

Mr. FOGARTY. Mr. Chairman, last March I introduced in the House a measure (H.R. 5999) designed to benefit the health of the American people. It was intended to provide a solid basis for the great aim of the President's Commission on Heart Disease, Cancer, and Stroke: to match medical research potential with public health achievement by making the advances of medical science more readily available to our people.

At that time I reminded all of you that heart disease, cancer, and stroke together accounted for 7 out of every 10 deaths in the United States each year. I reminded you that this toll could be sharply reduced—if only the medical profession and medical institutions could make available to their patients the latest advances in the diagnosis and treatment of these diseases.

A lot has happened since March to the various proposals—introduced into the Senate by Senator HILL and into the House by myself and the gentleman from Arkansas [Mr. HARRIS]—to implement a program for regional centers to combat these three killer diseases. On June 28 the Senate passed the measure and earlier this month the House Interstate Commerce Committee—after extensive hearings—reported out H.R. 3140, the Heart Disease, Cancer, and Stroke Amendments of 1965. It is this measure that I wish to rise to support, today.

It is a tribute to the remarkable understanding and dedication to matters of health by the chairman of the House of Interstate Commerce Committee—that a measure that was at one time considered controversial has now gained such acceptance that it may fairly be said that a consensus has been reached regarding it.

This measure now enjoys the support of such voluntary agencies as the American Heart Association and the American Cancer Society. It also enjoys the support of such respected professional organizations as the American Hospital Association and the Association of Ameri-

can Medical Colleges. It enjoys the support of numerous deans and officers of medical schools.

In addition, it now enjoys the qualified support of the American Medical Association. In a news release from the AMA on September 2 that organization reported that an AMA advisory committee had met with President Johnson to discuss this measure. AMA President James Appel said he was gratified that as a result of these meetings some 20 amendments to the bill were accepted by the administration and that—and I quote:

Many of the changes are substantial and will allay many of the fears the medical profession had about the original bill.

The AMA president was also quoted as saying:

We feel that we were successful in getting a number of major changes in the bill which will help preserve the high quality of medical care and the freedom of hospitals and physicians.

Now, the amendment we are considering is a complete substitute for the original bills and incorporates numerous changes intended to define the scope of the program and to guarantee that the legislation will accomplish its stated purpose without in any way interfering with the patterns or the methods of financing of patient care or professional practice or with the administration of hospitals.

I will not embark upon a section-by-section analysis of this bill—into which so much thoughtful compromise has gone. I will instead point out the significant elements of the bill that have emerged from compromises agreeable to both proponents and critics of the original measure.

One of the changes is in the title of the bill. We will hear no more of "regional medical complexes," but rather, of "regional medical programs." This is an important change. It is intended to make it unmistakably clear that it is not intended to amount a new construction program but rather to rely on existing facilities. Thus we emphasize the local nature of this program, its limited scope, and a firm base which includes local hospitals and local medical facilities. The construction authorized under this bill will be alternation, major repair or renovation of existing buildings or replacement of obsolete built-in equipment. No new construction will be permitted from any funds provided by this bill.

Another change undergone by the regional medical program has been to provide language so that this program will be concerned with heart disease, cancer, stroke and "related diseases," instead of—as in the original wording—"other diseases." My medical friends assure me that this in no way impairs the intent of this bill, but that the present wording is essential as a practical consideration. They cite heart disease as an example. A program of research, training, and demonstrations relating to heart disease, which did not include work on diabetes—when there is an apparent relationship between diabetes with its complicating arteriosclerosis and heart disease—would be incomplete. This seems eminently sound and above criticism.

A major limiting change made in the original measure was its reduction in size and scope from 5 years to 3 and from what some called an open-end authorization to \$340 million authorization.

The emphasis in the bill is now upon pilot projects and feasibility studies—in short, upon planning and exploration of mechanics. Section 903 of this bill authorizes grants to assist in the planning of regional medical programs. It is the intent of the bill's sponsors to take full advantage of the extensive planning and organization that have already been carried out in some areas of this country. Nor is this planning to be a one-time thing. After regional medical programs have been funded and some experience has accumulated, the Surgeon General is required to submit a full report on or before June 30, 1967. In the light of that report this House will consider extension or expansion of the present tentative effort.

Certainly one of the major reasons for the acceptability of the present bill by members of the medical profession is the new and clear-cut emphasis it gives to the participation of community physicians and health organizations. Borrowing from the experience of the great clinical center at the National Institutes of Health, all patients who will be treated under this program must be referred by practicing physicians. Thus, except in the case of patients who are referred by their physicians to a facility to receive care incident to research, training or demonstration, this bill will have no effect on the patterns or the methods of financing of patient care.

Related to this is a significant change in the composition of the National Advisory Council which enlarges physician participation. Of the 12 Council members 1 must be an authority in heart disease; 1 in cancer; 1 in stroke—and at least 2 other members must be physicians. The Surgeon General may not make a grant for any program except upon the recommendation of this Council.

The establishment of a National Advisory Council on regional medical programs is based upon the successful experience of the NIH with this reviewing mechanism for grants—an experience that extends over the past 25 years and more. I am confident that no wiser course of action could have been taken by the committee, chaired by my able colleague, the gentleman from Arkansas [Mr. HARRIS]. I am equally confident that one of the best assurances of the success of this program is to draw upon the excellent record of the NIH in its program administration and to concur in the Senate recommendation in this matter. There is no doubt in anyone's mind but that the NIH shall and will administer this program as ably as it has administered its many other pioneering research and health programs.

The Members of this House are considering today a bill which modifies the administration proposal as the result of constructive criticism by many diverse groups. It is one of the most carefully reworked measures I have encountered in the course of my years in Congress. I believe that this measure is no longer

controversial but acceptable to all reasonable men. I urge its passage by this House, today.