ADULT HEALTH PROTECTION ACT OF 1966

Mr. WILLIAMS of New Jersey. Mr. President, the 89th Congress convened a little over a year ago with a clear call from the President and people of this Nation. Our job was to act effectively on urgent legislation essential to a society in search of greatness. And high on our agenda for action were the medical manpower situation in this critical moment of increasing demand. Dr. Howard A. Rusk, director of the Department of Physical Medicine and Rehabilitation at New York University, summed up the medical manpower situation in his column of January 2:

Increased training of health personnel is essential.

To maintain our present ratio of 140 physicians for every 100,000 persons, 399,000 physicians will be needed by 1975. This will necessitate the annual graduation of 21,000 students, 3,600 more than the 1969 total. However, estimates indicate that by 1976 our annual graduation rate will be only 9,185.

The Surgeon General's Consultant Group on Nursing estimated in 1963 a projected need for 650,000 professionally trained nurses by 1976. This compares with a national supply of 580,000 in 1962, of whom 117,000 were working only part time.

Also reporting on the nurse shortage, the New York Times said in an editorial on November 9, 1965:

It is hoped that the Nurse Training Act of 1964, providing $863 million in aid to schools of nursing, over the next 3 years, will bring the total number of registered nurses in practice by 1970 to 680,000. But even if this goal is reached, it will provide only 38 percent of hospital patient care.

As doctors and others become increasingly alarmed about manpower deficiencies, we also hear questions about the heavy demands made upon the precious time of the physician. At the recent White House Conference on Health, for example, Dr. Robert M. Zolinger, professor and chairman of the Department of Surgery at Ohio State University, said:

No physician can today or in the foreseeable future have the time to take total care of his patients, and he must depend upon auxiliary help. I foresee that, by special training now proposed for the physician in family practice he will serve more and more as a triage officer by directing his problem patients to special centers for definitive treatment.

The Surgeon General of the United States, Dr. William H. Stewart, addressed the same Conference and said:

Year by year, our top professional personnel are being trained to perform still more complex tasks. How long can each profession afford to hang onto its simpler functions—the routine filling of a tooth, for example, or the several easily automated steps in a medical examination? How can we train the physician to make full use of the skills available in other people, freeing himself to perform only those duties for which he is uniquely qualified?

Demand on physicians and other professionally trained persons are further intensified by what might be called our system of crisis medicine. It is a system that demands superb skills, advanced knowledge and training, and excellent facilities for the care of the sick, but it is a system designed for maximum effectiveness at a time of emergency: illness or accident. For many of the very poor—the slum dweller, the migrant worker, the elderly person—our advanced medical system might as well have been on another planet. In a nation now committed to delivery of best possible health care to all citizens, obviously much more must yet be done.

If we are to improve dramatically the health and the health care of our Nation, there is one simple fundamental step we can take: a concentrated effort at the early detection in order to help prevent the onset of serious illness and the reduction of its severity.

Obviously, it is impossible to prevent all chronic illnesses—and it will become increasingly difficult to deal with them, using present methods, as larger numbers of Americans add more years to their lifespans.

But such illnesses could be held to a minimum, and the extent of disability or limitation of activity could be controlled or delayed if—

This Nation does all possible to keep people out of hospitals, not only for humanitarian reasons but also to keep the costs of medicare to a minimum. This Nation anticipates that shortages in medical manpower, together with increasing demands for professional treatment as the aging population of this Nation grows each year, will cause an intensifying need to make the best possible use of the experience, human understanding, and special training of those professionally trained persons who fight illness and death every day.

For these reasons I am introducing today a bill to establish a national program for health maintenance.

THE ADULT HEALTH PROTECTION ACT OF 1966

Mr. President, it has been said that war is the tragic consequence of failure by its preventive diplomacy. If I may draw a parallel, the costly and often futile treatment of long-term illness and disability represents the failure to prevent, or at least control, chronic disease and to maintain health.

Preventive medicine is not a new idea. One aspect of preventive medicine familiar to all is environmental—purifying our water supplies, reducing air pollution, exterminating mosquitoes. Almost every child is painfully familiar with the preventive medicine of the smallpox vaccination, the diphtheria shot, and the measles shot. The dramatic results of
this sort of preventive medicine can be seen in the increased life expectancy of today's American, and the virtual elimination of some disease within our borders. But the heavy emphasis on this aspect of preventive medicine has had some other obvious repercussions. As some diseases have been conquered, other diseases have been discovered. The rise in the number of deaths caused by heart disease and by cancer can in part be explained by the simple fact that more people live long enough to escape the diseases. As some diseases have been conquered, others may be discovered, and new scientific advances are in part responsible for the development of these and other crippling chronic diseases such as glaucoma, diabetes, and hypertension. The kind of preventive medicine that we are discussing is already being practiced on a limited scale in many parts of the Nation. It is not visionary but eminently practical and vitally necessary.

Therefore, in my judgment it is time that we had a national program for the early detection of tendencies toward serious illness. If this Nation established such a program now, if some diseases and effective enough, we could then have the facts and the new techniques necessary to prevent and reduce chronic illness in middle and late years.

Accordingly, I have drafted a bill to amend the Public Health Service Act by adding a new title authorizing a program to protect adult health through the establishment of locally operated health protection centers for the detection of disease. Any person past the age of 50 would be eligible for such screening if he wished to have it. Centers would use automated or semi-automated screening techniques which have already proven their worth in everyday use.

Eventually, millions of Americans could thus be encouraged to think in positive terms about the prevention of illness at a time in their lives when prevention is possible.

The beginnings of such a program are contained in the provisions of this bill.

**SUMMARY OF PROVISIONS**

This bill would authorize the Surgeon General to make grants to medical schools, community hospitals, health departments, and other public or nonprofit agencies to establish and operate health protection centers.

**REGIONAL HEALTH PROTECTION CENTERS**

The regional health protection centers would provide a series of basic tests to detect abnormalities in the cardiovascular, respiratory, gastrointestinal, gynecological, and skeletal systems, as well as defects in metabolism and organs of special sense. Specific diseases or conditions to be tested for might include:

- **Stroke**: First, hypertension, heart muscle enlargement, and disease; second, mouth, lung, breast, cervical, and other cancer; third, diabetes; fourth, kidney disease; fifth, arthritis; sixth, rheumatoid arthritis; eighth, gastrointestinal bleeding; ninth, anemia; tenth, obesity; eleventh, respiratory impairment; twelfth, hearing impairment; fourteenth, hypercholesterolemia; and fifteenth, gout.

The tests would be administered by technicians, medical aid specialists using automated or semiautomated equipment which has already been proven to give swift, accurate, and reliable results. To be entered into the test along with data provided by the person undergoing the health appraisal, would be fed into a computer. It is estimated that the battery of tests could be administered within 2% hours.

The results of the tests, summarized by the computer, would be referred to the private physician of the person tested. In cases where the person either did not have a private physician or did not have a private physician or was medically indigent, the test would be referred to a physician in accordance with local practice.

The regional health protection centers are intended to provide an efficient means for the detection of abnormalities or indications of disease. They would not replace full examinations. Their purpose is to place in the hands of the examining physician a summary of basic data and to place promptly under a physician's care a person with indications of possible disease.

The centers would be under the supervision of physicians, but they would be principally staffed by technical personnel. Health counselors would be on the staffs of the centers to explain the purpose of the tests, to insure proper referral and to follow up those cases where prompt medical treatment was indicated by the tests.

Health appraisals and disease detection tests would be available to any person age 50 or above on a voluntary basis. The regional health protection centers would conduct programs to study the operation of technical disease detection procedures and would research and develop new disease detection tests and equipment. Additionally, the regional centers would be authorized for operational research and for the establishment of internships to give on-the-job training to physicians, nurses, social workers, and other personnel. The centers would also conduct community education programs on preventive health care.

The availability of these testing services would be intended to encourage men and women approaching retirement to take regular health examinations and to facilitate the giving of full examinations by practicing physicians.

**COMMUNITY HEALTH PROTECTION CENTERS**

The Surgeon General would be authorized to make grants to medical schools, community hospitals, and other colleges and hospitals for the establishment of community health protection centers. They would be linked by data transmission lines to the regional centers and could use the same specialized electronic equipment and other facilities of the regional centers for the evaluation of some tests.

One of the criteria for the awarding of grants to regional centers would be their ability to provide services to the small community centers. Although the community centers would be directly connected to the regional centers, they would not necessarily be operated by the same institution which ran the regional centers. The purposes of community centers would be to make the services of the regional centers more widely available to a greater number of people.

Special facilities might be developed to meet the needs of these centers, and mobile units might be used in rural areas.

**OTHER PROVISIONS**

A 12-man Advisory Council on Adult Health Protection would be established to advise and assist the Surgeon General in the administration of this program.

The Surgeon General would be authorized to contract with educational institutions or other appropriate organizations for the conduct of educational programs. He would also be authorized to contract with profit and nonprofit organizations for the research and development of equipment, and to contract with profit and nonprofit organizations which would improve disease detection procedures.

Let me emphasize—this point bears emphasis—that the centers would not be diagnostic centers. They would be laboratories which give data to physicians, who would interpret that data and deal directly with patients when consultation would be needed.

The bill I am introducing requires that in every case the results of the screening test be given to a practicing physician. The health protection center could not be equipped or intended to provide treatment, although the staff of the centers would be expected to follow up cases and to make sure that a participant was promptly brought under a doctor's care if treatment was indicated by the tests. Even should the screening tests show no indications of possible disease, the data would provide basic information to a physician on his patient which would be extremely helpful for a full physical examination by a doctor or as base line data for future examinations.

Doctors would thus be given more time to perform the executive, expert functions that only they can perform. They would be given more time and more facts to help more people.

As the population continues to increase—especially the elderly population which is most susceptible to chronic disease and disability—physicians and others in the health professions will need all the time they can get.

**COST OF CHRONIC ILLNESS TODAY**

Before proceeding with our discussion, we should be aware of the important difference between the term "sick" and "illness." Disease is a pathological process which may not necessarily produce symptoms. Illness—or sickness—is a condition that comes from disease. Present knowledge does not permit us to prevent the onset of the majority of chronic diseases. However, available knowledge can be utilized as a potent weapon to prevent, mitigate, or delay the onset of the illness which is a byproduct of these diseases. An example is atherosclerosis, or hardening of the arteries. An individual may have arteriosclerotic with no obvious symptoms of the disease. He thus has a chronic dis-
ease without illness. Diagnosis in the crucial preclinical stage can have a far-reaching effect upon the future health status of the individual. Our failure to provide a nationwide program of health appraisal leading to early diagnosis may be directly charged with the high cost of chronic illness today.

Here are some appalling facts:

Chronic disorders afflict about 74 million Americans, some of whom have more than one ailment.

Among individuals 65 years old or older, more than half are functionally limited to some degree.

Last year, more than 900,000 persons died of heart disease.

It is estimated that as many as 25 percent of the Nation's adults are currently afflicted with heart disease.

Cancer takes more than 300,000 lives each year.

The President's Commission on Heart Disease, Cancer, and Stroke has reported that these diseases alone cost the Nation close to $30 billion each year in lost productivity and lost taxes due to premature disability and death.

Arthritis now claims 13 million sufferers—and costs the U.S. economy over $1 billion yearly. It cripples more people in low-income families than in other groups and disables more people than any other chronic disease.

More than 20 million people are affected by blinks, epilepsy, mental retardation and other neurological disorders.

Two million are known diabetics. Almost 1.5 million over 40 years of age are afflicted with diabetes.

Presently, we are spending $4 billion a year for maintenance and medical care of disabled people through public assistance programs, in annual compensation and pensions to veterans by the Veterans' Administration, and in Federal-State moneys for basic support of vocational rehabilitation services.

And, the Public Health Service is currently authorized to spend some $53 million for various programs attacking a number of the chronic diseases by means of extended community health programs, for research, for special programs attacking arthritis and rheumatism, and for treatment facilities for chronic respiratory disease, epilepsy, and other neurological disorders.

Just this month, I obtained some figures on the incidence of chronic conditions among persons 45 years of age and over. This is approximately the age group with which my legislation is concerned.

Prevalence of chronic disease in persons over 45

Per 1,000 population

Hypertension including hypertensive heart disease

Arthritis and rheumatism

Chronic bronchitis

Hearing impairment

Coronary heart disease

Vision impairment

Diabetes

Source: Public Health Service.

If these statistics seem to suggest that we have already been tardy in establishing detection and prevention programs, we can draw some comfort from pioneer-

ing work begun under private, State, or local auspices. The most dramatic and significant example is the automated diabetes screening project operating for the benefit of workers and their families on the west coast to members of the Kaiser Foundation health plan. This program, in fact, almost serves as a pilot precedent, clearly showing the practicality and value of an effective screening program.

The Kaiser Foundation Program

To those who use the Kaiser program, the word 'multiphasic' merely means 'combined', which in 21/2 hours they receive a battery of tests comparable, and in some respects superior, to traditional testing made without benefit of automation.

I will describe the procedure in some detail because of its direct relationship to my legislative proposal.

In the multiphasic health checkup, one participant registers every 2½ minutes, and is through in 2½ hours.

Upon arrival at the screening center, each participant registers at the reception desk. He receives a series of questions on IBM cards to which he will respond during waiting intervals between tests and, when completed, to be fed into the computer.

The first procedure involves an electrocardiogram of the heart, according to the computer's program, for the detection of heart abnormalities.

After the test is completed, the participant is asked to drink a measured amount of chilled, concentrated sugar solution. This is in preparation for the drawing of a blood sample 1 hour later for the blood sugar test for diabetes.

Before coming to the center, the individual was instructed to fast for a minimum of 4 hours in preparation for this test. A timer is stamped to record the exact time the sugar solution is taken.

Weight, height, and body build measurements are recorded directly on the IBM card. This information is important for future use, as changes in these base measurements at a later date could indicate the onset or development of a chronic disease.

A chest X-ray is then taken. This procedure is important not only for the detection of tuberculosis, but can yield significant information on other types of pathology in the lung, heart, large blood vessels in the chest cavity, and bony structure of the chest.

For women over 40, there is mammography, an X-ray examination of the breast. This procedure has proved to be a valuable aid in early diagnosis of breast cancer and precursors.

The eyes are next tested. Visual acuity is recorded, and eye pressure tests are conducted for the detection of glaucoma.

A test to measure lung capacity follows. A lung test is aimed at the detection of emphysema.

Hearing is then tested with an audiometer, and results are recorded on a graph and then transferred to the computer card. The computer is programmed to read out results in terms of hearing loss.

At this point, the 1-hour interval after drinking the sugar solution is reached. Blood is drawn and used for several groups of tests. Blood serum from this sample is placed in the automated analyzer, and eight completed tests are conducted simultaneously, with results available in 11 minutes. Among other vital findings, these tests indicate the pos-

sibility of diabetes, high cholesterol levels, chronic liver disease, gout, kidney disease, loss of calcium from the bones, and certain digestive diseases. Whole blood is used to determine the hemoglobin level and the white blood-cell count, thus throwing light on the presence of diseases such as anemia and leukemias.

A urine sample is then taken and tested for evidence of kidney infection and other diseases of the kidneys, as well as diabetes. Results are automatically recorded on the IBM card.

Following this, a photograph is taken of the inside of the eye which has the value of not only visualizing the optic nerve, but also the condition of the small blood vessels which are representative of those throughout the body. This test can yield important information about the presence of a wide variety of systemic diseases, including diabetes, leukemia, advanced hypertension, and even increased pressure within the head.

As a finale to the screening line, the blood pressure and pulse rate are recorded, and the information is correlated by the computer with other tests and diagnoses.

In the case of certain tests, and computer is so programmed that where abnormalities are identified, the person may be immediately tested for related tests or rechecked of the test taken. When all the results are completed and the information is recorded and fed into the computer, a printout is received from the computer which gives a health profile of the individual. The printout is provided to the physician for use in initiating the diagnostic and therapeutic measures indicated.

The efficiency and effectiveness of this automated system may lead one to think that this is a thoroughly depersonalized, assembly-line procedure. Fortunately, this is not so. The technicians and nurses have been carefully selected not only for their specialized abilities but also for their personal qualities, as well.

They are able not only to perform their tasks skillfully, but to maintain a cheerful attitude.

Though still in its early stages, the program has already yielded accurate summary findings. Almost 50,000 multiphasic examinations have now been completed.

Do these automated health estimates actually lead to diagnoses?

Among 9,760 participants on whom completed diagnostic examination records were available, the doctors confirmed the health appraisal findings as follows:

Verified diagnoses from findings of multiple screening procedures¹

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension and hypertensive heart disease</td>
<td>88.0</td>
</tr>
<tr>
<td>Anemia (women)</td>
<td>81.4</td>
</tr>
<tr>
<td>Emphysema and bronchitis (men)</td>
<td>34.2</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>26.1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>15.4</td>
</tr>
<tr>
<td>Coot (men)</td>
<td>9.5</td>
</tr>
</tbody>
</table>

¹ Program conducted by Permanente medicai group in Oakland, Calif.

Here is concrete evidence of the pricelessness of the preliminary health estimates as the ultimate control of heart disease, arteriosclerosis, diabetes, and many other degenerative diseases of aging.
Women examined showed a consistently higher percentage of impaired visual acuity than males, about 7 percent of persons in the age group 50 to 59. Photographs of the inner eye revealed some abnormalities in almost 1 of every 20 persons, including retinal arteriosclerosis—an important index to other aging arteriolar processes—in 3 percent of all patients.

There are at least a few facts pulled at random out of the multiphasic program’s most recent report. The electronic brain used to report out this information can also combine results of a wide range of tests and pose probabilities—which are infinitely helpful to the individual physician in his task of performing a more detailed examination leading to diagnosis.

In the year between September 1964 and the end of August 1965, a preventive health service research program was instituted by Kaiser directed toward investigating the feasibility of chronic illness and disability. The health protection centers established by my bill will do this kind of research into the effectiveness of health appraisal and preventive medicine.

But one of the strongest arguments for support of health appraisal services is this: the availability of a centralized, complete health estimate facility serves to motivate people to come in for preventive services, and with which some of the most one-third of the persons who participated in the screening program in the income area in New York City to detect serious diseases or conditions that are preventable. Preventive services are especially important to national welfare. It is totally inconsistent with the American spirit to put off doing something vital to national welfare.

For generations we have faithfully and persistently reached one frontier of medicine after another. Prevention of communicable diseases has long since become part and parcel of the objectives of public health. But the prevention of chronic diseases remains a hidden frontier; one we have not yet crossed despite all the time, effort, and money we are spending on research and experimentation to find ever more successful treatments.

My bill does not propose immediately to establish hundreds of elaborate health appraisal centers all over the country. Within 5 years we would have five regional centers and 50 related community centers in progressive operational stages. These will demonstrate the feasibility of extending similar services to other regions of the country as needed.

I am convinced that this is an eminently reasonable way to begin an attack on chronic disease. To delay now will only postpone the eventual day of reckoning, and the longer we delay the more we will burden our health service facilities with the provision of care for illness.
and impairment which might have been avoided or minimized.

I might add that the length of time it took to enact Medicare is a good argument for immediate consideration of ways to offer improved health services. The hour is indeed late.

SUPPORT FROM THE MEDICAL PROFESSION

No health program—neither my proposal nor any other—is going to succeed if local physicians and their medical societies during planning stages. I recognize the same need and the same opportunity in planning for the health protection centers provided for in my bill. I think we can demonstrate to the private physician the time-saving virtues of preliminary health estimates as an aid to the diagnostic work he must do personally. Automated summaries are not diagnoses. Rather, they offer a detailed health estimate on which a more complete, more accurate diagnosis may be based.

MANPOWER SHORTAGE

Almost all of the medical experts who had reservations about this proposal brought up the problem of recruiting and training personnel who would be adequately trained on already limited health care personnel.

I am well aware of the statistical shortage of doctors, nurses, aids, and medical research specialists, and the estimated additional numbers needed, for example, by 1975. There is a sizable school of thought, however, which reaches back to medical practice and asks whether we are using our available supply effectively. In the field of nursing alone, many studies have shown the waste of professional nursing time in the performance of manual services or in duties which do not demand their level of professional skill and judgment. I believe it is also common knowledge that many doctors continue to perform services which a nurse or technician could safely provide.

So we need to look at how we are using our health manpower resources as well as at how to recruit and train more of them.

Chronic illness care has not attracted practitioners as has acute medicine and surgery. But I believe there will be a strong attraction to the proposed multiphasic testing projects—because automation is new, because results of the tests are produced rapidly, and because dramatic findings of hereofore asymptomatic diseases often turn up in the patient's health estimate summary.

My proposal also has a built-in safeguard. The health protection centers will receive grants to train their own professional and technical personnel to adapt basic medical and allied knowledge to the demands of the automated procedures.

Now, as to the risk of draining already short supplies of medical manpower in order to offer more efficient preventive services.

It seems to me that the entire national philosophy is geared to the prevention of undesirable circumstances or conditions. We seek to prevent war, to prevent poverty, unemployment, air and water pollution, crime—even to prevent national and local environmental ugliness.

We have never faltered in our forward movement toward these goals for fear of being unable to recruit skilled professional or technical personnel to do the job. We have created the programs—and people have come forward to staff them.

I submit that the comparatively small numbers of medical and paramedical personnel can be found without jeopardizing the practice of medicine and that they will be people with sufficient vision to want to be part of a team which is not undoing damage but preventing it.

Extensive research is being provided to increase supplies of medical manpower of all kinds and to give them training in the management of chronic illness and disability prevention. Surely, these efforts must not and will not bypass the most fundamental service of all—early appraisal leading to early detection of incipient chronic diseases.

My bill provides that any adult aged 50 or over may be admitted to the multiphasic testing program in the region in which he resides.

Many correspondents suggested that younger individuals should be included. They pointed to the advantages of early identification of abnormalities in men of draft age or, for example, of applicability to the mass identification of personnel in our nonprivate sector.

However, it would be unrealistic at this time to hope to reach an entire population—as some have suggested—from infancy onward. Actually, pediatrics practice is in large part preventive and offers sound periodic health maintenance and care services to children.

I have no desire to eliminate the young adults whom we must hand the future. But in order to keep the size and number of the health protection centers within realistic bounds and still to come up with useful results, I thought it advisable to start with the critical decade, the fifties, and to include our older citizens as well, whose limited financial means may keep them out of any program of systematic health examination.

I see this as immediate and essential to back up medicare; to identify the chronic diseases before they become major care problems overtaxing community health resources, and to bring people into desirable treatment programs before they reach the age of eligibility for social security health insurance benefits.

RELATIONSHIP WITH NEW HEART, CANCER, AND STROKE COMPLEXES

Some experts have suggested that the health protection center be part of the regional heart, stroke, and cancer complexes established by truly historic legislation last year.

As I understand that program, which is just beginning, it is to provide for the cooperation of medical schools, clinical research institutions, and hospitals so that the advances in the treatment of cancer, heart, and stroke may be brought to the patient through locally or regionally administered programs of research, training, and continuing education.

This separate program is directed at the treatment of illness and is a coordinated attack on three major killers. My proposal is aimed at early detection and ultimate prevention and maintenance of good health rather than the treatment of illness. I think that it is wiser, so that we can have the fullest discussion and study of the goals and methods of preventive medicine, that the Adult Health Protection Act be considered separately from the heart, stroke, and cancer bill.

It is obvious that the two programs as they develop should be closely coordinated. I think that in actual practice the health protection centers and the heart, stroke, cancer complexes would be in close touch for the coordination and new techniques. Certainly both programs share the same basic goal—the improvement of the Nation's health. Ultimately, they would be joint partners in working toward that goal.

COMPUTER RELIABILITY

Several people have challenged the reliability of computerized testing, pointing out that only a physician is qualified to interpret medical findings, establishing significant relationships by use of his professional judgment.

Let me reemphasize, the computerized health estimate is not a diagnosis. It is a service to the physicians who will make the diagnosis. Furthermore, the health program will be under medical direction. Where determinations are necessary on any of the data, a physician will make them.

I do not think it necessary to defend computer accuracy in numbers any more than in industry or in space science. We have ample evidence from many reports, however, that the computer—of biology, for example—may be more consistently correct than manual readings which cannot be completely free from a margin of human error.

Dr. Ralph Thiers, of Duke University, reported last September that chemistry tests run at three hospitals, both manually and by automatic analysis, proved that the automated method can detect unexpected abnormalities often enough to significantly help physicians to understand and treat their patients. Dr. Thiers said that the data leave little question that a significant number of additional clinical chemistry abnormalities are being discovered by automation which manual analysis had missed.

This is one example.

You are probably aware that the Public Health Service is already developing and testing additional electronic screening methods for detection or measurement of disease—the spiromet, to record lung function important in bronchitis-emphysema; the phonocardiogram, to record heart sound; the electroencephalogram, to record electrical impulses given off by the brain.

Some of you may recall a demonstration in New York in an electronics system for analyzing electrocardiograms. Over 700 civil leaders, including Governor Rockefeller, and my distinguished colleague, Senator Javits, were taken, recorded on tape, transmitted by long distance telephone to a computer at George Washington University, here in the District. The computer took 20 seconds to compare the differences, ECCO with thousands of similar cases stored in its memory. In 3 minutes plus 4 seconds, the heart's ability to transmit electrically, discharge, recharge, and drive itself was determined and printed electrically in New York. The computer also sent back the average number of heartbeats per
minute and gave a brief analysis which have been raised.

Data.

A provocative article in the New Pork Times magazine by Prof. Jean Mayer, the historian on the history of public health. He says: "ought not be established on the basis of decay, mental illness, and arthritis appear insignificant," but on the basis of the White House Conference on Health by Dr. George James, adviser to the President and former New Pork City treurer on the health care legislation was hopefully designed to protect adult health by providing a comprehensive program of services, including mental health services, to protect the health of the elderly.

Mr. President, I ask unanimous consent to print the following:

Mr. WILLIAMS, I have long been convinced that the individual has an inescapable responsibility for his own health that he cannot delegate to any other person or agency. However, it is equally true that each individual has the resources to maintain health, regardless of his status in life. Whenever the demands exceed his physical resources, he must turn to community resources for the additional assistance he needs. It must be remembered that individual resources are not limited to money alone, but include education, knowledge, skills, technique, equipment, and even the desire to maintain good health.

Your proposed health protection centers could be of inestimable value as a community resource to help persons live up to the inescapable responsibility each has for maintaining his own health.

The key to achieving medicare's goal is to improve the health of the nation. The work of the multiphasic screening health protection centers could play a major role in this objective, provided that their facilities were available to everyone, in Georgia, the primary population group, the labor force.

Georgia has a total population of slightly more than 4 million people, living in 1.1 million households. These homes are supported by the salaries and wages of Georgia's 1.1 million wage earners, generally heads of these households, exert more influence upon the remaining 2.5 million Georgians than any other group. They therefore, should be the initial primary beneficiaries of the health maintenance program. The labor force must not only produce the goods and services which are essential to our national life, but also to our national health. A comprehensive program of health care for all workers is necessary to the health of the state and the nation.

Periodic multiphasic screening for early detection and refer to treatment for potentially disabling disease is the best way I can assure the maximum return from the medicare program.

A recommended screening schedule could be: (1) an initial screen at the age of 40, and unless the findings indicate more frequent intervals, rescreening once every 3 years until 50; (2) every 2 years while in the fifties; and (3) a screening once a year beginning at age 60. This schedule, subject to modification with experience, would initiate screenings at the age when the majority of chronic illnesses begin to manifest themselves, accelerating the frequency of screening to detect early signs of illness. It is good business and good medicine to detect persons approaching the eligibility age for medicare, to take reasonable care of the health problems they face, and to reduce the financial burdens they may face. Periodic multiphasic screening for early detection and refer to treatment for potentially disabling disease is the best way I can assure the maximum return from the medicare program.

Mr. President, I ask unanimous consent that a number of articles and letters relating to this proposal be printed in the Record.

The PRESIDING OFFICER. The bill will be received and appropriately referred; and, without objection, the articles and letters will be printed in the Record.

The bill (S. 2893) to amend the Public Health Service Act by adding a new title to protect adult health by providing a comprehensive program of services, including mental health services, to protect the health of the elderly.

Within the Georgia Department of Public Health we have developed and are operating a program of health protection centers for the detection of disease, by providing assistance for the training of personnel to operate such centers, and by providing assistance in the conduct of certain research related to such centers and their operation, introduced by Mr. WILLIAMS of New Jersey (for himself and Mr. METCALF), was received, read twice by its title, and referred to the Committee on Labor and Public Welfare.

The articles and letters presented by Mr. WILLIAMS of New Jersey are as follows:
I am trying to do. In fact, I sincerely hope that you will go on to develop the program. I know that most of us are realists in the sense that we believe that prevention is more economical of money and human suffering than is treatment. We have been trained in disease and illness as the control mechanism to keep manageable. By using multiphasic screening a scheduled health examination, we can keep manageable. And we can concurrently achieve another major objective—maintenance of health and productive capacity of our labor force.

Please accept my personal thank you for devoting your attention and energies in this field of preventive medical services so that badly needs your assistance. Do not hesitate to call upon me if I can help you in any way.

Sincerely yours, 
LESTER M. PETRE, M.D.,
Director, Branch of Preventable Diseases.

MICHIGAN DEPARTMENT OF HEALTH,

Hon. Harrison A. Williams, Jr.,
U.S. Senate,
Washington, D.C.

DEAR SENATOR WILLIAMS: I was very happy to hear about your work in providing screening and preventive medical services to the adult population. We have, as you implied in your speech to the Congressional Record, accomplished a great deal in terms of legislation for caring for the sick and disabled. Under the amendments to the Social Security Act, the Medicare and other maternal and child health services. The sick are given the benefits of modern curative medicine in two early stages of life—early life from conception until the age of 21 and later for the older person 65 years of age and over. This is being done for the group in the great productive years from 21 to 64 to conserve the health of those who must work and pay the taxes to care for the two groups aforementioned. Any program that can assist in the conservation of this group should be rich dividends and should be extended to society as a whole. The provisions of Medicare and the new legislation for regional health services for heart disease and stroke, and related diseases will not solve our problem of preventing disease and disability. Multiple or multiphasic screening, a scheduled health examination, is an important component for the early detection of incipient chronic disease and disability. Disease is being detected in people who presumably have abnormalities from those who presumably do not. Such activities save the time of the physician who can spend his time in a more productive manner for those who need his diagnostic and treatment skills and acumen rather than use a disproportionate part of his time for examination of healthy individuals. When such tests can be done by technicians and automated, they can be done expeditiously and at very modest cost.

In Michigan we have been doing multiple screening for a long time. These have been done mostly in apparently healthy young adults employed in small industries. The results of these have been very satisfactory and have revealed that many people who believe they are perfectly well have conditions which predispose them to disease or are beginning chronic diseases which have not as yet become symptomatic. Ideally, screening examinations should be done on all people 30 years of age and over but as a beginning I think they should start not later than 45 to 50 years of age. Until the medical profession is given the necessary time and support to do such screening, the ideal of a complete annual physical inventory for every person is not feasible to practical attainment for obvious reasons. Physicians have been trained to diagnose and treat overt disease and disability. They have had little training in preventive medicine and not oriented to conservation of health. Our present job is as the physician of the patient unless they are either sick or have pain. For these reasons, as well as the fact that if all for an annual physical examination there would not be enough physicians available to treat the sick, it makes the provision of annual physical examinations on a mass basis impractical. Nevertheless, it can be the means of detecting symptomatic disease and in promoting health, to a large degree the illness. In my opinion the time has come for us to prevent sickness rather than spending all of our time in patching up those who are already sick or disabled. The greatest thing that could be done for the older population is to find, treat and counsel those in the great middle years when they are incubating the diseases which will later cause them to require prolonged care and hospitalization.

I am enclosing from some of the multiple screening programs that have been done here in Michigan.

Incidentally, if you plan to have hearings on this legislation when it is introduced, the association of State and Territorial Chronic Disease Program Directors, of which I am the current president, would appreciate an invitation to testify.

Sincerely,
JOHN A. COWAN, M.D.,
Director, Division of Adult Health.

TULANE UNIVERSITY,
SCHOOL OF MEDICINE,
New Orleans, La., December 1, 1965.

Hon. Harrison A. Williams, Jr.,
U.S. Senate,
Washington, D.C.

DEAR SENATOR WILLIAMS: I wish to acknowledge receipt of your letter of November 23 and the attached copy of your Senate speech outlining the need for a health maintenance program. I will appreciate it if you will send me information on the proposed legislation as it develops.

I fully agree with your views and can only reinforce your suggestion that the passage of Public Law 89-97 makes a program of screening and preventive services feasible. Meanwhile, I wish to include a copy of Vårfrun study carried out in New York. The report of this study and it seems that in 2 years' time this is intended to cover all of the Swedish population. The meeting in Värmland in September of last year was attended by Dr. James W. Sweeney, vice president, director, Tulane biomedical computing system, because the Swedish study is tied in with the Tulane computer. Many of the automated techniques of recording have been worked out by Dr. Sweeney. You will therefore understand our interest. We are presently negotiating with the Public Health Service the establishment of a multiple screening program for elderly persons in New Orleans.

May I add my congratulations for your leadership in developing this excellent program.

Yours sincerely,
J. C. S. ANDERSON, M.D., P.R.C.P.,
Associate Dean and Director.

THE UNIVERSITY OF ALABAMA,
MEDICAL CENTER,

Senator Harrison A. Williams, Jr.,
U.S. Senate,
Washington, D.C.

DEAR SENATOR WILLIAMS: You are to be congratulated on your interest in the need for a health maintenance program for Americans. Automated centers such as described by Dr. Sweeney at Tulane could provide a partial answer to improving health. I would personally be very pleased if I lived close enough to take advantage of the comprehensive screening program described by Dr. Colen.

If one considers the economical value of keeping our most productive age group on the job, the program could justify consideration of such massive screening starting even earlier 50 to 50 years of age. If a person is healthy at age 40 and there are still 25 years of productive work years to be expected, this may prove to have more economic value on our economy than the detection of the person who has only 15 years of expected productivity, or who has retired from the work force.

I would like to have any information you have in regard to the proposed bill to provide disease detection and preventive care. The bill will include specific provisions for the educational programs which are necessary for such disease detection centers to be truly productive in people in the community or the individual. These components should consider both those necessary for education of professional people and for education of the lay public.

I shall appreciate any information you can send me about the developments in regard to your proposed bill. Please accept my best wishes for your success.

Sincerely,
Helen L. Tynin, Ph.D.,
Assistant Professor of Preventive Medicine and Public Health.

FEDERATION OF JEWISH PHILANTHROPIES OF NEW YORK,

Senator Harrison A. Williams, Jr.,
U.S. Senate,
Washington, D.C.

DEAR SENATOR WILLIAMS: Thank you very much for the opportunity to comment on your proposal to establish an adult health education program under the terms set forth in the bill which accompanied your letter of November 23, 1965.

When we examine the natural causes of death, we find that cancer is the leading cause of death during the period during which the disease is developing but goes unrecognized. It is not accompanied by recognized symptoms, nor does the involved person feel the need for medical care.

The above stage may very well antedate age 60, and I am in agreement with you that the need for a sound health maintenance program could bring substantial benefits to individuals at age 60.

I regret that my present professional services are limited to finding case studies and statistical data applicable to your project. I can, however, advise you that hospitals are beginning to introduce the practice of doing repeat tests on patients admitted to their inpatient accommodations. The belief is growing that the person of 50 is at risk. Instead of the individually selected tests related to a patient's clinical needs, is no higher and the higher productivity of meaningful results enables the physician to render a better qualitative service to his patient.

One of the hospitals which has instituted this practice, involving automated equipment, is the Mount Sinai Hospital, 100 Street and 5th Avenue, New York, N.Y. You may wish to get in touch with this program directly from Martin R. Steinberg, M.D., director.

I am taking the liberty to suggest that your office contact George James, M.D., former commissioner of health and presently dean of the Medical School of Medicine and executive vice president of medical affairs. He has spoken and written extensively on heart disease and is now arguing his tenure as commissioner of health, helped organize plans for a municipal hospital to include comprehensive medical services, health center programs, welfare center activities and community mental health programs. His heart health center deals with the problems of all age groups in much the same manner you propose for the older groups.

I am heartily in favor of what you want to accomplish through your proposed pro-
The population of this hospital's core area is approximately 500,000 with 50,000 to 60,000 individuals 65 years of age or older. In many parts of this area there is an estimated gap to 90 percent incidence of cataracts, which is the most desirable age for initiating periodic health examinations.

I hope that the preceding proves useful to you in considering the scope of your legislation.

Sincerely yours,

SAM SLEPZEN,
Director, Division of Research and Statistics.

STATE OF MARYLAND,
DEPARTMENT OF HEALTH,

Hon. Harrison A. Williams, Jr.,
U.S. Senate,
Washington, D.C.

Dear Senator Williams:

In reply to your letter of December 19, the following information is offered.

The Brookdale Hospital Center, at all levels—board of trustees, medical board, and staff—has recognized the need for dramatic changes in the traditional role of the general hospital as a provider of health care. We have therefore gone on record as committed to involvement in programming for the health needs of the community. Further, we have accepted the challenge of changing their role as health care providers, will receive the support they so urgently need to meet this challenge.

Cordially,

Léo Gitman, M.D.
Chief, Gerontology Section.

HEALTH INSURANCE PLAN OF GREAT NEW YORK,

Hon. Harrison A. Williams, Jr.,
U.S. Senate,
Washington, D.C.

My Dear Senator Williams:

This is in response to your letter concerning your proposal for a health maintenance program for Americans.

One of the benefits covered by the premium in the Health Insurance Plan of Greater New York is periodic general physical examination (including blood pressure determination, urinalysis, and a set of laboratory tests) for all persons age 20 and over who participate in the plan. The periodic examinations are intended to determine the value of periodic screening examinations of the breast for the lowering of mortality from breast cancer. Each breast examination includes palpation by a highly qualified clinician and mammography (soft tissue X-rays) of the breast if the screening program leads to the detection of a significant number of breast cancers that would have otherwise been undiagnosed and that a large proportion of the cancers are still localized when found. Additional observations are being made to see whether these results are also where mortality is improved because of the earlier detection of breast cancer.

With regards to your proposal, it represents a means for overcoming many of the present deterrents to increasing the proportion of persons with cancer who are detected periodically to receive a comprehensive physical examination. These deterrents include high cost, lack of accessibility to the facility, and the busy time on physician time which is already in short supply. However, there are several factors which would militate against the宣扬 of regional health examination centers which deserves attention. For instance, it may be beneficial to spread the network sufficiently to make the facilities accessible to the population in rural and urban areas, in the North, South, and West. Also, how will the program relate to the physician responsible for the follow-up care of the patient so as to avoid fragmentation and discontinuity of care? Also, is there any reasonable age for instituting periodic health examinations?

I hope that the preceding proves useful to you in considering the scope of your legislation.

Sincerely yours,

SAM SLEPZEN,
Director, Division of Research and Statistics.
Here then is an excellent example of a screening test to prevent a chronic permanent illness, which must be carried out at 3, 4, or 5 years of age.

As you well know the country was startled to learn from the medical examinations by Army Officers in World War II, that 1 out of 23 men were blind in one eye and usually didn’t know it. At this rate each year 100,000 children need immediate checking at the point at which they can be rescued—all for want of a simple, inexpensive and brief vision screen test to prevent loss of useful vision.

These two examples of screening tests are but a few of the many examples which I could give you to illustrate the enormous potential of early detection of chronic and disabling diseases at a stage where their disabling effect can be prevented or greatly ameliorated.

Diabetes can now be readily detected through tonometry, but organized community action by professionals is needed to ensure that detection is followed by adequate treatment aimed at retarding further development of blindness; this treatment, however, cannot be started until the patient is seen by a physician, thus broadening his capacity to detect the disease.

Now that large expenditures are about to be made for chronic illness and disabilities in old citizens (for conditions which often could have been prevented or mitigated), your letter which strikes a note for an early detection program is timely. Detection of new cases of heart disease, cancer, hypertension and arteriosclerosis is an essential complementary component to the regional medical complex just passed by the Congress. Screening examinations have particular application to medically indigent populations in case finding.

In Maryland, I look forward to the development of screening facilities—health protection centers to use your phrase—as a well established year round service in all of our 24 local health departments. This Department will fully support your efforts to achieve this.

I would especially like to congratulate you on the proposals for the National Health Act recently submitted by your groupan organization of 100 local health departments on the basis of the principles and procedures of the Adult Health Protection Act of 1966 and the Adult Health Program of the 1967 Medicare Bill. The Congress and the President have been under way in their considerations for these proposals.

As an indication of my interest in this matter of disease detection, I am enclosing a portion of a speech to the American Public Health Association on the subject of disease detection and prevention and in the case of children who need health care.

As an indication of my interest in this matter of disease detection, I am enclosing a portion of a speech to the American Public Health Association on the subject of disease detection and prevention and in the case of children who need health care.

Sincerely yours,

WILLIAM J. PEPPLE, M.D.,
Commissioner.


Hon. HARRISON A. WILLIAMS, Jr., U.S. Senate, Washington, D.C.

Dear Senator Williams: I have received two letters from your commission and staff on the subject of disease detection and prevention and in the case of children who need health care.

As an indication of my interest in this matter of disease detection, I am enclosing a portion of a speech to the American Public Health Association on the subject of disease detection and prevention and in the case of children who need health care.

Sincerely yours,

JOSEPH H. CANNON, M.D., M.P.H.,
Director of Health.

CITY OF MILWAUKEE Health Department
MILWAUKEE, Wis., December 2, 1965.

Hon. HARRISON A. WILLIAMS, Jr.,
U.S. Senate, Washington, D.C.

Dear Sir: I have received two letters from you, both dated November 30, 1965, relating to a proposed Adult Health Protection Act of 1966. One letter was addressed to me as commissioner of health of the city of Milwaukee, the other was routed to the Marquette University School of Medicine, where I am chairman of the department of public health.

I have reviewed the summary of your proposed legislation without deciding whether to support it. I have no opinion about the intent and scope of the proposed legislation.
The Milwaukee Health Department already possesses an appreciable quantity of automated equipment needed to carry out a broadly based multiphasic screening test program in this community. Currently, the principal impediment to launching a full-scale program is the lack of financial support to employ the necessary personnel. I am engaged in pursuit of some limited financial assistance from the Public Health Service for this purpose. I believe that further study may show that a price tag of $50 might be a realistic upper limit in a program designed to detect indications of disease. For every $50 spent, 50 men or women might receive an early diagnosis of disease. Early diagnosis is an essential step to the institution of early treatment.

The only significant criticism I have of the proposed Adult Health Protection Act of 1966, as summarized in the enclosure transmitted with your letter, relates to establishment of five health protection centers, to be carried out as of the date by establishment of health protection units linked to centers by data transmission lines. I believe that one or two health protection centers, to carry out the functions delineated in the third paragraph of the second page of your summary, would be in order. The most meaningful benefits of a multiphasic screening test program should be available through rapid development of many health protection units in many communities.

I feel that there is a strong need for the health protection units to be linked by data transmission lines to the centers, where interpretation of some tests, such as electrocardiographic tracings, could be performed by centralized electronic equipment. Small, highly sophisticated electronic interprocessors will soon be available at a cost low enough to justify their placement in the individual health protection units. For example, if cancer of the uterine cervix is to be reduced as a major public health problem, early diagnosis must be aimed at those women in their early twenties. There are many other examples, most of which I am sure you are well aware. I merely want to point out that in my opinion, there should be no age restriction relative to the eligibility of medical care of this sort.

You are to be congratulated for your active interest in and support of this particular type of health maintenance program. I hope you will be able to keep us informed of further developments on the proposed legislation.

Sincerely yours,
MICHAEL E. DEBANEY, M.D.
THE UNIVERSITY OF TEXAS, AUSTIN, TEXAS

DEAR PETER: I am taking the liberty of sending you a copy of the resolution which was passed by the New Jersey Ophthalmic Association on November 9, 1966, to your attention.

I am enclosing a news release that was sent to the public information office regarding our resolution. This was sent to all the dailies and weeklies in the State.

Pete, I think it is of great significance and I hope that it will motivate you to build this committee. I believe that a prevention resolution was passed unanimously by those in attendance at our annual meeting, Sunday, December 5, 1965.

Secondly, I am enclosing a news release that was sent to the public information office regarding our resolution. This was sent to all the dailies and weeklies in the State.

Pete, I think it is of great significance and I hope that it will motivate you to build this committee. I believe that a prevention resolution was passed unanimously by those in attendance at our annual meeting, Sunday, December 5, 1965.

The New Jersey Ophthalmic Association is to be congratulated for its position on the need for a health maintenance program. I believe that a prevention resolution was passed unanimously by those in attendance at our annual meeting, Sunday, December 5, 1965.

I am most impressed with the insight into the natural history of most chronic diseases which is suggested by the proposal. As much as the only possibility for significantly altering the impact of the chronic diseases on our population, the proposals for prevention, diagnosis, and treatment are indicated.

You are aware, I am sure, that much of the health progress of this century has been achieved through the application of public health procedures which either prevent disease from developing, or prevent its development to a more advanced stage when treatment is ineffective or less effective.

I would hope that these procedures would be extended to include appropriate attention to the application of existing screening procedures on a broad basis. One would wish to further hope that research for the development of new screening techniques and for the most effective methods of organizing such activities would be a high priority.

Much of my conviction regarding these proposals stems from my interest in the field of medicine and the disease process itself. I have been led to an opportunity to survey various patient populations receiving care for long-term disease, and the study of revealing health events and cancer programs of great importance, both of these are essentially therapeutic programs and are in some respects the prevention of the chronic diseases of aging which are so important today. We believe that the preventive approach to these diseases is the only one which will produce long-lasting results. When once these diseases have started, therapy can be at best ameliorate but can rarely cure. Very early detection is vitally important.

Our other point of disagreement reflects what you yourself have said in the second paragraph of your letter—that further study must be done. For instance, I believe that any program designed to detect indications of disease. For every $50 spent, 50 men or women might receive an early diagnosis of disease. Early diagnosis is an essential step to the institution of early treatment.

The purpose of this letter is to express to you what I feel to be the very great importance of programs designed primarily for the earliest possible detection of any disease process. Since the head of our research computer center here at the medical branch is also a member of the health protection unit, you can understand that we feel that a program such as you visualize will definitely entailing the development of automated or semiautomatic centers.

Whereas I can understand why you would wish to give priority to those individuals 50 years of age and over, I should also like to emphasize the importance of providing such services to all age groups. Just as a single example, if cancer of the uterine cervix is to be reduced as a major public health problem, early diagnosis must be aimed at those women in their early twenties. There are many other examples, most of which I am sure you are well aware. I merely want to point out that in my opinion, there should be no age restriction relative to the eligibility of medical care of this sort.

You are to be congratulated for your active interest in and support of this particular type of health maintenance program. I hope you will be able to keep us informed of further developments on the proposed legislation.

Sincerely yours,
DON W. MERRIN
Professor and Acting Chairman, Department of Preventive Medicine and Public Health

DEAR SENATOR WILLIAMS: I have read with interest your letter of November 23, 1965, along with a summary of legislation now being drafted to establish health protection centers.

I certainly feel a broadly based multiphasic screening test program should be available to any person age 50 or over who desires to participate. To limit the program to persons 65 years of age and over would seriously impair one of the primary purposes of the Public Health Service for this purpose. The purpose of this letter is to express to you what I feel to be the very great importance of programs designed primarily for the earliest possible detection of any disease process. Since the head of our research computer center here at the medical branch is also a member of our departmental staff, you can understand that we feel that a program such as you visualize will definitely entail the development of automated or semiautomatic centers.

Whereas I can understand why you would wish to give priority to those individuals 50 years of age and over, I should also like to emphasize the importance of providing such services to all age groups. Just as a single example, if cancer of the uterine cervix is to be reduced as a major public health problem, early diagnosis must be aimed at those women in their early twenties. There are many other examples, most of which I am sure you are well aware. I merely want to point out that in my opinion, there should be no age restriction relative to the eligibility of medical care of this sort.

You are to be congratulated for your active interest in and support of this particular type of health maintenance program. I hope you will be able to keep us informed of further developments on the proposed legislation.

Sincerely yours,
DON W. MERRIN
Professor and Acting Chairman, Department of Preventive Medicine and Public Health

THE UNIVERSITY OF TEXAS, AUSTIN, TEXAS
some of the complications demonstrated by these patients. That I continue to record deaths from cancer of the cervix in females, that blindness due to glaucoma continues to be diagnosed, that we constantly need to remind ourselves concerning the unknown diabetic in the population—all of these serve as justification for the program which you have envisioned. I will be interested in hearing how the proposed legislation will be received in Congress. Thank you for the opportunity to express my feeling.

Very truly yours,

Charles C. Cameron, Jr., M.D., M.P.H.
Professor, Public Health Administration.

THE JOHNS HOPKINS UNIVERSITY
School of Hygiene and Public Health

Hon. Harrison A. Williams, Jr.,
Senate Office Building,
Washington, D.C.

Dear Senator Williams: I wish to add my strong support for your proposed Adult Health Protection Act of 1966. The proposed legislation, I believe, would represent a most important contribution to the enormous problems we face in delivering medical care to individuals and communities efficiently and effectively.

One of the greatest health challenges to our nation on the categorical, disease oriented, approach both to medical research and to medical treatment, and the professional approaches which have been associated with enormous advances in our fundamental understanding of disease processes. In the long haul advances in the health of the people, both through prevention and through medical care, will come from such work. In the short haul, however, this approach relies on the cooperation of optimum medical care and the prompt delivery of what knowledge we now have. In the short haul it is medical care which interests society and it is early diagnosis which provides the greatest opportunity for favorably influencing the health of those now alive.

I have visited Dr. Morris Collen's "multiple health checkup program" in Oakland and believe in many respects it represents an important component in the medicine of the future. The approach to the study of the sensitivity, specificity, yield and costs of the various tests employed are most important aspects of the work at Kaiser-Permanente.

I support your approach to the initial establishment of five centers in appropriate universities. There is still much work to be done on the development of health protection centers before they could be efficiently utilized on a large scale by smaller institutions. Nevertheless their full impact can only be realized when such facilities are made available in local community institutions. For this reason the phasing of your proposed program seems appropriate.

I hope you will keep me informed about the development of the proposed legislation. If there is anything I can do to add my support, please let me know.

Sincerely yours,

Kerr L. White, M.D.,
Professor and Director,
lic health stood by watching, support lacking. In typically American fashion the pendulum has swung before swinging back. Now the shelves are brimming with unused medical discoveries and techniques. And enlightened congressional leaders like yourself are evidencing more awareness of this fact than the medical profession itself.

Perhaps then, with this type of support, health protection centers can be developed, effective local health departments can be financed, and dividends from the billions of dollars expended on basic research can finally be used for the full benefit of people. Since yours,

A. L. CHAPMAN, M.D.,
Assistant Surgeon General (Retired),
U.S. Public Health Service.

STATE OF NEW JERSEY,
DEPARTMENT OF HEALTH,

Hon. HARRISON A. WILLIAMS, Jr.,
Senator, Office Building,
Washington, D.C.

Dear Senator Williams: Your proposal to establish health protection centers is bold and stimulating. Your presentation to the Senate was masterful.

The logic of periodic examinations is clear. It is strange that the mechanism is used so little.

I have been interested in "multiphasic screening" for a long while, but have had very limited success. My enthusiasm has waned, but could readily be revived.

The Kaiser Foundation pilot program should provide new understanding with respect to yields, acceptance and use by people and costs per remediable defect found. I have not seen papers coming out of the Kaiser project. I notice that in Dr. Collen's letter, which you quoted, he said that cumulative statistical data were not then available.

We do fairly well in diabetes detection in New Jersey, but are having a hard time on cervical cancer testing. The latter is expensive as it is now done. Additional Federal dollars are about to be put into cervical cancer and I hope that they can be referred for diagnosis and, if indicated, for medical care. The importance of adapting each endeavor to the special interests, needs and capabilities of the community being served. Efforts to introduce comprehensive sophisticated programs will succeed in some areas but not in others. In the latter case it is far better to begin on a modest scale that is acceptable and feasible. Both situations require extensive planning and preparation. Participation of local physicians, paramedical personnel and related official and voluntary health agencies is essential.

You raised the question of a minimum age of eligibility for multiphasic screening. We feel that there should be no arbitrary age limitation. Though in general the yield of newly detected disease is higher among older persons, it is not always so. For example, amblyopia ex anopsia ("lazy eye") is a disease of early childhood. The best opportunity for correction of this significant cause of blindness arises when it is detected and treated before the patient is 5 years old. The most efficient screening programs direct their attention primarily to segments of the population with high prevalence of the condition to be detected. Age is an important but by no means the only factor used to identify such populations.

We hope these comments will be helpful. Please do not hesitate to call on us if we can be of further assistance.

Very sincerely yours,

LESTER BRESCLOW, M.D.,
Director of Public Health.