community's problems in satisfying them. He is undoubtedly an effective defender of research against external pressures exerted from Congress or the Office of Management and Budget. His banking expertise has helped him to argue the OMB's budget-parers out of certain proposed cuts, such as in the federal funds provided to the states.

The internal problems of the agricultural research system, however, are just as serious as the present financial bind, and in grappling with these, Long appears to be doing about as well as would a research scientist put in charge of the loan department of a large bank.—NICHOLAS WADE

Health Planning: New Program Gives Consumers, Uncle Sam a Voice

Some little-noticed legislation that wound its way through the last Congress and was signed by President Ford on 6 January could prove to be a major step toward public supervision of the $100 billion per year private health care industry in the United States. This was the National Health Planning and Development Act, principally sponsored by Edward M. Kennedy (D–Mass.) in the Senate and Paul G. Rogers (D–Fla.) in the House. The law establishes a new program of comprehensive health planning for the country and empowers a system of local planning agencies to oversee some federal health funds flowing to their areas, including funds for new hospital construction. Although not explicitly stated in the law, the new program is intended to provide a framework to review federal spending for national health insurance, which is expected to pass in the next year or two.

Those who backed the planning measure agree that federal and local health planning must be made more sophisticated and stronger if a major national crisis in health care costs is to be averted in the next few years. Estimates in late 1974 showed some costs for medical services rising at an annual rate of 26 percent, or more than twice the current general rate of inflation. Moreover, the prospect is that national health insurance, if enacted, would put pressure for more cost increases on the health care system—just as the start-up of the Medicaid and Medicare programs increased both the demand for and cost of health care in the mid-1960's. The seriousness of the situation is vouched for by the fact that the new law had the support of the Republican Administration, liberal Democratic congressmen, and the private health insurance industry.

The new program will replace three existing federal health planning efforts whose authorizations this year reached a total of more than $700 million: the Hill-Burton Hospital Construction Program, the Regional Medical Program (RMP), and the Comprehensive Health Planning (CHP) program.

At the heart of the new program will be a network of local health planning agencies, serving up to 3 million people each. These local agencies could be either private nonprofit groups, public bodies, or existing CHP agencies, provided that the Secretary of Health, Education, and Welfare (HEW) certified them according to criteria laid out in the law. A second layer of health supervision would take the form of statewide bodies to coordinate the work of local agencies.

The bills would also create something that the nation now lacks, namely, a set of guidelines for health care, which the localities, with the prodding of the new local agencies, would try to achieve. Also, states would appoint health planning agencies (many of these already exist), which would in some cases merely coordinate the work of the local agencies, and in others actively approve or disapprove actions of the local agencies. Because it involves several levels of government and even the nonprofit sector, the proposed health planning system has been nicknamed a "town meeting approach" to the subject. But some critics seize on the rather vague character of the local agencies, which nonetheless could wield great power, as one of the weak points of the legislation. Other critics, mainly the American Medical Association (AMA), go the other way and argue that the federal government would acquire too large a role. Eugene Rubell of HEW, who directs the outgoing programs and will run the new one, says, "This will be no panacea. But we hope it will be more efficient and effective than what has gone on in the past."

At present, there are few restraints on private hospital expansion, growth of medical fees, or the performance of unnecessary diagnostic tests or surgery —a situation which contributes to overall inflation rates in the medical field above the national average. Generally, if a group of doctors in a hospital wish to add a service, expand a facility, or raise their rates, the only approval they need is that of the hospital's board of directors—bodies which are not known for contravening doctors' wishes.

Present Controls Patchy

For the rest, controls are patchy or nonexistent. There is, for example, a provision in the Social Security Act by which the federal government can opt not to reimburse a hospital for the capital construction part of its Medicare, Medicaid, and maternal and child health care cost, if it decides that the hospital itself is unneeded. Also, 26 states have certificate-of-need laws, under which proposals for new facilities must be approved as necessary before a state license is granted. A few states including Maryland and Connecticut have gone farther and elected to regulate health care rates. Finally, some counties have controls on local health care.

The proposed bills would make many ongoing attempts at control more consistent from place to place and have them guided by national policy.

The country will be divided into discrete areas, each served by a new local Health Systems Agency (HSA). The HSA's may be private, nonprofit organizations or public groups.

Each HSA will then draw up a long-range plan outlining the strengths and deficiencies of health care within the

area and the goals it would like to see achieved. The plans would have to follow national health guidelines issued by the Secretary of HEW, but once established they would become the blueprints for subsequent review of new construction and federal spending in the area. The bill also authorizes $275 million through fiscal 1977 for local HSA planning grants to aid in implementation of the plans.

The local HSA's will also have the power to approve or disapprove proposed federal expenditures for new construction, alcoholism and mental health treatment, and some public health services in their areas. If an HSA disapproves a proposed use of funds which the federal government wants to go ahead and spend anyway, the Secretary of HEW will have to explain why publicly and consult with yet another group, the state health planning agency. In this way it is hoped the local HSA's will have clout in influencing federal health activites in their areas.

The bills try to control a chief cause of inflation in health care costs, namely, unused and underused facilities. The number of excess hospital beds in the United States is, according to various estimates, from 60,000 (with an annual carrying cost of $1.2 billion) to 100,000 (with an annual cost of $2 billion). Obstetrical wards are sometimes underused in areas with declining birth rates. Coronary care units have been built by hospitals with little demand for them. (In the Washington, D.C., area, experts estimate there are seven such units but enough business for only three). Curbing an increase in little-needed facilities, then, has become a major element in the fight to control costs.

Under the new law, both the local HSA and the state health planning agencies will conduct elaborate reviews of existing facilities and of any proposed construction. States are given 1 year to pass certificate-of-need legislation, which must then be administered by the state planning agencies that will be making these reviews. To fight rising costs directly, the bill authorizes $15 million through 1977 for up to six states that decided to engage in rate regulation.

The Hill-Burton hospital building program is continued in the new law, with $390 million through 1977. But instead of going for building any new inpatient facility, the law authorizes construction only of new outpatient facilities, conversion of existing facilities to new uses, and new inpatient facilities only in areas of rapid population growth.

A final important aim of the new legislation is to give the nascent consumer movement in health care as well as health care planning professionals a greater say in the direction of health care. At the state and local levels health planning activities will be overseen by governing boards, carefully constituted so that a majority will be consumers, professionals, and government officials. So-called "providers" of health care—the doctors, hospital administrators, and others with vested interests at stake—are legislated to form a minority on these boards.

The new program, as well as the legislation creating it, was opposed by some groups which it will phase out of existence. Paul D. Ward, of the California RMP, argues that the nonprofit character of the HSA's will make them irresponsible. "The destiny of the nation's health care system," Ward writes, "will be in the hands of corporate boards or staff that have little or no responsibility to the general public." Interestingly, however, the House committee report on the planning bill criticized the RMP's nationally for not having been more accountable to the public. "Where RMP efforts . . . did achieve some critical mass, as in the case of coronary care unit demonstration and training activities, they did not always address priority community problems and needs," the report said.

Both the AMA and the American Hospital Association fought the planning bill on the grounds that it gives too much control to the government, thus embodying a "public utility approach" to health care. But most observers say that the bills' gliding passage through both Houses of Congress was a testament in particular to the AMA's declining political influence. One Administration official, who nonetheless did not want to be quoted by name as criticizing AMA, explains that the dominant issue of cost control has overridden the AMA's principal issue —namely, who should control the medical care system. He added, "It was inconceivable that the kinds of things in those bills would have been discussed 10 years ago. You would have been called a communist."

Ralph Nader's Health Research Group also opposed the legislation. A staff associate of the group, Barry Ensminger, says that in all likelihood the new HSA's will become, like the CHP agencies they will succeed, captives of local hospital and medical associations. The HSA's "will still be reactive planners, reacting to things proposed for the future. But one out of every three hospital patients doesn't need to be there. One out of every ten patients undergoes unnecessary surgery. They're not set up to roll back the existing system."

Rubell, who is now setting up the new program for HEW, summarized his own hesitations about the program thus: "I'm not sure the whole approach [in the law] will work. But what it will do is give us a chance to try to make it work. If it fails, it will be because the idea is a bad one, not because it wasn't given a good try. Then the choice will be to have the big ol' government do it and that's something I fear very much."—DEBORAH SHAPLEY

RECENT DEATHS

Harold Abramson, 75; professor emeritus of pediatrics, New York Medical College; 13 October.

Emily C. Cardew, 67; former dean, College of Nursing, University of Illinois; 10 September.

Peter F. Curran, 43; director, biological sciences division, Yale University; 16 October.

Frank Cuttitta, 62; research chemist, U.S. Geological Survey; 4 November.

Harold E. Davis, 80; former professor of radiology, University of Miami; 12 October.

Samuel D. Gray, 83; former chairman, agronomy department, New York Agricultural and Technical Institute; 9 October.

Stephen P. Marion, 63; associate professor of chemistry, Brooklyn College, City University of New York; 7 October.

Max Seham, 86; professor emeritus of pediatrics, University of Minnesota; 15 October.

Carl R. Woodward, 84; president emeritus, University of Rhode Island; 2 October.

Erratum: Under Recent Deaths (1 Nov. 1974) the listing Robert R. Kaufmann should read Albert R. Kaufmann.

Erratum: Under Appointments (6 Dec. 1974) the entry for Julius S. Greenstein should read "chairman, biology department, State University of New York College, Fredonia, to dean, School of Mathematics and Natural Sciences, Shippensburg State College."