NATIONAL TUBERCULOSIS AND RESPIRATORY
DISEASE ASSOCIATION,
New York, N.Y., March 20, 1968.

HON. HARLEY O. STAGGERS,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.

DEAR MR. STAGGERS: The National Tuberculosis and Respiratory Disease Association wishes to express its support for continuation of Regional Medical Programs as provided for in H.R. 15758. Although Programs have been largely developmental, reports of progress throughout the country indicate that the majority will shortly be initiating operational activities. Reports indicate an earnest desire on the part of persons concerned with this Federal program to fulfill the purposes of the legislation; namely, that the American public receive improved medical services through coordinated and more efficient delivery of medical and paramedical skills and talents.

Authorization for funds must be adequate to meet the growing needs of the Programs in the next few years if they are to achieve their goal. The momentum of this Federal program, which involves relationships with many agencies and groups, is accelerating as operational activities are due to begin. Readiness to perform will be affected by the amount of Federal funds available. Therefore the Committee should consider whether or not the authorization of $65 million for fiscal 1969 is large enough to permit implementation of the extensive plans developed over the past few years.

The NTRDA is particularly eager that Regional Medical Programs be successfully launched into operational activities because of the great need to improve services for chronic pulmonary disease patients. At time of appropriating funds for fiscal 1968, Congress specified that between one and two million dollars of the RMP appropriation for that year be devoted to chronic respiratory disease programs.

The NTRDA had requested such action by Congress because of the critical situation in diagnosis and treatment of these diseases, particularly emphysema. Incidence of emphysema has so accelerated that it has become the second most frequent disease for which benefits are granted to workers who are retired for disability prior to age 65, at an annual cost of about $90,000,000. Other diseases of pulmonary insufficiency, such as chronic bronchitis, are widespread and responsible for much illness and restricted activity. Deaths from emphysema have been doubling approximately every five years in the recent past and along with asthma and chronic bronchitis now represent the tenth cause of death in the United States.

The seriousness of the chronic respiratory disease situation impelled the Public Health Service and the National Tuberculosis and Respiratory Disease Association to convene a Task Force in the Fall of 1966 to discuss how the control of these diseases could be improved. The critical needs in medical services for patients became a focus for much of the discussion and led to one of the Task Force's major recommendations; namely, that provision be made for pulmonary function laboratories, respiratory-care units, home-care, and rehabilitation programs.

Data indicate that the lack of such resources is widespread. Many community hospitals are even without the necessary apparatus to take care of seriously ill respiratory disease patients. Organized home-care programs exist in only a small percentage of our general hospitals, while outpatient clinics which can play a full role in rehabilitation and counseling of respiratory disease patients are virtually non-existent.

The community practitioner is particularly at a loss to help patients with chronic respiratory disease except for recommending hospitalization when the illness becomes critical. The average general practitioner is the victim of inadequate education because of the recency in the rise of these diseases. Thus, the type of supervision needed to protect patients from acute infections and to maintain their physical condition at as optimal a level as possible cannot be provided in most communities under existing conditions.

It is obvious that direction and supervision of high quality chronic respiratory disease programs must be provided by medical schools and medical centers. Demonstrations of patient diagnosis and treatment must be brought to the community practitioner through continuing education courses offered by these institutions and facilities. The Regional Medical Programs offer the most