Letters

Nuclear Testing

Neild and Ruina (14 Jan., p. 104) provide a valuable background and thoughtful commentary on the issue of a comprehensive ban on nuclear testing, but the authors touch too briefly on possibly the most vexing issue, at least from the U.S. viewpoint.

If the Soviet Union were to agree to a comprehensive test ban (CTB) solely as a temporary expedient to allow time for a gradual disintegration of U.S. nuclear weapon design teams and laboratories (while secretly keeping their own weaponeers busy, knowing that they would abrogate the treaty 20 years hence), the consequences could be serious.

Why not consider a "gradual CTB" in which the United States and the Soviet Union would agree to conduct no more than, say, 20 underground nuclear tests per year for the first 5 years, with the number dropping to 10 during the next 5 years, and so on, until a complete CTB is reached in 20 years.

This would provide time for each country to check not only the effectiveness of its monitoring techniques, but, more importantly, the good faith and intent of the other party.

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Health-Care Delivery

I read the editorial by William Bevan "The topsy-turvy world of health-care delivery" (10 Sept., p. 985) with some distress. I agree that the situation is a complex one. However, it is not made less complex by the generalities contained in the editorial.

No one disagrees that physicians' fees and hospital charges have risen relative to the Consumer Price Index. However, if one analyzes the price index for service fees of all types, one finds that physicians' fees have risen less rapidly than those of other service occupations. A large portion of the increase in hospital charges may be attributed to the fact that now many hospital service personnel are better paid than in the past, when salaries were minimal and often inadequate. In addition, many more complicated procedures are available now than there were 10 years ago. There is also an increasing number of complex cases. Little rational basis exists for the comparison of present charges with those of a decade ago.

I cannot agree that there is a trend toward the use of higher-cost facilities and services in preference to outpatient care. Today many people with problems such as pneumonia are no longer treated in the hospital. Many operative procedures, such as herniorrhaphy, appendectomy, or delivery of a child, require much less time in the hospital then they did 10 years ago. The relative cost of many specific problems is now less, and probably in some cases the absolute cost may be less. On the other hand, new procedures, such as coronary artery surgery, require expensive equipment run by expensive people. It is difficult to make an estimate of the value of such care in a patient who would have died without it 10 years ago. Society can with reason have almost any amount and kind of medical care it desires. However, it must decide where the point of diminishing return is. Huge sums can be spent on a few patients, such as those who receive heart transplants. Of course, a significant amount of knowledge about many aspects of myocardial and other diseases has been gained from the study of these relatively few cases.

Although Bevan does not mention which health-care systems other countries are using, he does refer to a number of alternative systems, many of which are being or have been tried. The real problem today is not the type of health-care delivery, but rather the complexity of new approaches to a variety of diseases now treatable by medical science.

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Neither Senator Beall's speech (*1*) nor William Bevan's editorial adequately addresses the question, Why isn't strengthening the existing National Center for Health Services Research and Development an adequate approach to the study of the changes required to improve health-care delivery?

Major problems sometimes require new agencies, but no evidence has been presented that this is true in the case of health-care delivery. The program of the national center is broad, encompassing political science, economics, operations research, computer and information science, social and survey research, administration, planning, health maintenance organizations, computers, intervention studies, basic research, development, health statistics, and a variety of other areas. Although it operates within the Health Services and Mental Health Administration (HSMHA), its research programs are administratively independent of most other HSMHA functions. This appropriately places the national center leadership in constant contact with men whose problems involve health-care delivery. An independent agency would not seem to offer any advantage.

Only a pittance of funds is being spent on understanding how health care is being delivered and what new delivery methods can improve it. The need for more money and the continued existence of the problems, however, do not in themselves make a new agency necessary. Senator Beall should investigate the record of the existing national center before proposing a new agency. If it does have defects that are critical, then these should be brought to public attention. If not, then the existing national center should be strengthened, to perform for health-care delivery what the National Institutes of Health have tried to perform for organic disease.

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Reference

1. J. G. Beall, Jr., "A proposed institute of health-care delivery," *Congr. Rec.*, 15 June 1971, p. S9086.

. . . William Bevan's suggestions and Senator Beall's proposal encompass much of what the Department of Health, Education, and Welfare (HEW) is attempting to achieve today. We currently have an institutional focus for health-care-delivery research. It is found in the National Center for Health Services Research and Development, an agency that has a broad congressional mandate to carry out most of the activities suggested by Beall and Bevan. Currently, the national center spends $34 million on health-services re-