligation until the President's announcement in December. The funds are to be obligated in fiscal 1974. In the fiscal 1975 budget's totals

for NIH research, the released funds appear as budget authority in the 1973 column, as obligations in the 1974 OMB column, and as outlays in both the 1974 and 1975 columns. The result is a set of conflicting pictures of NIH research activity for fiscal 1975. Comparisons of budget authority show a decrease of $28 million between funds appropriated by Congress for fiscal 1974 in the Labor-HEW bill (PL 93-192) and the President's fiscal 1975 request, at the same time there is a $51.7-million increase from the fiscal 1974 OMB apportionment of funds (under Congressionally approved authority to impound up to 5 percent of the appropriation) to the President's fiscal 1975 request. Comparison of obligations shows a $178-million drop from fiscal 1974 to fiscal 1975. Comparison of outlays shows a $143-million increase from fiscal 1974 to fiscal 1975. Each comparison is important, and none is "right" or "wrong," for they indicate different things. Budget authority represents new funds, sets a ceiling on obligations that may be incurred and thus is viewed as the best measure of federal commitment to a program. Obligations are the best indication of levels at which programs are to be operated. Outlays (the writing of checks to pay off an obligation) also closely measure program level but are more important in fiscal affairs as a measure of government impact on the economy. The Congressional appropriation process deals in budget authority, and on that basis the fiscal 1975 DHEW health budget is cut 10 percent below the fiscal 1974 level, which in turn was cut by the OMB 5 percent below the level of Congressional appropriations.

The following material presents information on DHEW and VA health-related programs of special interest to the Association. The information is compiled from the President's budget, from agency briefings and from personal contacts with agency officials. The information is believed to be currently accurate, but the situation is fluid in many agencies, and changes may occur. Updated supplemental information will be provided as necessary through appropriate Association publications.

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Alcohol, Drug Abuse and Mental Health Administration

	(Budget authority in millions)		
	1973	1974	1975
General mental health:			
Research and training	$200	$190	$150
Community programs	205	189	199
Total	$405	$379	$349
Drug abuse:			
Research and training	$ 48	$ 52	$ 44
Community programs	167	176	157
Total	$215	$228	$191
Alcoholism:			
Research and training	$ 20	$ 15	$ 12
Community programs	140	113	78
Total	$160	$128	$ 90

The legislation under which the programs of the ADAMHA are authorized will expire on June 30. Permanent provisions of this legislation contain authority for forward funding of these programs through fiscal year 1981.

Research and training: Most research and training programs of ADAMHA will be reduced in fiscal 1975. All categories of training programs are scheduled for phasing out, with some funding available for continuations in fiscal 1975, but not for new starts.

New awards for mental health research will be decreased across the board. The ADAMHA estimates that in fiscal 1974, $71.3 million will be available for obligation to support approximately 1,179 research projects. This amount would include approximately 300 new awards; $10.1 million of the total funding represents impounded fiscal 1973 funds. For fiscal 1975, $56.8 million are estimated to be obligated for approximately 866 projects, including continuations and competing renewals; no new starts are expected in fiscal 1975. For mental health training, $119.4 million are estimated to be available for obligation in fiscal 1974. Approximately $25.2 million of this total represents impounded fiscal 1973 funds. The obligations would support 1,763 training projects, approximately 112 of which would represent new starts. Approximately $3.2 million will be available for research training initiatives under the Weinberger training plan in fiscal 1974; details are not yet available on the distribution of these funds. With the exception of $1.3 million to be made available under the Weinberger plan, no new training awards would be made in fiscal 1975; however, approximately $59.5 million would be available to continue 1,045 projects.

For drug abuse programs, final figures are not yet complete. The total budget authority requested for fiscal 1975 drug research is $34 million, a decrease of $3 million from fiscal 1974. Estimated obligations of $10.6 million would be available in fiscal 1974 to fund approximately 117 competing projects, with approximately $6.6 million available in fiscal 1975 to fund 76 projects. An estimated $721,000 would be available to fund seven training projects in fiscal 1974. Training funds of $10 million for fiscal 1975 are requested to provide continuing support for short term training centers and other related projects. ADAMHA officials indicated that there will be no new training starts in fiscal 1975.

The Administration's budget request of $12 million for alcohol research and training programs is a $3 million decrease from fiscal 1974. Detailed figures on alcoholism programs are not yet available, but all indications are that alcohol programs will follow the general trend of the mental health and drug abuse programs. Continuation funds for training programs will be available in fiscal 1975, but no new awards will be made.

Community programs: The Administration proposes that the expiring legislative authorities for community mental health center programs not be extended. In line with this proposal, the Administration intends to terminate new staffing programs for community mental health centers. According to ADAMHA, over $155.5 million will be available for obligation in fiscal 1974 to fund continuation requirements plus approximately 55 new staffing awards. In fiscal 1975, this level would be increased to almost $172.1 million, for continuations only. The agency indicated that, although no new staffing grants would be made after fiscal 1974, the fiscal 1975 continuation funds would be sufficient to honor all previous commitments. Funding requests for children's mental health programs follow the same pattern as staffing grants. Approximately $19 million will be available for obligation in fiscal 1974 to continue previous commitments and to fund 37 new awards. In fiscal 1975, this level will be raised to $26.8 million for continuations only, with no new grants. Obligations for fiscal 1974 community mental health center construction grants will be $34.2 million. This figure, which includes $20 million of impounded fiscal 1973 funds, is intended to bring the total number of centers to 626. For fiscal 1975, the Administration intends for the centers program to be absorbed by the regular health service delivery system, with greater reliance on operational funding from third-party reimbursements or state governments, and therefore no funding is requested for construction in fiscal 1975.

For community programs in drug abuse, the Administration intends to reach a treatment capacity of 95,000 individuals throughout the country and to shift operational responsibility for treatment services to the states. The fiscal 1975 budget request of $157 million represents a drop of $19 million from the estimated fiscal 1974 level of $176 million. Treatment project grants and contracts will be funded at $122 million, a decrease of $38.8 million from the 1974 appropriation level, while the request for formula grants to states for fiscal 1975 is $35 million, an increase of $20 million over the fiscal 1974 level.

Data on alcoholism community programs indicate that current alcoholism staffing grants will be continued in fiscal 1975, with no new awards. The Administration has requested funds for project grants and contracts at a level of $32 million for fiscal 1975, a decrease of $39 million from fiscal 1974. It has also requested $45.6 million for formula grants to states for alcoholism programs in fiscal 1975, an amount equal to the fiscal 1974 appropriations. The Administration also plans to initiate incentive contracts with business organizations to deal with problems of alcoholic employees, and intends to assist states in implementing the Uniform Alcoholism and Intoxication Treatment Act.

On February 7, 1974 a U.S. District Court ordered the DHEW to award approximately $95 million in impounded fiscal 1973 funds plus $28 million in fiscal 1974 funds for mental health training grants and alcoholism training, project, and state formula grants. Approximately five weeks before this decision was handed down, HEW Secretary Weinberger had decided to release these funds voluntarily. The conditions under which these funds were to be released by DHEW were almost identical to those set by the District Court. Since the Department correctly anticipated the outcome of this litigation, spending plans for the current fiscal year will not be affected.

Center for Disease Control

	(Budget authority in millions)		
	1973	1974	1975
Disease control:			
Research grants	$ 2	---	---
Project grants			
Venereal disease	25	25	25
Immunization	14	6	6
Lead-based paint poisoning	11	7	7
Rat control	15	13	13
Disease investigations, surveillance and control	43	39	40
Laboratory improvement	9	8	8
Health education	6	2	3
Occupational health	28	29	26

These activities were formerly budgeted under Preventive Health Services. The presentation has been changed in the fiscal 1975 budget. The Administration's budget request for fiscal 1975 for these activities is $138 million, an increase of $2 million over the budget authority for fiscal 1974.

Funding of project grants for venereal disease, immunization, rat control, and lead-based paint poisoning will remain at fiscal 1974 levels, with no major new initiatives in these areas. Although no new funds are requested, increased emphasis will be placed on: strengthening syphillis screening programs; coordinating immunization services with those provided through Medicare; and reducing rat infestations and developing local capabilities to maintain rat control. According to the CDC, few, if any, new project grants will be funded in fiscal 1975. The budget request represents continuing awards, most of which go to state and local health departments.

For health education programs, the Administration has requested $3 million for fiscal 1975, an increase of $1 million over the fiscal 1974 level. Of the fiscal 1975 funds, $2 million have been targeted towards a new program to improve public awareness of individual health and utilization of the health care system.

Funding for occupational safety and health programs will be cut back by approximately $3 million in fiscal 1975, due to the withdrawal of federal support to clinical facilities, which the Administration expects to become self-sufficient through third-party reimbursements. In fiscal 1974, approximately $600,000 is available for 18 training projects. No funds are expected to be available for this purpose in fiscal 1975.

Health Resources Administration

Health services research and evaluation

Some uncertainty still surrounds the budget activity for health services research and evaluation, centering largely on the disposition of some $26 million in released fiscal 1973 funds. The budget data follow:

	(Amounts in millions)		
	1973	1974	1975
Budget authority	$ 67	$ 78	$ 69
Obligations	57.5	111.0	68.9

This budget item includes funding for the Bureau of Health Services Research and for the newly enacted program of federal assistance in the development of emergency medical services systems, which is operated through the Health Services Administration. Program levels for both activities are to remain essentially unchanged in fiscal 1974 and 1975. The research budget is $45 million in fiscal 1974 and $42 million in fiscal 1975; the EMS budget is $27 million in each year. The Bureau's research activities are to stress such areas as physician productivity, continued analysis of the effects of national health insurance on consumer demands for health services, and reimbursement methods for services provided by paraprofessionals. In research grants, present ratios of new and competing awards to continuations (45 percent new and competing; 55 percent continuations) are to be maintained. Training grants are still being phased out, and are not eligible at this time for modified support under the Weinberger fellowship program available for research training to the NIH. Of the EMS funds available, approximately $17 million will be used in the development of EMS systems, $6.7 million to support training, and $3.3 million to support research activities in the area of emergency medical services. Uncertainty surrounds allocation of the released fiscal 1973 funds because programs for which they were originally provided are being phased out. No decision has been made yet on reallocation of the funds.

Regional medical programs; comprehensive health planning: The legislative authorities for Comprehensive Health Planning and Regional Medical Programs expire June 30, 1974, and both Congress and the Administration are preparing proposals to integrate these programs into a single health planning system. Only the Congressional proposals have been introduced so far. The Administration is to propose legislation for a new program, Health Resources Planning, which will replace a number of existing federally supported approaches to health planning, including RMP and CHP. The Administration requests $75 million in budget authority in fiscal 1975 for its new Health Resources Planning program. The budget data follow:

	(Amounts in millions)		
	1973	1974	1975
Regional medical programs			
Budget authority	$144	$ 75	---
Obligations	102.1	150.7	---
Comprehensive health planning			
Budget authority	$ 38	$ 42	---
Obligations	33.1	40.2	---
Health resources planning			
Budget authority	---	---	$ 75
Obligations	---	---	65

The Administration plans to use $55 million of the $75 million to establish approximately 200 Regional Health Systems Boards to replace the existing CHP area-wide agencies. The Regional Boards, which will be developed along the lines of the existing CHP area-wide agencies, will be responsible for developing and stimulating the implementation of a comprehensive health plan for health care systems, including facilities, services, and manpower. The Administration anticipates that some of the existing CHP agencies, which will be supported through the first half of fiscal 1975, will form the nucleus of the new Regional Boards.

Approximately $10 million of the $75 million in budget authority requested for Health Resources Planning in fiscal 1975 will be provided to states to assist them in their regulatory efforts at cost control stimulated by the Economic Stabilization Program. The remaining $10 million of the $75-million total will be provided to states to support their capital expenditure review activities as encouraged by Section 1122 of the Social Security Act. The funds for both cost control and capital expenditure review activities will be allotted to the states on the basis of population and the costs of performing those functions necessary to carry out the requirements of federal law.

Included in the obligation levels for fiscal 1974 are $6.4 million for Comprehensive Health Planning and $89.9 million for Regional Medical Programs of released fiscal 1973 funds. On February 7, 1974, a U.S. District Court ordered the DHEW to obligate and permit expenditure of all available RMP funds. DHEW plans for complying are not completed.

Health manpower

The Administration's budget for health personnel education assistance is down nearly 35 percent from the fiscal 1974 level. The cut of $198 million is accounted for largely by the elimination of health professions and nursing construction grants, of separate assistance for allied health and public health education institutions, and of nursing capitation. Reduced health professions capitation and modification of the student assistance programs to include loan guarantees and service-commitment scholarships account for other large segments of the cutback. The budget data follow:

Health Manpower
(Budget authority in millions)

	1973	1974	1975
Health professions:			
Institutional assistance	$256	$257	$197
Student assistance	54	61	60
Nursing:			
Institutional assistance	$ 72	$ 58	$ 20
Student assistance	61	57	25
Public health	21	21	---
Allied health	36	35	---
Special educational programs	88	73	63
Sales insufficiencies	4	4	4
Total	$592	$567	$369

The budget reflects the Administration's health manpower legislative proposal which is to modify and extend expiring legislative authorities for federal assistance in the education of health professionals and nursing, allied health and public health personnel. The legislation, which is to cover the three-year period from fiscal 1975 through fiscal 1977, has yet to be introduced. The thrust of the Administration's proposal, according to descriptive material accompanying the budget, is toward maintaining the country's present training capacity while placing increasing emphasis of areas where there is a need for health personnel. Special attention is to be paid to problems of specialty and geographic maldistribution, utilization of paraprofessionals and the under-representation of women and minorities among the health professions.

Compiling budget data for health professions education assistance programs is complicated by the fiscal 1975 budget's redistribution of some HPEA budget information. Construction assistance for health professions teaching facilities, for example, has been shifted to a general line item for health facilities construction assistance, which also includes the Hill-Burton hospital construction program. Because of these changes, detail in the health professions budget below (displayed in the traditional format) will not add to the totals in the preceding table.

Health Professions Support

	(Budget authority in millions)		
	1973	1974	1975
Institutional support			
Capitation			
MOD	$ 138.5	$ 152.5	$ 132.5
VOPP	27.4	33.0	17.5
	$ 165.9	$ 185.5	$ 150.0
Start-up and conversion	11.7	6.0	4.7
Financial distress	15.0	10.0	5.0
Special projects	63.0	50.8	37.5
Subtotal	$ 255.6	$ 252.3	$ 197.3
Student assistance			
Loans	$ 36.0	$ 36.0	$ 30.0
Scholarships	15.5	14.6	6.9
Loan repayments	---	0.4	0.6
Physician shortage	2.0	2.0	---
National health service scholarships	---	3.0	22.5
Subtotal	$ 53.5	$ 56.0	$ 60.0
Construction			
Grants	$ 100	$ 95.0	---
Interest	1.0	1.0	1.0
Education assistance	20.0	9.5	10.0
Dental health	15.0	14.2	7.8
Direct operations	3.3	3.3	---
Total, health professions	$ 448.4	$ 431.3	$ 276.1

Capitation: Under the Administration's legislative proposal, capitation is to drop 40 percent by fiscal 1977. Specific capitation rates for fiscal 1974 have not yet been set, and the fiscal 1975 level authorized in the Administration's proposal has not yet been announced. Under the proposal, capitation no longer would be conditioned on enrollment increases; new conditions of changes in the present training process are to be required. Fiscal 1974 capitation applications are still coming into DHEW regional offices and must be processed there before aggregate national data can be compiled and a payment rate established. The average fiscal 1973 capitation rate for basic enrollment,

enrollment bonus students and physician assistants was approximately $2,000. The fiscal 1974 rate is expected to drop somewhat below the fiscal 1973 level. The exact fiscal 1974 rate will depend on the number of students graduating in three-year programs, on the number of enrollment bonus students and on the number of physicians assistants qualifying for support.

Start-up, conversion: Fiscal 1974 funds and the fiscal 1975 request are considered adequate by the DHEW to meet current commitments under the start-up assistance program. No funds are included in either year for new commitments of start-up assistance. The fiscal 1974 funds include amounts estimated by the DHEW as adequate to provide one-time-only conversion assistance to two basic-science schools developing degree-granting programs. Funds available for obligation in fiscal 1974 include $5.4 million in released fiscal 1973 funds. Thus the fiscal 1974 obligation level is $11.4 million.

Financial distress: Fiscal 1974 funds represent the full amount currently authorized under the Comprehensive Health Manpower Training Act. Based on fiscal 1973 financial distress awards totaling $9.2 million, the $10 million available in fiscal 1974 would appear to be adequate. An additional $5 million in fiscal 1974 financial distress funds was appropriated in the omnibus, end-of-session supplemental (PL 93-245), contingent on enactment of legislation raising the fiscal 1974 authorization level. No such legislation is pending at this time. The fiscal 1975 request appears almost certain to be inadequate since significantly lower capitation rates (as planned by the Administration) would exert increased financial pressure on many institutions.

Special projects: A combination of factors will make available in fiscal 1974 and 1975 some funds for new special project support. Released fiscal 1973 funds will add about $28.6 million to the funds available for obligation in fiscal 1974, bringing the fiscal 1974 special projects obligation level to approximately $79.5 million. Fiscal 1974 continuations will require about $50 million. Thus nearly $30 million will be available for new starts. Some forward funding is to be used to reduce the impact on future budgets of released fiscal 1973 funds. Despite the drop in budget authority from fiscal 1974 to fiscal 1975, it is estimated now that some $17.6 million may be available for new starts in fiscal 1975. In part, this is a result of concluding DHEW commitments of support under the physician augmentation programs. Present fiscal 1975 continuations account for about $20 million in support, leaving about $17.6 million available for new projects. The fiscal 1975 figures are the best information available now; but they are likely to change as new multi-year projects are undertaken in fiscal 1974 and as Congressional action proceeds on the Administration's legislative proposal and subsequent appropriations.

Student assistance: Fiscal 1975 funds for direct student loans and for health professions scholarships are only for continuations. Direct loans are to be replaced with loan guarantees and health professions scholarships are to be replaced with national health service scholarships, which require year-for-year service in the National Health Service Corps, the Indian Health Service or the Federal Health Programs Service. Both moves require legislation. The Administration proposes to recommend changes in the loan guarantee program

to increase the total loan ceiling from $10,000 to $25,000, to raise the annual ceiling, and to modify other provisions to make the program more suitable for health professions students. The Administration already has submitted legislation (on which no action has occurred) to make permanent the national health service scholarship program (which expires June 30,1974) and to provide an open-ended authorization level. It is estimated by the Administration that the requested $22.5 million in national health service scholarships could support an additional 2,000 students in fiscal 1975.

Construction: Program levels for fiscal 1974 grants-in-aid for construction of health professions teaching facilities remain unclear. Approximately $189 million is available for obligation, and construction grant applications have been mailed from the DHEW to the regional offices. Awards are planned during the summer, and it is expected now that the awards will total at least $94 million, the amount of released fiscal 1973 funds. It is not yet clear whether $95 million in fiscal 1974 funds will be released for obligation in fiscal 1974 by the DHEW Comptroller.

Educational assistance: Continuation of prior-year family medicine grants to hospitals will require about $5 million in fiscal 1974. The availability of $10 million in released fiscal 1973 funds means that approximately $14.5 million is available for obligation in fiscal 1974 for new family medicine grants. The full effect of these funds is to be reduced through forward funding of some fiscal 1974 awards. The availability of fiscal 1975 funds for new starts depends on the number of multi-year awards in fiscal 1974 and on Congressional action on the Administration's legislative proposal and subsequent appropriations. Family medicine grants are to be funded, beginning in fiscal 1975, through the Health Manpower Education Initiative Awards program.

Health Manpower Education Initiative Awards, another program in which the Association is interested, are included in the health manpower budget under special educational programs. HMEIAs are used to support area health education centers, recruitment of disadvantaged students, and new forms of education, training and health services delivery. They are available to any public or private nonprofit entity, not only to health professions schools. The budget data follow:

Health Manpower Education Initiative Awards

	(Budget authority in millions)		
	1973	1974	1975
Area health education centers	$28.7	$12.0	$12.0
Physician assistants	7.0	8.0	8.0
Manpower initiatives	---	19.5	12.3
Disadvantaged recruitment	6.3	7.0	6.7
OEO grants	---	---	0.6
Primary care residencies	---	---	5.0
Family medicine	---	---	10.0
Computer technology	6.0	2.9	---
Total	$48.0	$49.4	$54.6

Little expansion, if any, is planned for ongoing programs funded through HMEIAs. No new starts are provided for area health education centers or for physician-assistant programs, for example. The Administration is proposing a new program of support for primary care residencies, to be included in its health manpower legislative proposal. The fiscal 1974 funding level for AHECs still is uncertain, because of the availability of $28.7 million in released fiscal 1973 funds. Some forward funding of AHEC support may occur in order to reduce the impact on future year's budgets of the released funds. Two new programs are to be funded through the HMEIA program, beginning in fiscal 1975, that previously were funded elsewhere. Family medicine grants to hospitals previously were funded through the health professions portion of the health manpower budget. The line item for OEO grants reflects Administration phasing-out of the Office of Economic Opportunity and future funding of some OEO health activities under the broad authorities of the HMEIA program.

Health facilities construction

This line item is a new presentation in the fiscal 1975 budget, combining health manpower construction assistance and medical facilities construction (Hill-Burton) assistance. Details of the health manpower construction program, as it relates to health professions teaching facilities, are included in the discussion of Health Manpower (above).

In fiscal 1975, the only request for new budget authority is for the health manpower interest subsidy program. No new funds are requested for the Hill-Burton program, whose legislative authority expires June 30 and for which the Administration is not requesting an extension. The budget data follow:

	(Amounts in millions)		
	1973	1974	1975
Medical facilities construction			
Budget authority	$214.0	$197.0	---
Obligations	158.9	250.8	$188.6
Health teaching facilities			
Budget authority	$120	$114	---
Obligations	143.1	221.7	114.0
Interest subsidies			
Budget authority	$ 2.0	$ 2.0	$ 2.0
Obligations	0.5	2.2	4.8

In explaining its decision not to seek extension of the Hill-Burton program, the Administration made two assertions: (1) on a national basis, there is a general oversupply of hospital beds; and (2) institutional providers, as a result of federal and private third-party reimbursements, now have access to a

reasonably predictable cash flow in order to obtain loans for capital expenditures. In the grant program, $197.2 million in released fiscal 1973 funds have been distributed to DHEW regional offices for allocation to state agencies. Fiscal 1974 appropriations also are to be distributed for obligation. Activities to be supported by the Medical Facilities Guarantee and Loan Fund are still uncertain. The fund is used as a protection against defaulted guarantees, for interest payments on guaranteed loans to nonprofit sponsors, for direct loans to public agencies, for interest payments on direct loans which have been sold and guaranteed, and to repurchase direct loans that have been sold and guaranteed. The fund currently is capitalized at $107.3 million, including $50 million which is restricted against defaulted guarantees; a revolving fund of $30 million for direct loans to public agencies, and $27.3 million for interest payments. The limit on the outstanding principal of direct loans and loan guarantees is based on allocations to states, and based on 1971 and 1972 allocations the current limit is $999 million. It is expected by the Administration that the limit will be totally committed by June 30, 1974. The principal amount of guaranteed loans in fiscal 1973 was $145 million. In reaching the projected level, the DHEW is to decide how to treat fiscal 1973 allocations of some $500 million affected by impoundments, and that decision has yet to be made. The delayed effect of phasing out the program is the result of three-year availability of Hill-Burton funds. Thus fiscal 1974 dollars are available through June 30, 1976.

Health Services Administration

Community health centers

The Administration is requesting $200 million in budget authority for fiscal 1975 for community health centers. Although this amount is $5 million less than the fiscal 1974 authority for community health center projects, the DHEW believes that the lower funding level will not have a negative effect on the number of persons served, because improved management techniques and increased third-party reimbursement will be emphasized. The budget data follow:

	(Amounts in millions)		
	1973	1974	1975
Community health centers			
Budget authority	$209	$205	$200
Obligations	111	217	200

The fiscal 1973 budget authority figure includes $97 million for the transfer of the Office of Economic Opportunity neighborhood health centers project. This transfer did not occur until fiscal 1974. The fiscal 1974 obligations level includes $6 million in recently released fiscal 1973 funds impounded from the family health centers program. DHEW does not want to use these funds to finance new starts, but plans instead to enrich the family health center benefit package which does not now include hospitalization, dental services, or prescription drugs. The Administration plans to seek an extension of the program's legislative authority which expires June 30, 1974.

Health maintenance organizations

The Administration has requested a supplemental appropriation of $65 million for fiscal 1974 and budget authority of $60 million for fiscal 1975 for the development of health maintenance organizations (HMOs). The budget data follow:

	(Budget authority in millions)			
	1974		1975	
Activity	Number of projects	Amount	Number of projects	Amount
Feasibility studies	60	$ 3.0	60	$ 3.0
Planning	48	6.0	48	6.0
Initial development	20	16.0	39	31.0
Loans and loan guarantees	20	35.0	38	15.0
Program support		5.0		5.0
Total	148	$65.0	185	$60.0

Funds will be provided for grant support for an estimated 60 feasibility studies each year and 48 planning projects each year. In addition, HMOs in the initial development stage (20 in 1974 and 39 in 1975) will receive grant support. DHEW anticipates that activities for each of these stages of HMO development will take no longer than one year. In fiscal 1974 $35 million will be used to capitalize a fund for loans and loan guarantees for HMOs in the initial operational stage. The fiscal 1975 budget provides another $15 million to be added to this revolving fund. Loan funds would be available to an HMO during its first 36 months of operation or in the first 36 months following a significant expansion either in its membership or in the target area it serves. DHEW estimates that 20 operational HMOs will receive loans or loan guarantees in fiscal 1974, and that an additional 18 operational HMOs will receive loan assistance from the revolving fund in fiscal 1975. These 38 HMOs expected to be operational by the end of fiscal 1975 will eventually serve an enrolled membership of about one million people, according to DHEW estimates.

DHEW does not plan to award any HMO grants until regulations to implement the HMO program become final around June 1, 1974. The Department is not planning to operate the program under temporary regulations. In its request for a supplemental appropriation for 1974, the Administration will also request that the funds remain available until expended. In awarding the grants, DHEW plans to give some priority to eligible HMO projects currently receiving federal assistance, especially those in the operational stage now eligible for loans and loan guarantees.

National health service corps

For fiscal 1975, the Administration intends to enlarge the activities of the National Health Service Corps despite a drop in the budget request. The budget request of $9 million is $1 million below the fiscal 1974 budget authority. This apparent drop in fiscal 1975 funding is due to the termination of several one-time contracts which were supported by fiscal 1974 funds and which will not recur in fiscal 1975. Approximately 156 new positions and 45 new communities will be added to the NHSC program in fiscal 1975. The Administration estimates that the program will support over 530 health professionals in 245 communities designated as health manpower shortage areas.

Patient care and special health services

For fiscal 1975, the Administration has requested budget authority of $109 million for patient care and special health services, to operate eight general hospitals and 26 outpatient clinics for legal beneficiaries of the Public Health Service. The Administration's request also includes funds to provide health care and burial expenses for the untreated participants in the 1932 PHS study of syphillis in Tuskegee, Alabama.

The fiscal 1975 request is approximately $4 million over the fiscal 1974 budget authority. The HSA has indicated that almost all of this increase

will be absorbed by mandatory pay increases and increased costs of drugs and supplies.

In response to the Administration's attempts to close down PHS hospitals last year, the Congress passed legislation (PL 93-155) mandating that PHS hospitals remain open, but allowing DHEW to propose changes in PHS hospital operations and services. The Department is in the process of establishing a task force to consider possible options for the future use of these facilities, such as transferring them to local communities. The HRA indicated that no changes are planned in the current residency training programs at PHS hospitals.

National Institutes of Health

Research institutes

The Administration has requested approximately $1.8 billion for NIH research institutes and divisions, an increase of $52 million over budget authority for fiscal 1974. This increase is composed of a $73-million increase for the National Cancer Institute, a $23-million increase for the National Heart and Lung Institute, a $44-million decrease for the Division of Research Resources, and an increase of $1 million for all other research institutes combined. Obligations for fiscal 1974 will exceed budget authority because of the influx of previously impounded but now released fiscal 1973 funds. The following table provides the budget authority, obligation, and outlay figures for: fiscal 1973; the fiscal 1974 Labor-HEW appropriations bill (PL 93-192); the fiscal 1974 budget after discretionary withholding of 5 percent of funds, which was authorized in PL 93-192; and the President's fiscal 1975 budget:

National Institutes of Health
(amounts in thousands)

Fiscal year		1973	1974		1975
			PL 93-192	OMB	
Cancer	(budget authority)	$ 492,250	$551,191	$527,306	$600,000
	(obligations)	431,271		589,186	600,031
	(outlays)	384,310		530,998	559,411
Heart	(budget authority)	300,042	302,915	286,465	309,299
	(obligations)	255,728		329,511	309,309
	(outlays)	232,921		305,801	333,779
Dental	(budget authority)	46,998	45,565	43,949	43,959
	(obligations)	40,865		50,089	43,965
	(outlays)	39,413		47,381	50,047
Arthritis	(budget authority)	167,348	159,447	152,941	152,961
	(obligations)	142,838		177,471	152,961
	(outlays)	149,528		171,514	188,857
Neurology	(budget authority)	130,694	125,000	119,903	119,958
	(obligations)	107,478		143,372	120,158
	(outlays)	110,755		133,500	153,236
Allergy	(budget authority)	113,434	114,000	110,369	110,404
	(obligations)	103,347		121,237	110,804
	(outlays)	106,394		119,566	121,850
NIGMS	(budget authority)	183,212	176,778	168,329	168,329
	(obligations)	154,035		197,506	168,329
	(outlays)	170,841		197,515	208,505
Child Hlth	(budget authority)	130,450	130,254	124,867	124,897
	(obligations)	111,208		144,155	124,942
	(outlays)	114,718		134,125	145,099
Eye	(budget authority)	38,570	41,631	39,938	39,947
	(obligations)	34,391		44,103	39,947
	(outlays)	34,325		36,187	38,585
Envir. Hlth	(budget authority)	30,960	28,879	28,386	28,684
	(obligations)	26,137		33,122	28,684
	(outlays)	25,849		31,370	33,609
Research Resources					
	(budget authority)	75,091	133,472	126,935	82,700
	(obligations)	72,846		129,131	82,700
	(outlays)	73,280		124,275	141,417
Fogarty	(budget authority)	666	4,767	4,762	4,784
	(obligations)	3,899		5,729	4,984
	(outlays)	4,253		5,219	6,246
TOTAL - Research					
	(budget authority)	$1,713,715	$1,813,900	$1,734,150	$1,785,922
	(obligations)	1,484,043		1,964,612	1,786,814
	(outlays)	1,446,587		1,837,451	1,980,641

Research activities

Activity:	(Obligations in millions) 1973	1974	1975
regular research grants-			
noncompeting	$ 435	$ 452	$ 514
competing	176	291	195
	$ 611	$ 743	$ 709
research contracts	$ 261	$ 335	$ 362
research training-			
training grants	$ 105	$ 128	$ 57
fellowships	11	46	61
Weinberger plan	--	(27.5)	(55.5)
	$ 116	$ 174	$ 118
general research support	$ 21.1	$ 45.3	$ --
minority biomedical support	$ 5.0	$ 7.0	$ 7.3
other research activities	$ 469.4	$ 661.0	$ 562.6
Total	$1,483.5	$1,963.3	$1,785.9

Research grants: For fiscal 1974, the NIH estimates that $743 million will be available to fund over 10,000 research projects. The fiscal 1974 obligations for research grants will include fiscal 1973 funds which were impounded by the Administration and released in December 1973. For fiscal 1975, $709 million will be available to fund approximately the same number of research projects as in 1974. For both years, the number and funding of noncompeting research grants will increase, while the number and funding of competing grants will decrease. In terms of dollars obligated, research grants account for 37 percent of the fiscal 1974 research budget, and 39 percent of the fiscal 1975 research budget. Research contracts represent 17 percent of the NIH research budget in fiscal 1974, and 20 percent in fiscal 1975. (An itemized breakdown of competing and noncompeting research grants, distributed by NIH institutes, is on page 25.) There remains some uncertainty as to whether the fiscal 1974 and 1975 obligations will be sufficient to fund noncompeting continuations. Information available to the Association indicates that the NIH intends to fully fund all moral commitments. Officials at the NIH were unable to specify at this time whether all years of multi-year grants would be obligated in the first year or over a period of years. There are indications that new projects funded out of fiscal 73 money are to be at least partially forward-funded. This is designed to reduce the impact on future years' budgets of released fiscal 1973 funds.

Research contracts: Obligations for NIH research contracts will increase in fiscal 1974 and 1975. Virtually all of the $27 million increase in 1975 will be obligated for cancer- and heart-related research contracts.

Research training: Traditional research training grant and fellowship programs will continue to be phased out as the "Weinberger plan" of post-doctoral fellowships for priority research areas is phased in. The NIH may use part of the fiscal 1974 funds (which include the released fiscal 1973 funds), to support continuing training grant and fellowship obligations incurred in fiscal 1973 and previous years, and to support applications for these programs which had been submitted and were awaiting action by the January 29, 1973, cut-off date. After that date, no new starts under the traditional training or fellowship programs are to be made except for training grants in fields not attracting adequate numbers of Weinberger plan fellows. New obligations for fiscal 1974 and 1975 will be used to fund the Weinberger plan and to honor previous commitments. For fiscal 1974, approximately $27.5 million is available for new fellowship obligations under the Weinberger plan, while $55.5 million will be available for this purpose in fiscal 1975. The remaining funds will be used to phase out previous training commitments. DHEW estimates that the new fiscal 1974 fellowship awards will be made in late May or June 1974, and will support at least 1,825 researchers. The fiscal 1975 funding is estimated to support the continuation of earlier awards as well as approximately 1,825 new fellows. Legislation (HR 7724) proposing different versions of NIH research training authority is still pending in Congress. It is therefore not clear what type of training program or levels of funding would result if HR 7724 were enacted.

General research support grants: The Administration has proposed total termination of the general research support program in fiscal 1975. Support will continue for the Minority Biomedical Support Program and for the other programs sponsored by the Division of Research Resources. Released fiscal 1973 GRS funds will be obligated in fiscal 1974. Following is a summary of GRS grant obligations:

	(Allocations in millions)		
GRS Grants:	1973	1974	1975
Medical schools	$ 23.5	$ 24.3	$ 17.8
Other institutions	29.4	30.6	22.0
Total	$ 52.9	$ 54.9	$ 39.8

The NIH is in the process of completing its grant review, and hopes to send all notices out by April. For medical schools, approximately $9 million of fiscal 1973 GRS funds already have been distributed. The release of an additional $15.3 million in fiscal 1973 funds will bring the total fiscal 1973 obligations for GRS formula grants to 104 medical schools to $24.3 million. Initially in fiscal 1974, $17.8 million will be obligated to 104 medical schools. A later award cycle is to distribute an additional $5 million in fiscal 1974 funds among medical schools and other institutions after the formula grants have been recalculated.

Minority biomedical support: The Administration will continue this program in fiscal 1975, as part of the regular program of the Division of Research Resources. The minority program will not be affected by the decision to terminate GRS support.

Other research activities

Approximately $661 million are to be obligated in fiscal 1974, and $562.6 million in fiscal 1975 for other NIH research activities. Included in these totals are $34 million and $45.1 million for cancer control programs in fiscal 1974 and 1975, respectively; $51 million and $22 million are to be obligated for cancer construction programs in those same fiscal years. Additional components supported by these research funds are multidisciplinary research centers and other special programs.

National Library of Medicine

	(Amounts in thousands)		
	1973	1974	1975
Budget authority	$28,568	$26,309	$27,738
Obligations	$25,933	$31,030	$29,238

For fiscal 1975, the Administration estimates total obligations for the NLM to be $29.2 million, which is approximately $2 million less than estimated fiscal 1974 obligations. Included in this decrease is a proposed $1.4 million cutback in extramural assistance to medical libraries, from $7.7 million in fiscal 1974 to $6.3 million in fiscal 1975. Legislation currently pending in Congress (HR 11385) would authorize $17.5 million for fiscal 1975 for medical library assistance programs, whose authorizations will expire on June 30. No funding has been requested to construct facilities for the Lister Hill Biomedical Communications Center. NLM research grant obligations are estimated at $900,000 to fund 28 grants in fiscal 1974, and a similar amount to fund 32 grants in fiscal 1975.

The Administration's fiscal 1975 budget presented funding information in a new format, listing obligations by program activity, rather than by funding mechanism (see page 26). The NIH is in the process of developing a "cross-walk" to translate the new budget request into functional areas. When this information is developed, it will provide figures on the distribution of research grants, contracts, training, and other funds through the NIH institutes and divisions.

OBLIGATIONS FOR REGULAR RESEARCH GRANTS

Institute:	(includes impounded FY 1973 funds) FY 1974 Funds (millions)	FY 1974 number of projects	FY 1975 Funds (millions)	FY 1975 number of projects
NCI total:	$116	1,740	$116	1,773
noncompeting	$ 65	1,030	$ 75	1,240
competing	$ 51	710	$ 41	533
NHLI total:	$178	1,910	$173	1,687
noncompeting	$ 112	996	$ 127	1,156
competing	$ 66	914	$ 46	531
NIDR total:	$ 16	243	$ 13	227
noncompeting	$ 10	170	$ 11	192
competing	$ 6	73	$ 2	35
NIAMDD total:	$113	1,204	$103	1,642
noncompeting	$ 68	1,135	$ 69	1,153
competing	$ 45	69	$ 34	489
NINDS total:	$ 68	1,231	$ 70	1,241
noncompeting	$ 36	622	$ 48	721
competing	$ 32	609	$ 22	520
NIAID total:	$ 63	1,135	$ 56	926
noncompeting	$ 43	791	$ 44	727
competing	$ 20	344	$ 12	199
NIGMS total:	$ 83	1,301	$ 82	1,363
noncompeting	$ 55	918	$ 67	1,152
competing	$ 28	383	$ 15	211
NICHD total:	$ 66	878	$ 61	940
noncompeting	$ 40	608	$ 48	745
competing	$ 26	270	$ 13	195
NEI total:	$ 27	433	$ 26	410
noncompeting	$ 17	276	$ 19	303
competing	$ 10	157	$ 7	107
NIEHS total:	$ 13	190	$ 9	152
noncompeting	$ 6	92	$ 7	121
competing	$ 7	98	$ 2	31
NIH TOTAL:	$743	10,265	$709	10,361
noncompeting	$ 452	6,638	$ 515	7,510
competing	$ 291	3,627	$ 194	2,851

DHEW - NATIONAL INSTITUTES OF HEALTH: OBLIGATIONS BY BUDGET ACTIVITIES
(amounts in millions)

	1973 Obligations 1/	1974 Obligations	1975 Budget Authority (Obligations)
Cancer			
Cancer cause and prevention research	115.3	145.8	151.7
Detection and diagnosis research	27.0	40.3	43.2
Treatment research	144.9	193.9	205.1
Other cancer biology	63.8	84.8	89.8
Resources development	69.1	89.8	64.3
Cancer control - demonstration	5.5	34.6	45.8
Subtotal	425.6	599.2	600.0
Heart			
Heart and vascular diseases	146.5	198.2	174.2
Lung diseases	28.3	44.6	45.3
Blood diseases and resources	41.7	51.0	50.3
Intramural laboratory and clinical research	19.3	21.7	22.4
Research management and program services	12.1	15.3	17.0
Subtotal	247.9	330.7	309.3
Dental			
Caries	8.5	10.1	9.0
Periodontal and soft tissue diseases	7.2	10.0	7.3
Craniofacial anomalies	5.1	8.3	6.1
Restorative materials	3.5	3.4	2.8
Pain control and behavioral studies	.7	1.1	1.0
Dental research institutes	6.2	6.9	7.2
Intramural laboratory and clinical research	6.4	7.3	7.6
Research management and program services	2.8	3.0	3.1
Subtotal	40.4	50.1	44.0
Arthritis			
Arthritis, orthopedics & skin disease research	21.7	25.7	22.3
Diabetes, endocrinology and metabolism research	43.3	57.1	46.5
Digestive diseases and nutrition research	21.4	33.8	27.1
Kidney disease	17.4	20.2	17.3
Blood diseases	10.3	11.7	10.6
Intramural laboratory and clinical research	20.8	22.6	23.3
Research management and program services	5.2	5.8	5.9
Subtotal	140.1	177.0	153.0
Neurology			
Communicative disorders	13.4	18.8	14.4
Neurological disorders	53.0	64.8	55.4
Stroke, nervous system trauma	13.0	23.1	19.0
Fundamental neurosciences	10.8	14.0	12.2
Intramural laboratory and clinical research	6.5	7.7	8.3
Research management and program services	8.9	14.2	10.7
Subtotal	105.6	142.6	120.0
Allergy			
Allergic and immunologic diseases	25.2	30.8	27.2
Bacterial and fungal diseases	22.6	28.6	24.0
Viral diseases	20.8	24.1	21.9
Parasitic diseases	9.3	10.8	9.8
Intramural laboratory and clinical research	18.7	20.5	21.6
Research management and program services	4.7	6.0	6.0
Subtotal	101.3	120.8	110.4
General medical sciences			
Pharmacology-toxicology	23.4	27.8	26.2
Biomedical engineering	18.0	24.6	21.4
Clinical and physicological sciences	20.3	26.0	23.3
Genetics	40.2	50.0	46.1
Cellular and molecular basis of disease	42.5	57.0	44.9
Research management and program services	5.5	6.6	6.5
General research support	---	5.3	---
Subtotal	149.9	197.3	168.3
Child Health			
Population research	34.8	46.7	40.2
Child health	46.6	61.9	52.4
Aging	8.4	12.8	9.1
Intramural laboratory and clinical research	13.0	14.2	14.7
Research management and program services	7.2	8.3	8.5
Subtotal	110.0	143.9	124.9
Eye			
Retinal and choroidal diseases	11.6	14.0	12.5
Corneal diseases	4.8	6.9	6.0
Cataract	2.4	3.5	3.0
Glaucoma	3.5	5.1	4.5
Sensory-motor disorders and rehabilitation	6.3	8.3	7.5
Intramural laboratory and clinical research	3.7	4.3	4.5
Research management and program services	1.6	1.9	2.0
Subtotal	33.9	44.0	39.9
Environmental health			
Environmental health science centers	3.7	4.0	5.1
Envir. mutagenesis and reproductive toxicology	1.7	3.0	2.8
Etiology of envir. diseases and disorders	4.5	5.6	4.1
Environmental pharmacology and toxicology	5.1	7.9	4.3
Environmental pathogenesis	1.7	2.9	1.8
Intramural laboratory and clinical research	7.9	8.3	9.2
Research management and program services	1.4	1.4	1.4
Subtotal	26.0	33.1	28.7
Research resources			
Clinical research	41.3	42.5	42.5
Biotechnology research	10.7	11.9	11.9
Laboratory animal sciences and primate research	17.6	18.9	17.5
General research support	21.1	45.3	----
Minority biomedical support	5.0	7.0	7.3
Chemical/biological information handling research	1.0	1.0	1.0
Research management and program services	2.2	2.5	2.5
Subtotal	98.9	129.1	82.7
Fogarty international center			
Gorgas memorial laboratory	.5	.5	.5
Scholars	1.0	2.4	1.2
Research management and program services	2.4	2.7	3.1
Subtotal	3.9	5.5	4.8
TOTAL, Institutes and Research Divisions	1,483.5	1,963.3	1,785.9

1/ Comparable for CRSG and Scientific Evaluation
NOTE: May not add due to rounding

Social and Rehabilitation Service

The key activities of the Social and Rehabilitation Service that affect the medical schools, other than the SRS role in the Medicaid program which this Memorandum is not including, are certain rehabilitation research and training programs and university affiliated centers for the developmentally disabled. No major changes in these programs from previously announced policies are expected in either fiscal 1974 or fiscal 1975. The budget data follow.

	(Obligations in thousands)		
	1973	1974	1975
Rehabilitation services and facilities			
Research	$21,810	$20,096	$20,000
Training	32,016	15,572	11,500
Grants for the developmentally disabled			
University affiliated facilities	4,464	4,335	4,250

In research, a major area for emphasis in fiscal 1975 is the rehabilitation of the spinal cord injured and the severely disabled. The training program continues in the process of being phased out. The developmental disabilities centers program is to support 33 centers, providing specialized services to more than 50,000 trainees from more than 60 disciplines.

VETERANS' ADMINISTRATION

The health-related budget of the Veterans' Administration is to increase about 10 percent in fiscal 1975 over the fiscal 1974 level. Some increase is spread among nearly all programs. Of special interest to the Association, the VA's new program of assistance to health personnel education institution is to operate at a $10-million level in fiscal 1974 and a $20-million level in fiscal 1975. More detailed comments are provided under the budget headings of medical care, medical and prosthetic research, assistance to health manpower training institutions, medical administration and miscellaneous operating expenses, and construction.

Medical care

The $3.2 billion in budget authority requested for the VA's medical care activities is $315.9 million over fiscal 1974. Budget data on selected items follow:

	(Obligations in thousands)		
	1973	1974	1975
Hospital care	$1,743,618	$1,954,360	$2,091,312
Outpatient services	437,134	494,215	587,135
Education and training	138,130	154,159	180,861

The average daily patient census in VA hospitals is to increase from 81,500 in fiscal 1974 to 82,000 in fiscal 1975, and average employment is to grow from 124,695 in fiscal 1974 to 129,766 in fiscal 1975. The result is that staffing ratios are to improve from 1.5 in fiscal 1974 to 1.6 in fiscal 1975. Fiscal 1975 staffing ratios are to be 1.70 in medical bed sections, 2.07 in surgical bed sections, and 1.10 in psychiatric bed sections. The number of outpatient visits is to increase from 11.9 million in fiscal 1974 to 13.8 million in fiscal 1975. Based on new VA-medical school affiliations, the number of physicians and dentists in the VA medical education and training program is to increase from 29,800 in fiscal 1974 to 30,900 in fiscal 1975. Included in the budget are funds for the initiation or expansion of emergency care programs at eight hospitals, geriatric research and clinical centers at six hospitals, sickle cell screening and counselling at 12 hospitals, hypertension screening and treatment, and patient health education. The budget also provides funds for activation expenses of relocation and replacement general hospitals and new hospital bed buildings at Columbia, Mo.; San Antonio, Texas; San Francisco; Tampa, Fla.; and White River Junction, Vt.

Medical and prosthetic research

The VA research budget is to increase about 8.5 percent in fiscal 1975 over fiscal 1974. The budget data follow:

	(Obligations in thousands)		
	1973	1974	1975
Medical research	$75,399	$81,756	$88,675
Prosthetic research	3,186	3,344	3,675

The additional funds are for initiation and growth of research programs in new and replacement hospitals and expanded laboratory facilities; initiation of research programs in hospitals newly affiliated with medical schools; and development and expansion of special VA research programs in aging, sickle cell disease, hypertension, and alcohol and drug dependence.

Assistance to health manpower training institutions

This program was authorized in the Veterans' Administration Medical School Assistance and Health Manpower Training Act of 1972. Because of difficulties encountered establishing the program, initial implementation has been delayed until fiscal 1974. The budget data follow:

	(Obligations in thousands)		
	1973	1974	1975
Grants for new state medical schools	---	$5,000	$8,500
Grants to affiliated medical schools	---	3,000	6,500
Grants to other health manpower institutions	---	1,500	3,500
Expansion of VA hospital education and training capacity	---	500	1,500
Total	---	$10,000	$20,000

Congress has appropriated budget authority of $45 million for this VA-supported,

OMB-opposed program. Funds appropriated for the program are available for obligation and expenditure up to six years after the fiscal year in which they were appropriated. This fact is cited by the Administration in explaining why there is no request for new funds in fiscal 1975. The program provides grants to assist in the establishment of up to eight new state medical schools to be operated in conjunction with VA hospitals; for grants to existing medical schools affiliated with the VA to expand and improve their training capacities; for grants to other health manpower institutions affiliated with the VA to coordinate, improve and expand the training of professionals, allied health and paramedical personnel; and for expansion of the VA hospital education and training capacity, including the development or initiation of improved methods of educating and training health personnel. The first deadline for receipt of grant applications is March 1; a later grant application cycle is expected about mid-summer. Only about two or three applications for new-school assistance are expected to qualify in fiscal 1974. Another one or two additional schools may qualify in fiscal 1975. About 15-20 applications for assistance to existing affiliated schools are expected, with academic medical centers accounting for an additional 10-12 applications.

Medical administration and miscellaneous operating expenses

Activities in this budget which interest the Association are VA postgraduate and inservice training, research and development in health services, and exchange of medical information. The budget data follow:

	(Obligations in thousands)		
	1973	1974	1975
Postgraduate and inservice training	$5,166	$8,000	$10,130
Research and development in health services	963	3,006	4,828
Exchange of medical information	2,033	3,000	3,000

The VA research and education associates program is to expand and new applications are being accepted. The clinical associate and medical investigator programs are being phased out; no new applications are being accepted, but persons holding appointments are to serve out the term of the appointment. No new applications are being accepted for senior medical investigator, the senior position in the VA career development program. A portion of the budget increase for research and development in health services reflects the higher costs of a VA staff reorganization, but the bulk of the increase is to fund ongoing projects and new projects aimed at improvement in the delivery of health care.

Construction

The VA's construction budget is up sharply in fiscal 1975 compared to fiscal 1974. Comparable budget authority figures are $181 million in fiscal 1973; $110.6 million in fiscal 1974; and $276 million in fiscal 1975. Budget data follow on segments of the construction program of most interest to the Association:

	(Amounts in thousands)		
	1973	1974	1975
Hospital replacement and modernization (budget authority)	$75.1	$37.0	$201.9
(obligations)	5.9	26.6	65.9
Research and education (budget authority)	12.4	5.7	---
(obligations)	0.5	7.4	7.6

Major fiscal 1975 projects include replacement hospitals at Loma Linda, Calif.; Los Angeles; and Bronx; and a new bed building at Columbia, S.C. The major research and education project continues to be in connection with the Louisiana State University School of Medicine in Shreveport.

Budget Action on Expiring Health Programs

A large number of legislative authorities for federal health programs are to expire June 30, 1974. As a result there are no fiscal 1975 authorization levels for such programs, and thus it is difficult to measure the President's fiscal 1975 budget request against a Congressionally determined level of need. The following chart lists health programs whose authority is to expire, legislation (if any) to modify and extend the programs, the fiscal 1975 authorization level in the pending legislation, and the President's fiscal 1975 request. Because of differences in proposals supported by the Congress and the Administration, some pending authorization and budget request figures are not precisely comparable. Nevertheless, they provide the best basis for comparison at the present time. Also, some bills are to extend more than one program.

Expiring program and pending legislation to extend and modify	Pending fiscal 1975 authorization level (in millions)	Fiscal 1975 budget request (in millions)
Research		
National Cancer Act	$800	$600
S 2893 (hearings concluded 1/30)		
HR 12314 (hearings concluded 2/6)		
Health Services		
Health services research	$65.2	$69
Health statistics	30.0	24
Medical library assistance	17.5	6.3
HR 11385 (passed 1/21)		
S 2996 (introduced 2/8)		
Regional medical programs		--- [a]
Comprehensive health planning		--- [a]
Medical facilities construction (Hill-Burton)		2
HR 12053 (introduced 12/20)	$232	
S 2994 (introduced 2/8)	198[b]	
Community mental health centers	)	
Mental health of children	) 116.5	630[c]
Alcohol, drug abuse control	)	
Family planning	15.5	101[c]
Developmental disabilities	77	53
Migrant health	50	24
Comprehensive health services	100	90
HR 11511 (hearings underway)		

Expiring program and pending legislation to extend and modify	Pending fiscal 1975 authorization level (in millions)	Fiscal 1975 budget request (in millions)
Health services (cont'd)		
National Health Service Corps (no bill introduced to date)	---	$9
Health manpower		
Health professions	---	$257
Nursing	---	45
Allied health	---	---
Public health	---	---
(no bill introduced to date)		
National health service scholarships HR 11539 (introduced 11/15)	Such sums as may be necessary	$22.5

a. The Administration proposes a $75-million health resources planning program to combine the present RMP and CHP programs.

b. The Senate bill does not include the Hill-Burton program, which the Senate will consider in separate legislation not yet introduced.

c. Program appropriations are authorized by more than one legislative authority.

The figures below were released at a Press Conference by HEW on Saturday, February 2, 1974.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
NATIONAL INSTITUTES OF HEALTH

1975 President's Budget
(Budget authority in thousands)

	1973	1974	1975	Change
National Cancer Institute	$ 492,250	$ 527,306	$ 600,000	$ 72,694
National Heart and Lung Institute	300,042	286,465	309,299	22,834
National Institute of Dental Research	46,998	43,949	43,959	10
National Institute of Arthritis, Metabolism, and Digestive Diseases	167,348	152,941	152,961	20
National Institute of Neurological Diseases and Stroke	130,694	119,903	119,958	55
National Institute of Allergy and Infectious Diseases	113,434	110,369	110,404	35
National Institute of General Medical Sciences	183,212	168,329	168,329	------
National Institute of Child Health and Human Development	130,450	124,867	124,897	30
National Eye Institute	38,570	39,938	39,947	9
National Institute of Environmental Health Sciences	30,960	28,386	28,684	298
Research Resources	75,091	126,935	82,700	- 44,235
John E. Fogarty International Center for Advanced Study in Health Sciences	4,666	4,762	4,784	22
Total, Research	$1,713,715	$1,734,150	$1,785,922	$ 51,772
National Library of Medicine	28,568	26,309	27,738	1,429
Buildings and Facilities	8,500	8,000	3,000	- 5,000
Office of the Director	11,755	12,875	18,124	5,249
Total, National Institutes of Health	$1,762,538	$1,781,334	$1,834,784	$ 53,450

HEALTH PROGRAMS
(Dollars In Millions)

	1973	1974	1975	1975 Change Over 1974
Food and Drug Administration	$ 149	$ 165	$ 200	$ +35
Health Services Administration	1,082	1,176	1,177	+ 1
Center for Disease Control	160	136	138	+ 2
National Institutes of Health	1,758	1,781	1,835	+54
Alcohol, Drug Abuse and Mental Health Administration	881	833	735	-98
Health Resources Administration	1,249	1,137	574	-563
Assistant Secretary for Health	76	74	97	+23
(PSRO'S)	(5)	(34)	(58)	(+24)
Subtotal, Health Agencies (Budget authority)	5,355	5,302	4,756	-547
Outlays	(4,341)	(5,270)	(5,592)	(+322)
Medicare and Medicaid Benefits	(14,079)	(18,007)	(20,699)	(+2,692)
Total, Health Outlays	(18,420)	(23,277)	(26,291)	(+3,014)

HEALTH SERVICES ADMINISTRATION
(Budget Authori in Millions)

Comprehensive Health Services	$ 299	$ 295	$ 290	$ -5
Health Maintenance Organizations	-----	65	60	-5
Maternal and Child Health	267	266	266	-----
Family Planning	131	101	101	-----
Migrant Health	24	24	24	-----
Indian Health	220	250	281	+31
National Health Service Corps	8	10	9	-1
PHS Hospitals	96	105	109	+4
Program Administration and Other	37	60	37	-23
Total, Health Services Administration	$1,082	$1,176	$1,177	$ +1

ALCOHOLISM, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
(Budget Authority in Millions)

General Mental Health:				
Research and Training	$ 200	$ 190	$ 150	$ -40
Community Mental Health	205	189	199	+10
Drug Abuse:				
Research and Training	48	52	44	-8
Community Programs	167	176	157	-19
Alcoholism:				
Research and Training	20	15	12	-3
Community Programs	140	113	78	-35
Saint Elizabeths Hospital	36	40	42	+2
Administration and Information	64	58	53	-5
Total	$ 881	$ 833	$ 735	$ -98

HEALTH RESOURCES ADMINISTRATION
(Budget Authority in Millions)

Health Resources Planning	$-----	$-----	$ 75	$ +75
Comprehensive Health Planning	38	42	-----	-42
Regional Medical Programs	144	75	-----	-75
Research and Evaluation	67	78	69	-9
Health Manpower:				
Institutional Assistance	265	267	159	-108
Student Assistance	132	134	90	-44
Special Projects	196	166	120	-46
Subtotal, Health Manpower	$ 592	$ 567	$ 369	$ -198
Construction:				
Medical Facilities	$ 214	$ 197	$-----	$ -197
Teaching Facilities	120	114	-----	-114
Interest Subsidies	2	2	2	-----
Subtotal, Construction	$ 336	$ 313	$ 2	$ -311
National Health Statistics	20	21	24	+3
Administration and Other	55	42	35	-7
Total	$1,249	$1,137	$ 574	$ -563

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