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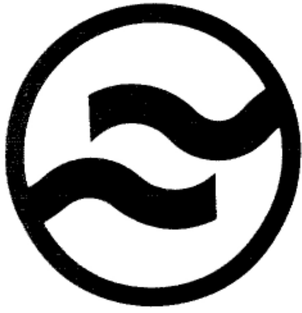

forum

Lakes Area Regional Medical Program

VOL. VIII, NO. 2 OCTOBER, 1975

NARMP Conference at San Diego Says —

New Health Law Has Many Problems, Critics, But Efforts Must Be Made to Make It Work

It's not a particularly good law, it will be difficult and cumbersome to implement and may not be as effective as we want it to be, but we have to do our best to make it work.

This was the consensus of over 400 health care officials attending the second Annual Meeting of the National Association of Regional Medical Programs, Inc., September 23-25 in San Diego, California.

The law being referred to is P.L. 93-641, the National Health Planning and Resources Development Act of 1974, which was signed into law by President Ford on January 4, 1975.

The new law has been a primary topic of criticism by health planners and officials since before its enactment in January. It scraps three federally funded health care programs in favor of a national network of Health Systems Agencies which will function across the country. Regional Medical Programs, Comprehensive Health Planning and the Hill-Burton hospital construction programs will be phased out under the new law. Virtually every convention speaker, including Kenneth Endicott, M.D., administrator of the Health Resources Administration, freely admitted that the law is not a "good" piece of legislation, that it is ambiguous, contradictory and may take three years before it can be fully implemented.

Iowa Governor, Robert D. Ray, a severe critic of the law lashed out stating, "I was outraged when the law passed and I am still outraged. The Midwestern Governors recently voted to ask to have this law repealed. I think most governors would like to reverse it and start all over. But it (the law) is here and it's unrealistic to think that it's not going to be here, so the real questions are, how can it be improved and how can we make it work." In amending the law Gov. Ray would place emphasis on complete health service care instead of arbitrary population limits, change membership requirements of agency governing boards to avoid vested interest pressure groups and provide public accountability to the people.

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WHO IS THE COMMUNITY?

A report from a consulting firm on the east coast begins with the observation that Western New York, in particular Buffalo, has "no sense of community." The comment itself is an indictment to which some will immediately take issue. There are others whose response to this provocative statement will respond with the inevitable "so what's new?"

One of our leading citizens observed that it is safer for a consulting firm to speak the truth, especially one from out of state, than for one of us.

A consulting firm is defined as a body paid excessively to tell us what we already know and unable to implement the theoretical solutions to the problems defined.

Community is a nebulous term at best. One dictionary definition is that of "a social group sharing common characteristics or interests and perceived or perceiving itself as distinct from the larger society within which it exists." It follows that community can be a group of three or three million.

We are currently assailed by the terms "consumers" and "providers" both seen as labels to communities. Furthermore current legislation, specifically separates the two groups in fairly rigid terms. An attempt is made to define two areas of vested interest wherein one, the consumer in his demands has fractional ascendency

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Options Noted For Possible HSA Governing Board

A specially appointed Ad Hoc Steering Committee, working on the development of a Health Systems Agency (HSA) for the Western New York area, met on October 7 in the Lakes Area Regional Medical Program, Inc. conference room to review a number of possible organizational models for the HSA governing board.

Earlier this year Steering Committee Co-Chairmen—Theodore T. Bronk, M.D. (LARMP) and Kenneth Eckhert, M.D. (CHP/WNY) appointed Robert M. Whitrock, M.D. of the Veterans Administration Hospital, Batavia, New York as chairman of a Special Task Force whose function was to draft a number of options for organizing the proposed HSA governing body. The task force includes three representatives from each of the eight Western New York counties. The Task Force drafted four options and added a fifth option at the suggestion of the Ad Hoc Committee. This fifth option is referred to as a mixed model. All five options are described below. They are:

Option I: Limiting governing board size to a maximum of 30 persons. Names of governing board members would be submitted by the subarea or County Committees.

Option II: Same as Option I, except that names would be submitted by county governments.

Option III: Governing board size would be greater than 30 members. In addition, an executive committee of the governing body would be created. Nominations to the govern-

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In This Issue

—NARMP Annual Meeting — San Diego
—LARMP Quality Assurance Programs
—Rural Extern Program Best Ever
—Health Systems Agency Facts
—Options on HSA Governing Board
—Arthritis Plan Public Hearings
—New HEW Secretary
—Who Is The Community?
—Federal Regulations Printed
—Public Hearings on Health Issues

WHO IS THE COMMUNITY

(Cont'd from Page 1)

over the smaller group, the provider. *The contention is that "health care" is at stake!*

The issue is the availability of medical services, the equity of access thereto and the cost thereof.

It seems that we are unable to distinguish between **health** which is dominantly, but not exclusively, the province of the individual, the **disease** which is the province of those taught to manage it.

Good organization comes out of discipline and unless we can apply this to the words we use, we shall remain unable to communicate. Inability to do this will not bring about the cooperation needed and we will remain unable to refute the accusation recorded in the first paragraph of this communication namely that we have no sense of community.

What is a community and how is it structured? Where professions and business interests are concerned the title to community is qualified by a specific, well-defined communal cause.

The consumer community as an entity is much more difficult to define. So difficult is this, that the new National Health Planning and Resources Development Act (P.L. 93-641) avoids it altogether as do the regulations for the implementation of the law.

In 1967, the Regional Medical Program set out to establish county committees that would speak to medical service needs, the priorities of these, and the manner in which they would address Western New York as a community. The justification for RMP expenditure of money had to relate **not** to institutional but to "people,' or "population needs." When established, these committees were not restricted in membership for the simple reason that involvement in a decision-making process on a regional or large community basis required the greatest possible input irrespective of provider or consumer label. We were short of people. Subsequently these groups or committees became more formal entities and now serve the needs of the current Regional Medical Program and Comprehensive Health Planning.

In the future, involvement in the planning, data collection, project development process, all of which will be coalesced in one agency, will require much more time from the volunteer.

We require a consortium of interested parties.

In the early days of the Regional Medical Program, we were instructed to define the area needs, document them and come up with projects to respond to them. This we did to the extent permitted by the funds available.

We did, however, learn some painful lessons about community and the need to define it. We found that there were two types in the area — those built from a group of strong individual interests and the second a constituency developed by one leader.

In the first type there needed to be, without doubt, an individual or small group of organizing people with sufficient feeling and momentum about certain problems to get under way — i.e. develop a voice representative of a body of people and sophisticated enough to develop a structure of leadership.

The second type was the community developed uniquely around one individual without whose obsessive drive in developing a support to his concepts would never have convened or unified. One became very chary about the individual using the royal "We" especially the activist able to window-dress and co-opt heads as evidence of support to his opinion, but in no sense partners or participants in the content of his ideas. This we saw as unreliable and invalid as a measure of success, just as a large audience at a medical seminar is no index of the impact of the teaching mechanism.

Whichever way a community evolves however, has to have a cause. The problem that we are currently facing is the existence of many communities both 'provider' and 'consumer' who are seen as in conflict, whereas they have some basic inalienable human aspirations in common. A body of people irrespective of label who are placed in rivalry by their label; whose allegiance to the individual (or group) with which they have aligned themselves results in a belligerence in territorial prerogative — such as for the birds!

Can we not examine what is feasible in Western New York by examining what we need in common rather than perpetuating the scenario of a fragmented society?

In the present economic climate we need to use our resources to the full — a process which cannot come about without cooperation. Furthermore, money to develop projects such as those of the Regional Medical Program will not be forthcoming for several years, and when they do, they will be subject to a decision-making process that has to involve "the entire community" — a group that can see the whole canvas rather than a particular segment.

It would seem that the public meetings soon to be held for the establishment of a Health Systems Agency for the eight counties of Western New York have to be responsibly structured. It is to be hoped that not only will we be able to conduct ourselves with dignity and responsibility but that we shall acquire a discipline of terminology, and a base of common objectives that will justify the term community. Furthermore, those that become involved in the Health Systems Agency should have opportunity to be instructed in a systemmatic fashion on the principles inherent in responsible planning and the economic feasibility of various services demanded.

Familiarity with jargon, glib indulgence in acronyms and creation of a mystique by a diarrhea of technical terms is a major hindrance to cooperative multi-interest involvement. It frustrates the development of **community.**

Public Hearings on Health Issues Slated In State

Seven public hearings have been scheduled throughout New York State by the State Assembly's Standing Committee on Health. Persons wishing to present pertinent testimony to the Committee at one of these hearings should get in touch with the contact person listed with each meeting notice. Oral testimony will be limited to ten minutes duration. The hearing dates and their subjects are as follows:

QUEENS

November 13, 1975 — 10:00 a.m., Sloman Lowenstein Building Auditorium, 2nd Floor, Long Island Jewish Hospital, Hillside Division, 263rd Street and 76th Avenue, Glen Oaks, Queens.

SYRACUSE

November 19, 1975 — 10:00 a.m., Auditorium - Public Safety Building, 511 South State Street.

Subjects: 1. Should the Legislature enact Assembly Bill 7841-B, the Committee's bill to stimulate the expansion of home health care services in New York State.

2. What will be the effect of the recent Federal Medicaid regulations relating to home health services (45CFR-249)?

3. Hospital Costs and Care for Convalescence - a comparison of operating costs for maintaining a patient in a hospital and costs for at-home care.

Purpose: To consider appropriate action by the 1976 Legislature to stimulate the expansion of home health care.

Contact Person - Florine Levin, Executive Administrator, Assembly Committee on Health, New York State Office Bldg., Room 1103, 270 Broadway, New York, N.Y. 10007, Phone - (212) 488-5734.

QUEENS

November 17, 1975 — 10:00 a.m., Second Floor, Auditorium, City Hospital Ctr. at Elmhurst 79-01 Broadway, Elmhurst.

Subject: Physicians peer review.

Purpose: 1. To consider whether the Legislature should enact Assembly Bill 7662.

2. To consider the most appropriate means of implementing the Federal professional standards review organization (PSRO) legislation in New York State.

Contact person - Florine Levin, Executive Administrator, Assembly Committee on Health, New York State Office Bldg., Room 1103, 270 Broadway, New York, N.Y. 10007, Phone (212) 488-5734.

NEW YORK CITY

December 4, 1975 — 10:00 a.m., Hearing ROOM G, 6th Floor, New York State Office Building, 270 Broadway, New York City.

Subject: Is there a need for a statutory determination of death?

Purpose: To determine whether the Legislature should enact Assembly Bill 9860-A and what amendments, if any, should be made prior to the bill's considerations.

Contact person - Lawrence A. DeLong, Staff Director, Assembly Committee on Health, Legislative Building, Room 831, Albany, N.Y. 12224, Phone (518) 472-3540.

NEW YORK CITY

December 10, 1975 — 10:00 a.m., Hearing Room G, 6th floor, New York State Office Bldg., 270 Broadway, New York City.

Subject: Is the "Rhode Island Plan" to deal with catastrophic illness appropriate for New York State?

Purpose: To determine whether the Legislature should enact a statute regarding the above subject, and how that statute should be framed to be appropriate for application in New York State.

Contact person - Lawrence A. DeLong, Staff Director, Assembly Committee on Health, Legislative Bldg., Room 831, Albany, N.Y. 12224, Phone (518) 472-3540.

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Record Number 67 Students Participated

Best Ever Rural Externship Program Held This Summer

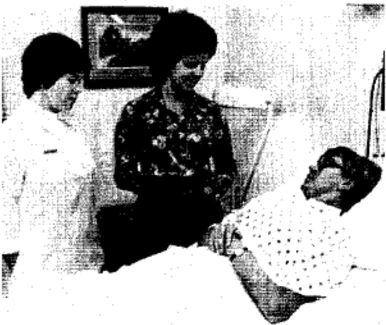
Another Rural Externship Program was completed on August 8, 1975. Sixty-seven health science students representing many health disciplines participated in the eight-week summer experience. Sponsored by the Lakes Area Regional Medical Program, Inc., students were assigned to preceptors in several rural locations around Western New York and Northwestern Pennsylvania. Each student received a stipend of $75.00 per week. The intent of the program is to expose students to rural health delivery and to encourage them to consider settling down and setting up their practices in these areas after they complete their education.

Some typical comments from students who took part in the program this past summer are: Medical student Jay Brachfeld, "I've been in surgery, the delivery room, and the emergency room. My experience has been invaluable. I find it easier talking to patients now. I never had an opportunity like this before." Physical Therapy student Michael Margolies, "living in a rural area has given me a broad view of health care delivery. It has changed my opinion of rural practice favorably." Medical student Lois Polatnick, "some patients come to this Medical Center from as far as 30-40 miles away. They like the personalized and professional attention they receive. I've learned to talk to patients, that's an experience in itself." Dietetics student Mary Jane Olivieri, "being able to relate my planning of patients' menus directly with the patient is the kind of experience you don't get at school. I've learned more in the last two months than I have since I began my college course." Respiratory technician student Mary Beth Nichols, "I feel so much more at ease with patients now and I've done treatments, blood gases, and so many other things. It's one of the greatest things that's ever happened to me." Medical technology student Robert Zercie, "I'm surprised at the sophistication of the laboratory procedures used here. They are up to date and very adequate. I've learned a lot here." The complimentary comments go on and on from students and preceptors alike. Since the rural externship was established by LARMP in 1970 some 244 students have participated in the program. Although it is too soon to assess the degree of success of this project, a recent telephone survey of health science students who participated in the program since 1970 showed that of the 61 students reached, 55 are now in practice. Of this number 55% or 30 of them are now in rural practice. The survey was on a limited basis and will be continued with a more complete report due later on.

Of particular interest is the fact that a number of local legislative bodies and individuals when contacted for financial support of the program last Spring, thought enough of the project to actually provide funds to help pay some of the students' stipends. They supported the concept and proved it with their contributions.

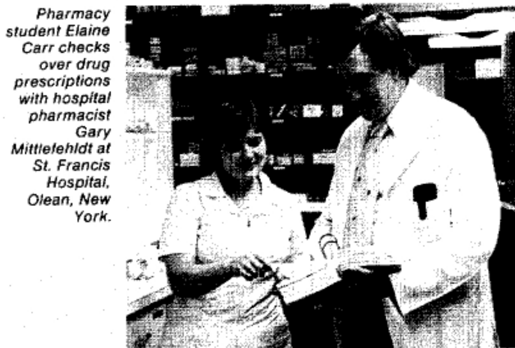
Contributors include:

Theodore T. Bronk, M.D., Buffalo, N.Y.
Brooks Memorial Hospital, Dunkirk, N.Y.
Cattaraugus County Legislature
Chautauqua County Legislature
City of Dunkirk, New York
City of Jamestown, New York
Genesee County Legislature
McKean County (Pa.) Medical Society
New York State Podiatry Society
Niagara County Legislature
Olean Medical Group
Welch Food, Inc., Westfield, N.Y.



Dietetics student M. Joanne Lang (center) talks with a patient about a special diet as Mary Kehoe, assistant dietitian at St. Francis Hospital, Olean, New York, looks on.

Nursing student Michelle Forquer (extreme right) listens as (l-r) Mary Blume, R.N. and Mary Chipola, R.N., nursing director discuss patient chart at St. Francis Hospital, Olean, New York.



Pharmacy student Elaine Carr checks over drug prescriptions with hospital pharmacist Gary Mittlefehldt at St. Francis Hospital, Olean, New York.

Physical therapy student Judith Bailey (center prepares to work with a patient as Olean General Hospital Administrator Theodore W. Gundlah and Evelyn J. Schoonover, a physical therapy assistant, watch.

Medical students Jay Brachfeld (l) and Mark Kramer receive some emergency room tips fro Mrs. Barbara Budniewski, R.N. at Brook Hospital, Dunkirk, New York.

Medical technology student Janet Sprotzer (r) runs a laboratory test as Lab Director Doris Weigan, Olean General Hospital observes.

Dr. Joseph D. Lee, a radiologist at St. Francis Hospital, Olean, New York discusses a patient's x-ray with Medical Students (l-r) David Silverstein and

Medical student Lois Polatnick observes as her preceptor Dr. Duncan Wormer of Portville, New York conducts a patient examination.

Facts You Should Know About Health Systems Agencies (HSA's)

The National Health Planning and Resource Development Act of 1974 (P.L. 93-641) is an important piece of health legislation that was signed into law on January 4, 1975 by President Ford.

It calls for the development of a network of Health Systems Agencies (HSA) across the country which are intended to assume the functions of Regional Medical Programs and Comprehensive Health Planning under one umbrella super agency in individual localities. Once fully organized the new HSA will have control over millions of federal tax dollars coming into a pre-approved Health Service Area.

The National Act is designed to improve the quality and accessibility of health services, restrain skyrocketing health care costs, and prevent unnecessary duplication of health resources.

Below are some of the most commonly asked questions about the new law.

I. What Is A Health Service Area?

A Health Service Area is a geographical portion of the State consisting of a group of counties that have been joined together to plan better health care for all persons living in the area.

II. What Is A Health Systems Agency (HSA)?

A Health Systems Agency is a new type of local health planning agency. One Health Systems Agency will be established in each Health Service Area of the State. This agency must develop a Health Service Plan for its area that pays equal attention to the unmet health needs of the many different kinds of consumers that live in the different part of the area.

III. Why Is There Talk Now About Health Systems Agencies?

A Federal Law is now in effect that requires Health Systems Agencies HSA's) to be established in every area of the nation. It is called the "National Health Planning and Resource Development Act of 1974," Public Law 93-641. It was passed by the Congress in late December, 1974, and was signed by the President in early January, 1975.

IV. Can The Health Systems agency Really Change Anything Important?

Yes. This law mandates stronger authority and more control over investments of Federal and State health dollars than has ever been given to a local health planning agency. In addition, this law mandates that a majority (51% to 60%) of consumers must be members of the agency policy board. These consumers must represent as many special consumer interests as exist in the area. When these consumer representatives sit on the board they can vote in the best interests of special consumer problems.

V. What Is Meant By Special Consumer Interests?

Special consumer interests are social, economic, linguistic, racial, and employment circumstances that create problems for consumers when they need health care.

VI. What Other Interests Will Be Represented On The Agency Policy Board?

The law mandates that special interest of different geographic areas in the Health Service Area, major purchasers of health care, providers of health care, and local government must also be represented.

VII. Will The Health Systems Agency Provide Health Services?

No. The agency will not own or operate hospitals or clinics, nor will it employ doctors, nurses and other personnel to give health care.

VIII. Will the Health Systems Agency Have Any Effect On Doctors In Private Practice?

Yes. They will be encouraged to do work that answers the community needs.

IX. Will The Health Systems Agency Affect Hospitals and Nursing Homes?

Yes. They will control construction and purchase of equipment costing more than $100,000. Any such project must be reviewed and approved by the HSA in that specific area. In addition, the HSA will be reviewing costs and charges for institutional health care in their areas. This information, in turn, will be forwarded for Federal review. It is the intent of the Act to improve institutional management and prevent unnecessarily high costs.

X. What Are The Functions Of A Health Systems Agency?

1. Improve the health of residents.
2. Increase accessibility, acceptability, continuity and quality of health services.
3. Restrain increases in cost of providing health services.
4. Prevent unnecessary duplication.
5. Assume responsibility for effective health planning.
6. Reduce documented inefficiencies.
7. Implement the health plans of the agency.
8. The agency shall assemble and analyze data concerning:
   - A. The status and conditions of the residents of the health service area.
   - B. The status of the health care delivery system in the area — and the use of that system by the residents in that area.
   - C. The effect of the delivery system on the health of the residents of the area.
   - D. The number, type, and location of the area's health resources (including health services, manpower, and facilities).
   - E. How the area's health resources are being used.

XI. Aren't These Functions Being Done Now?

These functions are now the responsibility of several different agencies in each area. In the future, only one Health Systems Agency will receive Federal approval to operate in each health service area. All these functions will now be performed by one single agency that will have enough authority to enforce the new Act. (P.L. 93-641)

XII. How Can One Health System Agency Represent and Give Equal Treatment to the Many Different Communities In a Large Health Service Area?

A Health Systems Agency can establish "Sub-Area" Advisory Councils to represent each part of its health service area that has special and different health planning and health resource problems. The special part may be a geographic section or a group of people with special needs. Consumers who represent a special geographic part or group of people in the Health Service Area should get together and work towards organizing a Sub-Area Health Planning and Resource Council to represent them. An agency that files application to become an HSA must show in its application how it will guarantee equal representation to all such "Sub-Area" Councils on its agency governing board. Before any HSA application is sent to Washington, it is planned to have each reviewed at the State level to insure all area consumer interests have been given fair and equal consideration.

XIII. Will There Be Jobs (Paid And/Or Volunteer) Within The Health Systems Agency For Consumers Who Want To Participate?

This will depend on how effective consumers are in:

1. Organizing and maintaining active interest in establishing Sub-Area Councils.
2. Contacting and recruiting other consumers and consumer organizations to support strong and regular expression of the consumer point of view.
3. Participating as working members on the governing board of the agency.
4. Working with the agency on subcommittees to: secure special information; collect data; and contact other consumers; consumer organizations, churches, labor groups, ethnic groups, all language groups, age groups, economic groups and any other special group necessary for democratic decision making.

OPTIONS (Cont'd from Page 1)

ing board would come from county government.

Option IV: Same as Option III except that nominations would come from subarea or county committees.

Option V: Mixed Model. Nominations to the governing board come from both county government and the subarea or county committees.

Rather than approving a single option, the Steering Committee voted to invite county organizations of RMP, CHP and government to form unified county HSA organizations and to convene public meetings within each county for the purpose of reviewing provisions of the law and to examine the five options. It is hoped that consensus within the community will identify the best option.

Staffs from LARMP, CHP/WNY and county government will be available to assist county organizations in conducting public meetings.

Meanwhile the Steering Committee will continue to function on an expanded basis. In addition to the current membership consisting of three persons from each county (representing LARMP, CHP WNY, and county government) three more *consumers* from each county will be added. This will expand the Steering Committee from 26 to 50 members.

Members of the Steering Committee include — *Co-Chairmen:* Drs. Bronk, Eckhert; *Allegany County*—Virginia Barker, Ed.D., R.N., Alfred University School of Nursing, Irwin Felsen, M.D., Wellsville physician, Paul Taylor, legislator, Belmont, New York; *Cattaraugus County*—Marilyn J. Gibbin, County Division of Nursing Homes, Olean, Fred A. Printz, Allegany, William E. McIlwaine, public health administrator, Olean; *Chautauqua County*—Murray Marsh, WCA Hospital Administrator, Jamestown, Joseph Gerace, county executive, Doris Mitchell, county health department, Mayville; *Erie County*—Clifford M. Carpenter, Human Services Planning, Buffalo, Paul G. Rohrdanz, Buffalo, Gerald L. Schofield, deputy director for administration, Roswell Park Memorial Institute, Buffalo; *Genesee County*—J. Albert Bausch, county legislature, Batavia, Sidney Sherwin Jr., Batavia, Robert M. Whitrick, M.D., V.A. Hospital, Batavia; *Niagara County*—Francis J. Clifford, M.D., County Health Commissioner, Lockport, Cortland Van Deusen, M.D., Niagara Falls, Joan Wolfgang, Youngstown; *Orleans County*—George Bane, Lyndonville, Betty Hassall, Medina, John Staeble, Administrator, county health department, Albion; *Wyoming County*—Charles Grider, Jr., Arcade and Patricia Stopen, R.N., public health administrator, Couunty health department, Warsaw.

LARMP Quality Assurance Programs Attract Thousands

The need for continuing education programs for all levels of health professionals is well known. The Lakes Area Regional Medical Program, Inc. has developed a successful format for providing these continuing education programs on a "circuit rider" approach, whereby high quality programs are brought to and staged in rural communities upon request. Health professionals from the community decide what topics they would like presented and then the LARMP machinery goes into gear. Arrangements are made, speakers obtained, brochures mailed out and the program is publicized. The response has been overwhelming. Since these programs first started in 1968, over 20,-300 persons have participated. Evaluation sheets returned after the program have shown that the programs are well-received and of tremendous value to education-hungry health workers. Programs on an interdisciplinary level have been emphasized. The series of Cancer Teaching Days conducted throughout the region, featuring specialists from Roswell Park Memorial Institute and other famous health institutions has proven to be very popular and successful. The range of cancer topics is varied and interesting. Other programs have included subjects such as hypertension, nutrition, aging, medical genetics, interpersonal relationships, pacemakers, emergency medical services, crisis death in the hospital and many others.

Many grateful participants have attested to the fact that the LARMP continuing education programs are most welcome and valuable, and perhaps the only link to professional education available in many of the rural communities served by the program.

Niagara Gazette Photo

EMERGENCY CARE SEMINAR—Drs. John Border, (left) and Melvin Dyster, demonstrate cardio-pulmonary massage on a model during a teaching day probrem held September 17 in Niagara Falls, New York.

LARMP Qualtity Assurance Coordinator, Patricia Hoff, R.N.,M.A. says, "I think that the key is to involve the community in planning. The community has to tell us what they need and we have to give and take a little; even though we may perceive the need to be more extensive. We, after several planning sessions, develop a program which is 'their' program. We are able to offer programs more economically than most as we operate on a narrow margin and keep the price within reach of all health workers."

The system seems to be working well and benefiting thousands of education conscious health professionals throughout the region.

PROPOSED FEDERAL REGULATION PRINTED

Proposed Federal regulations for designating and funding of Health Systems Agencies (HSA's) have been printed in the October 17, 1975 issue of the Federal Register. The regulations set forth the eligibility and operational requirements for HSAs and describe Federal grants to help support their operation. HEW will consider comments received in the next 30 days before publishing final regulations.

The law requires the Secretary of HEW to consult with the governors in the HSA designation process, and HEW has invited governors to play a major role in the process. HEW plans to give considerable weight to recommendations of the governors in designating the HSAs.

Applications for designation and funding may be submitted prior to publication of final regulations in accordance with application requirements included in the notice of Proposed Rulemaking. For further information contact Dept. HEW, Rockville, Maryland 20852.

NEW HEW SECRETARY

David Mathews, Ph.D., 39-year old president of the University of Alabama has been named the new Secretary of the U.S. Department of Health, Education and Welfare, replacing Caspar Weinberger.

Dr. Mathews, reportedly overwhelmed by the enormous complexities of administering the largest budget in the President's Cabinet, is for the moment shunning confrontations on health or welfare policy with organization representatives, congressional committees or the specialized press.

Described as a "tough administrator," Dr. Mathews is supportive of the concept of preventive medicine and the team approach to health care delivery.

SAN DIEGO MEETING

(Cont'd from Page 1)

The threat of a lawsuit came from Joseph F. Boyle, M.D. of Los Angeles who said the American Medical Association would carry through on its previous declaration to take the government to court as promised if the law is implemented. The AMA will claim the law is unconstitutional, usurping states rights. He stressed, however, that physicians must be prepared to stay on the scene to be aware of developments in Health Systems Agencies and lend advice where needed.

Optimism

Nathaniel Polster urged the association to maintain its information lines both to and from Congress. He detailed the priorities in which Congress is seemingly interested and for which funds may be likely appropriated. Among the health activities attracting Congressional attention are public education in preventive health, almost any health program that promises results that are measurable, developmental activities in mental disabilities, research in health services, emergency medical services and rural health activities.

He suggested that if RMPs would focus on the priority programs and demonstrate effectiveness, the impressive record thus established would leap to RMP leadership in rewriting the law when the time comes.

Paul Ward, executive director of the California Regional Medical Programs, opined that the law must be amended for a variety of reasons among them: 1) HSAs are not immediately organized and productive; 2) their funding will be low, unequal even to that of the CHP,(b) agencies; 3(developmental activities (projects) are at least three years away; 4) while HSAs by law must look to other sources such as local governments for supplements, there is no present evidence that they are doing this or that, if they do so in the future, they will be successful. The reason is that county governments and other sources are pinched for money; 5) since the law gives "unusual powers to the HEW Secretary," the threat of law suit will probably slow down HSA development; 6) development of standards for delivery of health care services, as well as uniform systems for cost accounting and rate settings will also delay HSA establishment and operation.

Ward also listed as serious problems the HEW Secretary's regulatory power and the continuing inflation which makes Congress less eager to fund any health activities. "Eventually the curve in congressional appropriations for health will turn up," he said, and "we must be prepared to provide the leadership and to keep current and aware of the handling of extensive legislation when the time arrives, which is expected to be about the first of the year."

Eugene Rubell, acting director, Bureau of Health Planning and Resources Development conceded that technical changes in the law are needed and noted they could not be expected to be made until after the law was implemented and a number of the HSAs established.

PUBLIC HEARINGS

(Cont'd from Page 2)

ROCHESTER

November 14, 1975 — 10:00 a.m., City Hall Council Chambers, 30 Broad Street.

ALBANY

November 20, 1975 — 10:00 a.m., Assembly Parlor Room 306, New York State Capitol.

Subject: To consider the significant aspects of proposed Federal action to establish a system of national health insurance.

Purpose: To determine the appropriate response by New York State, and by the Legislature in particular in anticipation of Federal action.

Contact person - Nancy Barrett, Staff Assistant, Assembly Program Subcommittee on the Impact of National Health Insurance. Legislature Bldg., Room 125, Albany, New York, Phone (518) 472-8150.

Public Hearings Set to Discuss Arthritis Plan

The National Commission on Arthritis and Related Musculoskeletal Diseases has scheduled a series of public hearings around the country to receive testimony from the public and interested individuals regarding the development of a long-range Arthritis Plan. Some of the hearing locations are noted below. For those interested persons who are unable to attend one of these hearings and would like to express their viewpoint on such matters as specific recommendations for new programs of professional and public education, basic and clinical investigation, demonstrations of patient care at the community level, and the creation of a national data system to support arthritis control, send your written comments to Ephraim P. Engleman, M.D., National Commission on Arthritis and Related Musculoskeletal Diseases, University of California-San Francisco, 1356 Third Avenue, San Francisco, California 94143.

Meetings will be held November 10—Milwaukee, Wisconsin; November 11—St. Louis, Missouri; November 12—Little Rock, Arkansas; December 8—St. Petersburg, Florida; December 9—Atlanta, Georgia; December 10—Houston, Texas. Meetings will be held from 9:00 a.m. to 1:30 p.m. For further details contact the Commission Chairman at San Francisco.

Petition for Incorporation Filed

On September 19, 1975, a petition for charter of incorporation for Hawaii Health Systems Agency, Inc. was filed with the Department of Regulatory Agencies. The petitioners were Gerald Payne, George H. Mills, Edward Bryan and Satoru Izatsu.

Lakes Area Regional Medical Program, Inc.
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