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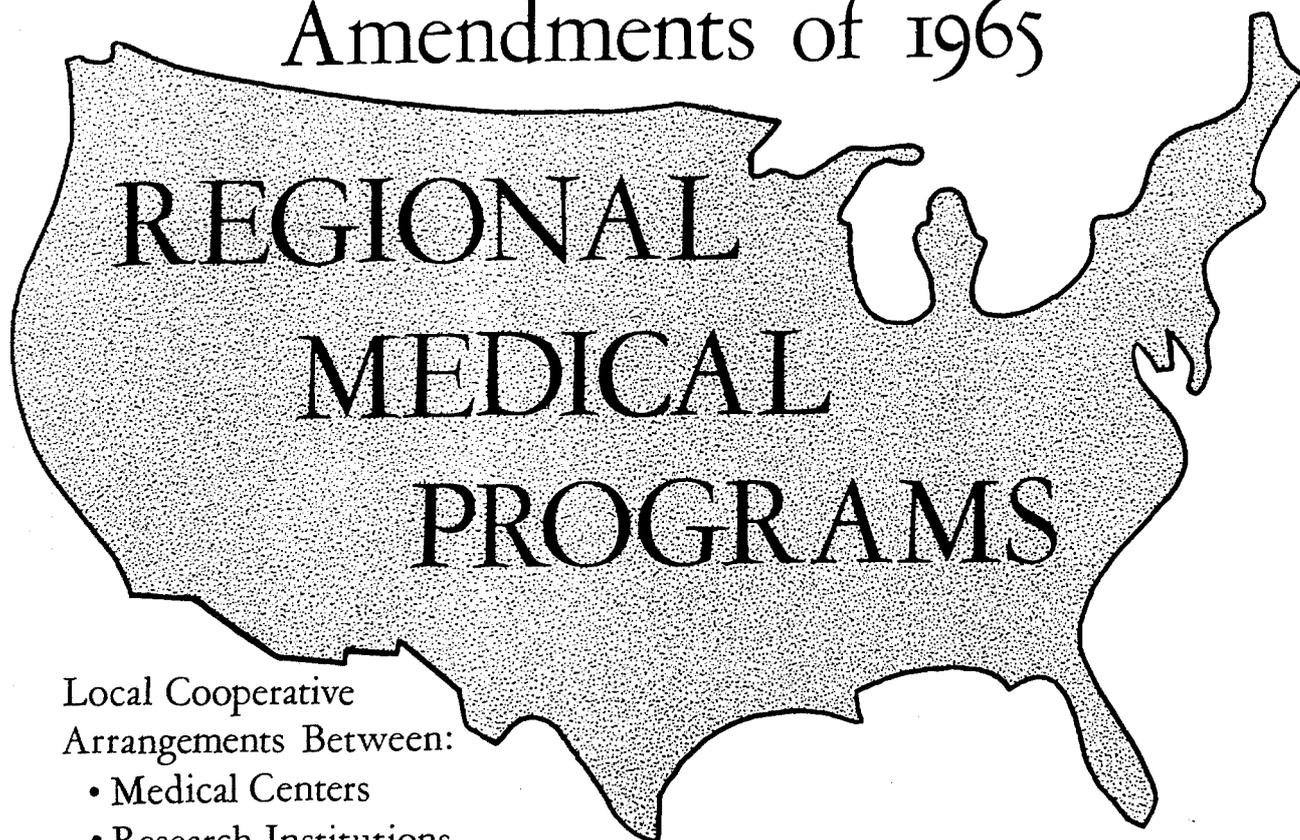
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HEALTH
EDUCATION
AND WELFARE

Indicators

November 1965

Heart Disease, Cancer, and Stroke Amendments of 1965



Local Cooperative
Arrangements Between:

- Medical Centers
- Research Institutions
- Hospitals



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the Under Secretary



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REGIONAL MEDICAL PROGRAMS: THE HEART DISEASE, CANCER, AND STROKE AMENDMENTS OF 1965 (P.L. 89-239)

Karl D. Yordy and Jane E. Fullarton

Passage of the Heart Disease, Cancer, and Stroke Amendments of 1965 (P.L. 89-239) marks the launching of a major assault on the Nation's three major killing diseases: heart disease, cancer, and stroke. The Amendments, signed into law by President Johnson on October 6, 1965, implement the major recommendations of the 1964 Presidential Commission to study the problems and recommend means to achieve significant advances in the prevention, diagnosis, and treatment of these three disease groups which today exact such a staggering toll of human life and suffering. In 1963, heart disease, cancer, and stroke accounted for 71 percent of all deaths in the United States, causing nearly 1¼ million deaths in that year alone.

The principal purpose of the new program is to provide the medical profession and medical institutions of the Nation greater opportunity to make available to their patients the latest advances in the diagnosis and treatment of heart disease, cancer, stroke, and related diseases. This is to be accomplished through the establishment of regional programs of cooperation in research, training, continuing education, and demonstration activities in patient care among medical schools, clinical research institutions, and hospitals.

Provisions of the Bill

To accomplish these goals, P.L. 89-239 authorizes a three-year, \$340 million program of grants for the planning and establishment of regional medical programs. These grants would provide support for cooperative arrangements which would link major medical centers--usually consisting of a medical school and affiliated teaching hospitals--with clinical research centers, local community hospitals, and practicing physicians of the Nation. Grants will be made for planning and for feasibility studies, as well as for pilot projects to demonstrate the value of these cooperative regional arrangements and to provide a base of experience for further development of the program.

The objectives of the legislation are to be carried out in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies, and without interference with patterns or the methods of financing of patient care, or

Mr. Yordy is a Branch Chief and Miss Fullarton is a Legislative Analyst on his Staff, Office of Program Planning, National Institutes of Health, Public Health Service, U.S. Department of Health, Education, and Welfare.

REMARKS BY PRESIDENT JOHNSON
UPON SIGNING THE
HEART DISEASE, CANCER, AND STROKE AMENDMENTS OF 1965

October 6, 1965

Before this year is gone, over a million productive citizens will have been killed by three murderous diseases. Seven out of ten Americans who lose their lives this year will be the victims of heart disease or cancer or stroke.

Now these are not dry statistics; these are deadly facts whose anguish touches every single family in this land of ours.

This year, in this Nation at least twenty-five million people are going to be crippled by heart ailment.

More than two million citizens are survivors of stroke.

The economic cost of this death and disease is staggering beyond one's imagination; an estimated 45 billion dollars last year alone; more than \$4 billion annually just in direct medical expenses.

And the cost in human agony is far too great to ever tell.

With these grim facts in mind . . . I appointed a commission to recommend national action to reduce the toll of these killer diseases. . . .

One of the world's great surgeons and teachers, Dr. Michael DeBakey of Houston, Texas, headed this commission. Their report last December set forth a series of extremely bold and daring proposals -- the seeds which will grow and flower into a much healthier America. . . .

And then the careful deliberation of both committees of both Houses produced this measure -- the Heart Disease, Cancer and Stroke Measure of 1965.

Its goal is simple: to speed the miracles of medical research from the laboratory to the bedside.

Our method of reaching that goal is simple, too. Through grants to establish regional programs among our medical schools, clinical research institutes, we will unite our Nation's health resources. We will speed communication between the researcher and the student and the practicing physician.

Our Nation desperately now needs more medical personnel. Under this Act, we will make the best use of existing medical personnel in these critical diseases, and then we will start improving the training of these specialists.

Our Nation desperately needs better medical facilities and better equipment, and under this program we will get them -- and we will use them to help the victims of these killer diseases.

Our Nation desperately needs to help physicians and health personnel continue their education, and this Act will make that help possible.

We cannot close the dark corridor of pain through which sufferers must pass. But we can do all that is humanly possible to increase the knowledge about these diseases -- to lessen the suffering and to reduce the waste of human lives.

It has been written: "Men who are occupied in the restoration of health to other men are above all the great of the earth. They even partake of divinity, since to preserve and renew is almost as noble as to create."

professional practice, or with the administration of hospitals. To insure this cooperation, the grant applicant must designate an advisory group to advise the applicant together with the participating institutions, in formulating and carrying out the plan for the establishment and operation of that regional medical program.

The legislation authorizes appropriations for \$50 million for FY 1966, \$90 million for FY 1967, and \$200 million for FY 1968, the funds for each fiscal year to remain available until the end of the following fiscal year as well. Grants may be made to pay all or part of the cost of the planning and other activities related to establishment of the regional medical programs. Funds for renovations and built-in equipment, however, may not exceed 90 percent of the cost.

The National Advisory Council on Regional Medical Programs will be appointed to advise and assist the Surgeon General in the formulation of policy and regulations regarding the regional medical programs, and to make recommendations to him concerning approval of applications and amounts of grant awards. The Council will consist of the Surgeon General as Chairman, and twelve leaders in the fundamental sciences, the medical sciences, or public affairs. In particular, one of the twelve council members must be outstanding in the field of heart disease, one in cancer, and another in stroke, and two must be practicing physicians.

To assist physicians and other interested persons, the Surgeon General must establish and maintain a current list of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer, and stroke. The Surgeon General may also maintain a record of the advanced specialty training available in these institutions, along with other information he deems necessary. In order to make this information as useful as possible, the legislation requires the Surgeon General to consult with interested national professional organizations.

The Surgeon General is also required to make a report to the President and the Congress by June 30, 1967. In addition to recounting the activities carried out as a result of this legislation, the report must analyze the effectiveness of the activities in meeting the stated objective of the regional medical programs, as well as recommendations for extension and modification of this important program.

Background

In his Special Health Message to the Congress in February 1964, the President stated, "I am establishing a Commission on Heart Disease, Cancer, and Stroke to recommend steps to reduce the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge we already have." When the Commission was convened at the White House in April, the President said, "Unless we do better, two-thirds of all Americans now living will suffer or die from cancer, heart disease, or stroke. I expect you to do something about it."

With this mandate, the Commission set about to determine what could be done. The Commission heard testimony from scores of leaders in medicine and public affairs. Its overwhelming conclusion was that something could and must be done to reduce the deaths and disability caused by heart disease, cancer, and stroke. The Commission cited the many advances in diagnostic and therapeutic techniques made possible by the rapid progress of medical science. Further progress can be expected through exploitation of the results of the greatly expanded medical research effort. The testimony of leading medical experts convinced the Commission that the toll of these diseases could be reduced significantly if the latest medical advances already developed or developed in the future through extended research opportunities could be made more widely available to our citizens. They believed that there was danger of an increasing gap between the diagnostic and therapeutic capabilities found in the major medical centers--where an effective interplay between research, teaching, and patient care can bring rapid and effective application of new medical knowledge--and the medical capabilities available more widely in the communities. The Commission recognized that the complexities of modern techniques in the fields of heart disease, cancer, and stroke make more difficult the task of making these techniques available to more disease victims. Believing that the medical resources of this Nation were equal to this challenge if given the necessary assistance and encouragement, the Commission presented a series of recommendations aimed at reducing the toll of these diseases through the development of more effective means of bringing the latest medical advances to the benefit of more people and through the provision of additional opportunities for research. The major recommendations of the Commission are the basis for the proposed regional medical programs authorized by P.L. 89-239.

Legislative History

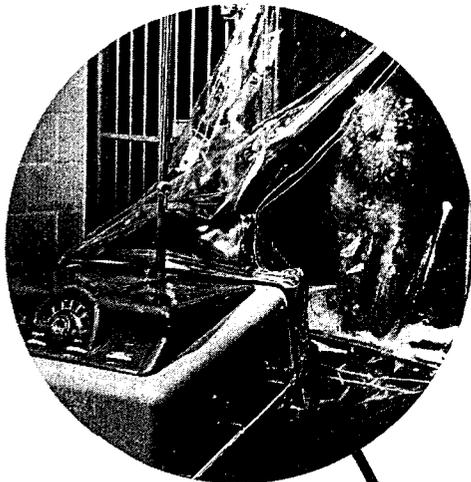
President Johnson's first legislative message to the 89th Congress sent on January 7, 1965, called for a broad health-care program, including regional medical complexes to combat heart disease, cancer, stroke, and other major illnesses. On January 19, companion administration bills--S. 596 and H.R. 3140--were introduced in the Senate by Senator Lester Hill and in the House by Representative Oren Harris, giving concrete, legislative form to the President's proposals.

The bills were submitted to the Committee on Labor and Public Welfare in the Senate and the Committee on Interstate and Foreign Commerce in the House. After being reported with amendments by the respective committees, and further floor amendments in the House, the Senate passed the bill on June 28, 1965, and the House passed it on September 24, 1965.

The Senate-passed bill stayed closer to the original Administration bill than did the House-passed bill. The House-passed version provided for appropriation of specific amounts for fiscal years 1966, 1967, and 1968. The Senate bill included funds for fiscal 1969.

The House bill provided for planning, conducting feasibility studies, and operation of pilot projects for establishment of regional medical programs. A regional medical program was defined as a cooperative arrangement

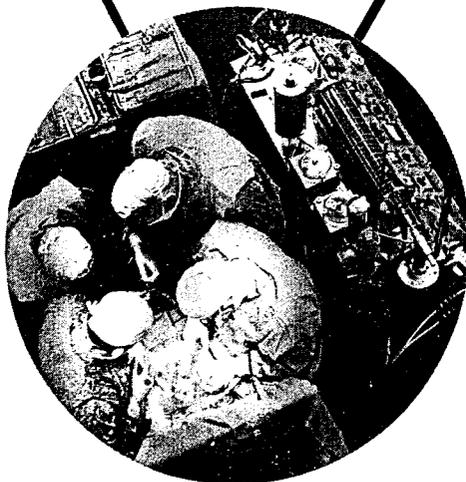
Regional Medical Programs Aim at Effective Interrelationship of Research, Teaching, and Patient Care



RESEARCH



TEACHING



PATIENT CARE

*Photos courtesy of
National Institute of Health*

among a group of institutions or agencies engaged in research, training, diagnosis, and treatment related to heart disease, cancer, and stroke and related diseases. The group was to be constituted similarly to the regional medical complex group under the Senate-passed bill, except that the term "categorical research center" was changed to "clinical research center," and the term "diagnostic and treatment station" was changed to "hospital." A "hospital" was defined as a health facility in which local capability for diagnosis and treatment is supported and augmented by the program undertaken under the bill. Thus, further emphasis was put on supplying assistance through physicians, rather than directly to patients.

The House-passed version of the bill was more acceptable to the medical community than the Senate-passed bill. On September 29, 1965 the Senate agreed to the House amendments, clearing the bill for the President. On October 6, 1965, President Johnson signed it into law at the White House.

Nature of the Program

Basically, the new legislation provides support for cooperative arrangements among medical institutions and practitioners which are planned and established on a regional basis. The legislation was purposely written broadly to provide essential flexibility for the regions of the Nation to exercise initiative in mobilizing their existing resources to meet their needs as they perceive them.

There are certain elements, however, which will be essential components of a planning or pilot project application. The applicant for a grant may be any public or nonprofit private university, medical school, research institution, or other public or nonprofit private institution and agency interested in planning, conducting feasibility studies, and in operating regional medical programs of research, training, and demonstration activities in their own region of the Nation. Under the provisions of the law, a "regional medical program" is a cooperative arrangement among a group of institutions engaged in research, training, diagnosis, and treatment related to heart disease, cancer, and stroke. The region to be served will be a geographic area composed of part or parts of one or more States which the Surgeon General determines to be appropriate for the purposes of the program. The plan for the development of a regional medical program must include the participation of one or more medical centers (defined as a medical school or other medical institution involved in post-graduate medical training and the hospitals affiliated for teaching, research, and demonstration purposes), one or more clinical research centers, and one or more hospitals, involved in cooperative arrangements which the Surgeon General finds to be adequate to carry out the purposes of the program.

The emphasis of the program is clearly on local initiative and local planning involving relevant health institutions, organizations, and agencies of the region. The local advisory group, which is to advise the applicant and the participating institutions, must be designated before the application can be approved by the Public Health Service. This advisory group should include interested health groups: representatives of the practicing physicians of the region, medical centers, hospitals, medical societies, voluntary health

agencies, and other groups concerned with the program such as public health officials and members of the public. The participation of a representative advisory group should help to insure the wholehearted cooperation of the many components so vital to the success of the regional medical programs.

A great opportunity has been presented to the medical institutions and personnel of this Nation by the recent enactment of the legislation authorizing the planning and establishment of regional medical programs for heart disease, cancer, and stroke. Grants made available under this authority will enable medical centers, hospitals, other medical institutions and medical practitioners to work together in developing means to make more widely available the latest advances in the diagnosis and treatment of these diseases. In keeping with our American traditions, effective implementation of these programs will be largely dependent on initiative and imaginative approaches developed at the regional level. As Surgeon General, I take particular pleasure in this new program for the opportunities which it presents are, to a significant extent, a measure of the success of other programs of the Public Health Service in the support of medical research, the construction of facilities, and the training of manpower. The regional medical program will build on our previous accomplishments and will create a new resource on which new activities may go forward.

William H. Stewart
Surgeon General

Within these general guidelines, the projects to be undertaken under this program will be quite varied, depending on the particular problems, resources, and relationships within the various regions of the country. It is evident that a program that will meet the needs in a sparsely settled rural area with small and widely separated hospitals will be very different from the program appropriate for a congested urban area.

Examples of programs which provide some elements of a regional medical program already exist. The Bingham Associates Program, established in the early 1930's to connect rural Maine with the medical resources of Boston, grew into a cooperative network of many small Maine hospitals affiliated with the New England Medical Center in Boston.

More recently, a variety of attempts have been made in other areas of the country to meet some of the objectives of the regional medical programs. In improved continuing education, the Ohio Medical Education Network of the Center for Continuing Education, Ohio State University, since 1962 has presented a series of radio-telephone conferences with more than 40 participating hospitals (including one in West Virginia), with physician attendance exceeding 10,000 during the 1962-64 academic year. Another significant post-graduate education program is conducted by the Department of Postgraduate Medicine of the Albany Medical College, connecting 72 hospitals in eight States with participating faculty from 20 medical schools. Physician participation has exceeded 90,000 in the ten years of the program's existence. The Albany Medical College also conducts a regional hospital program linking a number of community hospitals in that region with the medical college for purposes of improving the quality of medical care in the hospitals.

These examples indicate that some regions of the Nation have existing foundations for development of a regional medical program. Other regions

can benefit from this existing experience in the development of their own program. The pilot projects will also provide cumulative experience for the development of new regional programs. The specific context of regional plans and programs will depend on the facilities and resources available and the relationships which are established among these resources. Coordinated patient referral, interchange of personnel, continuing education for physicians, the provision of equipment, training in the use of this advanced equipment, and the development and support of medical teams trained in the latest techniques for diagnosis and treatment may all be aspects of the regional cooperative efforts which can be carried out.

This program provides a key opportunity for the medical resources of the Nation to engage in long-range, coordinated planning and development beyond the scope of existing programs and facilities. Such a comprehensive opportunity should make possible the most effective provision of quality medical care for all citizens, realized through the efficient utilization and further development of the unique resources of an area in meeting its own needs and goals for coping with these major disease problems.

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