I think we would not want to imply that either these programs or some of the other programs that have been initiated in the last 3 years that have been making good progress would in any way have done so. They may have contributed, but certainly, as far as the national figure is concerned, it would be a slight contribution to date.

Mr. CARTER. Actually, there are improved methods of treatment, really, different medicines used in treatment of strokes that have been mainly responsible for this.

Dr. LEE. Yes, sir. I think the improved drugs and the earlier diagnosis of the hypertensive association that they get under treatment at an earlier stage of the disease have contributed to this.

Mr. CARTER. I would like to know how the specific organization of a region is. Could you give us a plan, who is head of it, and how it branches down?

Dr. MARSTON. I think what one needs, Dr. Carter, is the organization of more than one region to achieve what you want.

The one thing that has to be established in each region is a broadly representative regional advisory group. It is a requirement of the law that this be established.

In every region, so far as I can remember, there are task forces in the areas of heart disease, cancer, and stroke, which include people with special knowledge in these areas.

In each region there is also a core administrative unit, a staff that varies in size. But on the average in the regions funded for planning only, it is about 20 to 26 people, and in the operational regions, the staff that is actually paid on an average number about 90.

Operation of the program is set up differently in different regions. In Connecticut there are 10 subregions. In Kansas there are 10 subregions. In Georgia, there is really a subregion for each county, with representatives from every hospital in the State, and with representatives from every county medical society. These local-level groups are active in determining their local needs. In some instances these units are called local advisory groups.

Now, to come to a specific region, in Kansas these local action groups may either respond to information that has come from studies carried out by the regional staff or, indeed, other groups in the State. Or the local action groups may propose projects that they themselves identify as being particularly needed in that area. In designing these projects, the local action groups can work with the staff of the regional medical program, calling on experts from outside of the region, if necessary.

Kansas has a substantive review committee, that is, a committee that reviews, on the basis of scientific and professional merit, the proposals.

Finally, with the results of this review available, the application, which may have been stimulated either at the local level or may have been stimulated as the result of data that has been gathered elsewhere, comes before the regional advisory group, which must approve all operational project proposals.

A recent example of this process in Kansas resulted in about half of the proposals that came to the regional advisory group being returned to the originators for one reason or another for additional work before final approval at the regional level. After regional ad-