

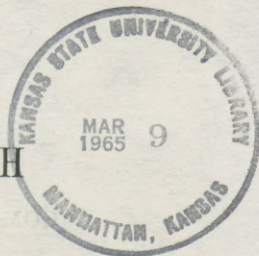
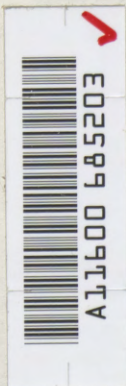
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PUBLIC HEALTH GRANTS AND CONSTRUCTION OF HEALTH RESEARCH FACILITIES

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HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

FIRST SESSION

ON

S. 510 and S. 512

BILLS TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR
GRANTS-IN-AID AND THE CONSTRUCTION OF HEALTH
RESEARCH FACILITIES

JANUARY 27, 1965

Printed for the use of the
Committee on Labor and Public Welfare



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PUBLIC HEALTH GRANTS AND HEALTH RESEARCH FACILITIES

WEDNESDAY, JANUARY 27, 1965

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 4232, New Senate Office Building, Senator Lister Hill, chairman of the subcommittee, presiding.

Present: Senators Hill (presiding), Yarborough, Williams, Pell, and Kennedy of Massachusetts.

Committee staff members present: Stewart E. McClure, chief clerk; John S. Forsythe, general counsel; Robert W. Barclay, professional staff member; and Michael J. Bernstein, minority counsel.

The CHAIRMAN. The subcommittee will kindly come to order.

The subcommittee is meeting this morning to receive testimony on S. 510 and S. 512, bills that are a part of the President's health program.

S. 510 would extend the vaccination assistance program, the program of health services for migratory workers, the formula grants authorized by sec. 314(c) of the Public Health Service Act, and the special project grants for community health services that are authorized by section 316 of the Public Health Service Act.

These four grant programs are outstanding examples of Federal-State cooperation against disease and disability.

S. 512 would extend for an additional 5 years and expand the matching grant program first authorized in 1956 for the construction of health research facilities.

This bill would also authorize the Surgeon General to award non-matching grants for the construction and operation of specialized regional or national health research facilities.

In addition, S. 512 would permit the Public Health Service to finance research through contracts. The Public Health Service Act, at present, authorizes only grants for financing research.

Finally, this bill would authorize three additional Assistant Secretaries of Health, Education, and Welfare.

(S. 510 and S. 512 follow.)

89TH CONGRESS
1ST SESSION

S. 510

IN THE SENATE OF THE UNITED STATES

JANUARY 15, 1965

Mr. HILL introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Community Health
4 Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

- 6 SEC. 2. (a) The first sentence of subsection (a) of
7 section 317 of the Public Health Service Act is amended
8 by striking out "and" before "\$11,000,000" and by inserting
9 "and such sums as may be necessary for each of the next
10 five fiscal years" immediately after "June 30, 1965,". The

VII—O

1 second sentence of such subsection is amended by striking
2 out "the fiscal years ending June 30, 1963, and June 30,
3 1964" and inserting in lieu thereof "any fiscal year ending
4 prior to July 1, 1970". The third sentence of such sub-
5 section is amended by striking "and tetanus" and inserting
6 in lieu thereof "tetanus, and measles", and by striking out
7 "under the age of five years" and inserting in lieu thereof
8 "of preschool age".

9 (b) Subsection (a) of such section is further amended
10 by adding at the end thereof the following new sentence:
11 "Such grants may also be used to pay similar costs in connec-
12 tion with immunization programs against any other disease
13 of an infectious nature which the Surgeon General finds
14 represents a major public health problem in terms of high
15 mortality, morbidity, disability, or epidemic potential and to
16 be susceptible of practical elimination as a public health prob-
17 lem through immunization with vaccines or other preventive
18 agents which may become available in the future."

19 (c) Subsection (b) of such section is amended by strik-
20 ing out "of limited duration", by striking out "against polio-
21 myelitis, diphtheria, whooping cough, and tetanus" and
22 inserting in lieu thereof "against the diseases referred to in
23 subsection (a)", and by striking out "who are under the age
24 of five years" and inserting in lieu thereof "of preschool
25 age".

1 (d) Such section is further amended by striking out
2 “intensive community vaccination” wherever it appears in
3 subsections (a), (b), and (c) and inserting in lieu thereof
4 “immunization”.

5 MIGRATORY WORKERS HEALTH SERVICES

6 SEC. 3. Section 310 of the Public Health Service Act is
7 amended by striking out “the fiscal year ending June 30,
8 1963, the fiscal year ending June 30, 1964, and the fiscal
9 year ending June 30, 1965” and inserting in lieu thereof
10 “each fiscal year ending prior to July 1, 1970”, and by strik-
11 ing out “any year” and inserting in lieu thereof “any year
12 ending prior to July 1, 1965”.

13 GENERAL PUBLIC HEALTH SERVICES

14 SEC. 4. The first sentence of subsection (c) of section
15 314 of such Act is amended by striking out “first five fiscal
16 years ending after June 30, 1961” and inserting in lieu
17 thereof “first six fiscal years ending after June 30, 1961”.

18 SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH
19 SERVICES

20 SEC. 5. The first sentence of subsection (a) of section
21 316 of such Act is amended by striking out “first five fiscal
22 years ending after June 30, 1961” and inserting in lieu
23 thereof “first six fiscal years ending after June 30, 1961”.

89TH CONGRESS
1ST SESSION**S. 512**

IN THE SENATE OF THE UNITED STATES

JANUARY 15, 1965

Mr. HILL introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act provisions for construction of health research facilities by extending the expiration date thereof and providing increased support for the program, to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Health Research Facili-
4 ties Amendments of 1965".

5 HEALTH RESEARCH FACILITIES CONSTRUCTION GRANTS

6 SEC. 2. (a) Section 704 of the Public Health Service
7 Act (hereinafter referred to as the "Act") is amended by

II

1 inserting after "\$50,000,000," the following: "and for the
2 fiscal year ending June 30, 1967, and the four succeeding
3 fiscal years, an aggregate of not to exceed \$400,000,000,"
4 and by inserting "(other than facilities constructed under
5 section 712)" after "facilities".

6 (b) Subsection (a) of section 705 of the Act is
7 amended by striking out "June 30, 1965" and inserting in
8 lieu thereof "June 30, 1970".

9 (c) Part A of title VII of the Act is amended by in-
10 serting after section 711 the following new section:

11 "CONSTRUCTION AND OPERATION OF SPECIALIZED

12 REGIONAL OR NATIONAL FACILITIES

13 "SEC. 712. (a) When the Surgeon General finds, in
14 accordance with regulations, that the purposes of this part
15 can best be achieved through the construction of research,
16 or research and related purposes, facilities of particular value
17 or significance for the Nation or a region thereof, and that
18 because of the cost of such facilities or their use as a national
19 or regional resource for research or related purposes a grant
20 pursuant to the preceding provisions of this part does not
21 provide an effective or appropriate means of financing the
22 construction of such facilities, he may construct or make
23 arrangements for constructing, through contracts for paying
24 (including advance or installment payments) part or all of
25 the cost of construction or otherwise, facilities for the conduct

1 of research, or for research and related purposes, in the
2 sciences related to health. The Surgeon General may,
3 where he deems such action appropriate, make arrangements,
4 by contract or otherwise, for the operation of such facilities
5 (for the conduct of such research, or research and related
6 purposes) or may make contributions toward the cost of such
7 operation of facilities of this nature whether or not con-
8 structed pursuant to, or with aid provided under, this section.
9 Title to any facility constructed under this section may be
10 transferred by the Surgeon General on behalf of the United
11 States to any public or nonprofit private institution com-
12 petent to engage in the type of research, or research and
13 related purposes, for which the facility was constructed.
14 Such transfer shall be made subject to the condition that the
15 facility will be operated for the research, or research and
16 related purposes, for which it was constructed and to such
17 other conditions as the Surgeon General deems necessary
18 to carry out the objectives of this part and to protect the
19 interests of the United States. Any laborer or mechanic
20 employed by any contractor or subcontractor in the perform-
21 ance of work on the construction of any facility constructed
22 under this section shall be paid wages at rates not less than
23 those prevailing on similar construction in the locality as
24 determined by the Secretary of Labor in accordance with the
25 Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5).

+

1 The Secretary of Labor shall have, with respect to labor
2 standards specified in the preceding sentence, the authority
3 and functions set forth in Reorganization Plan Numbered 14
4 of 1950 (15 F.R. 3176; 64 Stat. 1267), and section 2 of
5 the Act of June 13, 1934, as amended (40 U.S.C. 276c).
6 “(b) There are hereby authorized to be appropriated for
7 the fiscal year ending June 30, 1966, and for the five
8 succeeding fiscal years such sums as may be necessary for
9 carrying out this section; and any sums appropriated for
10 construction pursuant to this section shall remain available
11 until expended.”

12 (d) So much of section 707 of the Act as precedes
13 clause (a) is amended by striking out “funds have been
14 paid” and inserting in lieu thereof “a grant has been made”.

15 CONTRACTS FOR RESEARCH

16 SEC. 3. Section 301 of the Act is amended by striking
17 out “and” at the end of subsection (g), by redesignating
18 subsection (h) as subsection (i), and by inserting immedi-
19 ately before such subsection the following new subsection:

20 “(h) Enter into contracts for research in accordance
21 with and subject to the provisions of law applicable to
22 contracts entered into by the military departments under
23 title 10, United States Code, sections 2353 and 2354,
24 except that determination, approval, and certification

1 required thereby shall be by the Secretary of Health,
2 Education, and Welfare; and

3 ADDITIONAL ASSISTANT SECRETARIES OF HEALTH,
4 EDUCATION, AND WELFARE

5 SEC. 4. (a) There shall be in the Department of Health,
6 Education, and Welfare, in addition to the Assistant Secre-
7 taries now provided for by law, three additional Assistant
8 Secretaries of Health, Education, and Welfare, who shall be
9 appointed by the President, by and with the advice and
10 consent of the Senate. The provisions of section 2 of the
11 Reorganization Plan Numbered 1 of 1953 (67 Stat. 631)
12 shall be applicable to such additional Assistant Secretaries
13 to the same extent as they are applicable to the Assistant
14 Secretaries authorized by that section.

15 (b) The office of Special Assistant to the Secretary
16 (Health and Medical Affairs), created by section 3 of the
17 Reorganization Plan Numbered 1 of 1953 (67 Stat. 631), is
18 hereby abolished.

19 (c) Paragraph (17) of section 303 (d) of the Federal
20 Executive Salary Act of 1964 (78 Stat. 418) is amended by
21 striking out “(2)” before the period at the end thereof and
22 inserting in lieu thereof “(5)”; and paragraph (95) of
23 section 303 (e) of such Act is repealed.

24 (d) The President may authorize the person who im-

1 mediately prior to the date of enactment of this Act occu-
2 pies the office of Special Assistant to the Secretary (Health
3 and Medical Affairs) to act as one of the additional Assistant
4 Secretaries authorized by the first section of this Act, until
5 that office is filled by appointment in the manner provided
6 by such section. While so acting, such person shall receive
7 compensation at the rate now or hereafter provided by law
8 for Assistant Secretaries of executive departments.

The CHAIRMAN. Dr. Dempsey, Dr. Terry, and you other gentlemen, we are very happy to have you here this morning.

Will you proceed first. Dr. Dempsey?

STATEMENT BY DR. EDWARD W. DEMPSEY, SPECIAL ASSISTANT TO THE SECRETARY, HEALTH AND MEDICAL AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY RUFUS E. MILES, ADMINISTRATIVE ASSISTANT SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DR. LUTHER L. TERRY, SURGEON GENERAL, PUBLIC HEALTH SERVICE, AND DR. STUART M. SESSOMS, DEPUTY DIRECTOR, NATIONAL INSTITUTES OF HEALTH

Dr. DEMPSEY. Thank you, Mr. Chairman. May I introduce Mr. Miles, who is on my right, Administrative Assistant Secretary of the Department of Health, Education, and Welfare.

The CHAIRMAN. Glad to have you, sir.

Dr. DEMPSEY. And Dr. Terry, whom I introduced to you, and Dr. Sessoms of NIH, are here with me this morning.

The CHAIRMAN. Glad to have you, gentlemen. You may proceed now, Doctor.

Dr. DEMPSEY. Thank you.

Mr. Chairman and members of the subcommittee, I am pleased to present, on behalf of Secretary Celebrezze, the views and recommendations of the Department of Health, Education, and Welfare on S. 512, the Health Research Facilities Amendments of 1965, and on S. 510, the Community Health Services Extension Amendments of 1965, both of which have been introduced by the distinguished chairman of this committee, Senator Hill. I shall speak first to the health research facilities bill, S. 512.

S. 512

This bill would amend the Public Health Service Act to extend and expand the program of matching grants for the construction of health research facilities. It would also provide new authority to finance the research construction and operational costs of facilities for national or regional purposes. Another provision of the bill would provide additional research contract authority for the Public Health Service similar to authority already available to the Department of Defense. I would like to speak to these three parts of the bill in the order in which they occur.

During the past year, the President's Commission on Heart Disease, Cancer, and Stroke has worked hard over a report concerning these three dread killers. In their report, the Commission made numerous recommendations for expanding current health activities and for initiating new ones. One of their recommendations specifically concerned health research facilities construction, the subject of S. 512, and others will appear, in separate bills which have been introduced into the Congress. As a former member of the Commission, I am pleased that many of its recommendations are reflected in the total program set forth in the President's health message.

MATCHING GRANTS FOR THE CONSTRUCTION OF HEALTH RESEARCH FACILITIES

The program of matching grants for the construction of health research facilities was first authorized by the Congress in 1956 with an annual appropriation authorization of \$30 million. It has been extended three times; the annual authorization has been increased to \$50 million. Since its inception, 1,263 construction grants, totaling about \$320 million, have been awarded to 399 institutions in every State of the Union, the District of Columbia, and Puerto Rico. The total cost of the laboratories built with support from this program has exceeded \$800 million, so that for each Federal dollar that has been spent, more than \$1.50 has been provided locally.

Under present authorization, this program will expire on June 30, 1966, and authority to accept applications terminates on July 1, 1965. Therefore, to continue this program without interruption, its extension must be authorized this year.

We believe the extension and increase in authorization provided for in the bill now before the committee to be essential for our national medical research effort.

The great postwar expansion in our medical research effort has been made possible by the progressive collaboration of Federal agencies and non-Federal universities, medical schools, and other research institutions. The health research facilities construction program has contributed substantially to the improvement and expansion of the research space which these institutions have provided for this national effort.

However, the funds available under the current health research facilities construction program have not been adequate for the best development of space and facilities to house our national and institutional programs.

This program has had a continuous backlog of applications, judged by our advisers to be sound and important, but which could not be financed because of the limited funds available under the current authorization. At the present time, the failure of the construction of health research facilities to keep pace with expanded research and research-training programs is the most important single bottleneck to the further development of the Nation's capability for health research. The present imbalance among the components of an effective research effort needs to be corrected. This bill would go far toward meeting this urgent need by authorizing the further appropriation of \$400 million over a 5-year period.

Many positive contributions to grantee institutions under the health research facilities program can be cited. Clinical research has been expanded; diagnostic aids for heart disorders have been created; and continuous development of basic science has been possible. We would be glad to furnish, for the record, a detailed analysis of the accomplishments of this program, to date, including: information on the types of research which are conducted in these facilities; the types of institutions receiving these awards; the geographic distribution of the facilities; and the total amount of research space constructed.

The CHAIRMAN. If you will furnish us that, we will have it appear in the record. We will be happy to have that.

Dr. DEMPSEY. Thank you, Mr. Chairman.

(The material referred to follows:)

HEALTH RESEARCH FACILITIES BRANCH DIVISION OF RESEARCH FACILITIES AND RESOURCES
 Total estimated cost of 990 projects—1,263 grants to 399 institutions in 50 States, the District of Columbia, and Puerto Rico, involving grants totaling \$319,994,909

[Obtained from estimates in the applications, from Public Health Service form 2844-2, construction schedule and final financial summaries]

TOTAL ESTIMATED COST OF THE FACILITIES

Region	1957	1958	1959	1960	1961	1962	1963	1964	1965	Total
I.....	\$24,919,030	\$59,158,720	\$67,390,771	\$41,480,581	\$97,156,964	\$56,326,847	\$66,006,937	\$73,107,712	\$41,568,225	\$527,055,787
II.....	39,389,771	20,651,531	46,239,646	21,711,860	33,570,860	15,802,795	25,024,347	34,628,355	23,903,144	261,236,529
III.....	21,421,011	30,002,328	41,041,028	31,062,148	22,681,893	15,530,850	60,274,077	83,129,553	49,802,034	374,944,419
IV.....	32,588,760	30,645,209	21,120,915	47,090,687	28,262,563	26,288,070	76,031,182	91,926,966	58,531,977	411,459,269
Total.....	118,318,572	140,460,788	175,752,360	141,345,276	201,970,937	112,918,562	227,336,543	282,787,586	173,805,380	1,574,096,004

TOTAL COST OF HEALTH RESEARCH FACILITIES PORTION OF THE CONSTRUCTION

I.....	\$22,080,220	\$35,206,966	\$21,233,521	\$27,080,976	\$28,841,524	\$42,748,837	\$38,964,119	\$49,293,046	\$28,051,217	\$293,480,426
II.....	15,192,460	6,535,389	17,136,170	9,554,413	17,200,783	7,506,824	16,031,734	18,063,883	16,951,507	124,170,863
III.....	15,592,084	20,194,753	21,202,246	16,301,753	16,185,183	9,716,281	39,388,898	36,898,178	25,638,624	200,067,960
IV.....	14,792,524	15,079,369	9,774,418	25,346,938	15,543,634	20,921,229	27,014,940	41,028,722	32,223,236	201,725,016
Total.....	67,657,288	77,016,477	69,346,355	78,264,080	77,771,124	80,893,171	121,549,657	143,781,829	103,164,584	819,444,265
Space (net square feet).....	1,455,000	1,410,000	1,368,000	1,325,000	1,284,000	1,249,000	2,027,000	1,972,000	1,920,000	14,010,000
Employees (full-time equivalent).....	7,270	7,050	6,840	6,620	6,420	6,240	10,130	9,860	9,600	70,030



14 PUBLIC HEALTH GRANTS—HEALTH RESEARCH FACILITIES

Financial profile of the health research facilities program—1957-64

Item	Number	Amount	Average
Applications received.....	1, 650	\$564, 892, 201	\$342, 359
Applications approved.....	1, 308	384, 941, 947	281, 390
Approved, but unfunded applications (backlog).....	41	28, 428, 456	693, 379
Approved, but deactivated or withdrawn applications.....	64	30, 514, 202	570, 534
Applications awarded.....	1, 263	319, 999, 199	253, 364
Number of institutions, awarded.....	399	319, 999, 199	802, 003
Projects awarded, construction not yet started.....	135	67, 349, 004	498, 882
Projects awarded, construction in process.....	186	114, 357, 700	614, 826
Projects completed.....	669	138, 292, 495	206, 715
Total projects awarded.....	990	319, 999, 199	323, 232

¹ The balance of \$10,000,801 funds available will be awarded between Jan. 1 and June 30, 1965.

Awarded projects by professional discipline through Dec. 31, 1964

Professional discipline	Number of projects	Amount requested	Awarded fiscal years 1957-65
Total.....	990	\$411, 656, 149	\$319, 999, 199
Anatomy.....	5	716, 691	564, 311
Anatomy, microscopic/histology.....	1	170, 000	153, 538
Biochemistry.....	16	5, 184, 583	4, 528, 716
Biochemistry (unspecified).....	4	1, 359, 879	1, 329, 579
Biochemical engineering.....	2	1, 141, 675	371, 616
Biology or biological science (unspecified).....	2	52, 278, 143	35, 641, 899
Biophysics.....	5	2, 414, 580	2, 006, 580
Botany/physiology (unspecified).....	2	644, 273	371, 200
Chemistry.....	30	7, 195, 590	5, 181, 892
Dentistry (unspecified).....	25	7, 997, 336	6, 863, 302
Environmental health.....	33	13, 017, 087	9, 209, 880
Epidemiology (unspecified).....	5	3, 180, 706	2, 834, 234
Genetics.....	1	270, 369	229, 321
General medical sciences (multidisciplinary).....	106	63, 795, 017	52, 251, 321
Medical technology (unspecified).....	1	42, 200	42, 200
Medicine (unspecified).....	290	154, 644, 051	123, 695, 203
Mental health.....	18	5, 060, 096	3, 265, 594
Mental retardation.....	3	1, 921, 575	1, 246, 750
Microbiology.....	10	3, 917, 210	2, 761, 729
Neurology.....	1	30, 000	28, 641
Nutrition.....	11	2, 650, 236	1, 213, 081
Ophthalmology.....	2	343, 385	188, 500
Pathology.....	10	1, 074, 074	1, 007, 567
Pharmacy.....	23	5, 263, 482	3, 156, 507
Pharmacology.....	8	771, 491	700, 862
Physical medicine.....	1	195, 748	195, 748
Physiology.....	8	1, 490, 521	1, 474, 486
Plastic surgery.....	1	62, 237	62, 237
Psychology, unspecialized.....	35	7, 384, 466	4, 933, 936
Psychiatry.....	27	7, 963, 541	6, 141, 689
Radiobiology.....	7	1, 789, 551	1, 646, 338
Radiology.....	13	2, 816, 644	2, 176, 051
Sanitary engineering (unspecified).....	34	1, 839, 107	1, 482, 438
Statistical and experimental design.....	1	600, 000	379, 124
Surgery.....	20	5, 657, 234	4, 563, 986
Veterinary science/dairy science.....	37	8, 482, 942	6, 520, 478
Zoology (unspecified).....	7	1, 363, 187	866, 356
Anatomy, pharmacology.....	2	2, 523, 497	2, 115, 513
Biochemistry, biophysics (unspecified).....	1	60, 000	60, 000
Biochemistry, dental.....	1	133, 820	133, 800
Biochemistry, physiology (unspecified).....	1	25, 750	25, 750
Biology or biological sciences, chemistry.....	2	211, 650	141, 800
Biology or biological sciences, psychology (unspecialized).....	2	1, 358, 355	1, 249, 595
Biomedical engineering, general medical science (multidisciplinary).....	1	152, 677	67, 007
General medical sciences (multidisciplinary), medicine (unspecified).....	22	13, 714, 888	11, 524, 924
General medical sciences (multidisciplinary), physiology (unspecified).....	2	2, 353, 367	2, 204, 717
Dentistry, medicine.....	3	9, 426, 681	6, 723, 145
Dentistry, pharmacy (unspecified).....	2	1, 074, 783	757, 426
Medicine (unspecified), sanitary engineering (unspecified).....	1	86, 033	39, 900
Medicine (unspecified), surgery.....	7	602, 072	531, 887
Microbiology, pathology.....	1	232, 500	151, 000
Medicine (unspecified), radiobiology.....	1	3, 429, 216	3, 172, 736
Pharmacology, physiology.....	1	5, 548	5, 469
Dentistry (unspecified), medicine, microbiology.....	1	1, 536, 645	1, 473, 095

PUBLIC HEALTH GRANTS—HEALTH RESEARCH FACILITIES 15

Awarded projects by type of institution through Dec. 31, 1964

Type of institution	Number of projects	Amount requested	Awarded, fiscal years 1957-65
Total.....	990	\$411,656,149	\$319,999,19
Schools.....	698	319,998,776	257,351,024
Dentistry.....	23	6,345,746	5,882,971
Medicine.....	278	187,173,461	161,080,564
Osteopathy.....	1	5,548	5,489
Pharmacy.....	21	4,935,107	2,884,445
Public health.....	9	7,913,068	7,052,834
Technical college.....	20	3,409,126	2,289,152
University or college.....	325	99,275,343	68,782,019
Veterinary medicine.....	16	3,715,853	3,257,559
Dental and pharmacy.....	2	1,074,783	757,426
Medical and dental.....	2	1,720,901	1,614,295
Medical and public health.....	1	3,929,240	3,744,240
Other institutions.....	292	91,657,373	62,648,175
Hospitals.....	179	56,598,908	39,756,544
Research institutes.....	113	35,058,465	22,891,631

Geographic distribution of projects through Dec. 31, 1964

Area	Number of projects awarded	Amount requested	Awarded, fiscal years 1957-65	
			Amount	Percent
United States total.....	990	\$411,656,149	\$319,999,199	100.0
New England.....	130	49,660,627	38,184,027	11.9
Connecticut.....	24	14,122,512	10,359,123	-----
Maine.....	7	178,475	158,291	-----
Massachusetts.....	80	29,553,046	23,028,639	-----
New Hampshire.....	4	1,353,592	1,168,198	-----
Rhode Island.....	11	2,948,502	2,163,301	-----
Vermont.....	4	1,504,500	1,306,475	-----
Middle Atlantic.....	191	93,209,540	72,006,780	22.5
New Jersey.....	23	6,066,498	3,069,763	-----
New York.....	104	65,812,010	51,955,105	-----
Pennsylvania.....	64	21,331,032	16,981,912	-----
East north central.....	193	86,254,673	60,948,117	19.0
Illinois.....	71	36,630,644	25,811,602	-----
Indiana.....	25	4,955,562	3,520,800	-----
Michigan.....	26	15,517,807	11,244,414	-----
Ohio.....	46	18,590,715	13,141,010	-----
Wisconsin.....	25	10,559,945	7,230,291	-----
West north central.....	116	22,803,974	18,202,469	5.7
Iowa.....	22	3,445,233	2,594,733	-----
Kansas.....	16	3,431,364	2,186,740	-----
Minnesota.....	34	6,300,410	5,527,974	-----
Missouri.....	30	6,542,198	5,413,120	-----
Nebraska.....	6	1,988,022	1,843,102	-----
North Dakota.....	6	796,624	462,643	-----
South Dakota.....	2	300,123	174,157	-----
South Atlantic.....	109	45,789,467	38,940,229	12.2
Delaware.....	1	406,915	298,155	-----
District of Columbia.....	8	3,013,937	1,177,106	-----
Florida.....	24	8,054,467	6,787,781	-----
Georgia.....	15	5,922,922	4,677,871	-----
Maryland.....	20	10,767,711	10,209,157	-----
North Carolina.....	25	11,351,690	10,017,674	-----
South Carolina.....	2	576,172	568,484	-----
Virginia.....	10	5,079,937	4,947,685	-----
West Virginia.....	4	615,716	266,316	-----

Geographic distribution of projects through Dec. 31, 1964—Continued

Area	Number of projects awarded	Amount requested	Awarded, fiscal years 1957-65	
			Amount	Percent
East south central.....	43	\$15,142,802	\$13,219,439	4.1
Alabama.....	12	2,980,728	2,775,676	
Kentucky.....	9	4,436,999	3,931,737	
Mississippi.....	4	2,398,161	2,337,863	
Tennessee.....	18	5,326,914	4,174,163	
West south central.....	42	21,718,185	18,102,568	5.7
Arkansas.....	2	1,503,450	1,216,000	
Louisiana.....	7	5,233,744	4,238,940	
Oklahoma.....	11	2,967,835	2,224,686	
Texas.....	22	12,013,156	10,422,942	
Mountain.....	54	18,851,286	14,347,251	4.5
Arizona.....	10	2,132,396	1,102,086	
Colorado.....	20	6,273,766	4,872,963	
Idaho.....	1	19,076	19,076	
Montana.....	6	2,157,803	1,026,112	
Nevada.....	1	158,667	56,614	
New Mexico.....	6	2,163,775	2,146,602	
Utah.....	9	5,885,318	5,072,039	
Wyoming.....	1	60,485	51,759	
Pacific.....	111	58,157,591	45,980,315	14.4
Alaska.....	1	791,506	500,000	
California.....	66	46,202,574	35,411,398	
Hawaii.....	2	451,353	293,125	
Oregon.....	15	3,247,845	3,195,769	
Washington.....	27	7,464,313	6,580,023	
Puerto Rico.....	1	68,004	68,004	
Puerto Rico.....	1	68,004	68,004	

Dr. DEMPSEY. This program has made possible a great expansion of this Nation's medical research effort and continuing advances in the quality of that effort.

Although these accomplishments are impressive, they have far from met the total demands. One measure of the current need is the increasing backlog. It is estimated that, by the end of the fiscal year 1965, the backlog of grant applications which have been approved as meritorious by the National Advisory Health Research Facilities Council, but which cannot be funded out of available funds, will near \$80 million.

Furthermore, the demand for health research facilities is far from static. We should anticipate continued expansion of medical research. The advancing age of the population and the growing load of debilitating and chronic diseases have created new demands for increased research efforts against heart disease, cancer, stroke, mental impairment, and other major diseases. Heart disease, cancer, and stroke alone produce a great burden—more than \$30 billion per year—on our society.

The passage of the Health Professions Educational Assistance Act of 1963 is also a factor in increasing the demand for health research facilities. This act has encouraged establishing vitally needed new medical schools but the applications submitted by these schools dramatically show that research facilities are an essential and integral part of any medical, dental, or other health professional school.

Thus, the expansion of medical education in this country requires new research space. For, without research facilities, a new school cannot attract the faculty necessary for the instruction and inspiration of high-caliber students.

Superior education requires contact with the rapidly moving frontiers of research. Many of these new schools are located in States and cities where no medical school previously existed and the provision of research facilities for these schools, therefore, insures a broader geographic distribution of research funds.

Other demands for new research facilities arise out of the rapid changes in the nature of medical research. Modern methods of research can bring to bear, on major health problems, the full array of new scientific techniques but these new techniques often require additional space for the sophisticated instrumentation required. These new procedures often require complex and large-scale instrumentation involving higher standards of air conditioning and more precise environmental control. The rapid developments in biomedical research also call for the provision of more flexible research space which can be easily altered to accommodate new equipment without major alteration costs.

Increasing demands are being placed on health research facility funds to provide highly specialized facilities that serve as resources for many disciplines within an institution; such as, computer and bioinstrumentation facilities, clinical research centers, radioisotope laboratories, and facilities for germ-free animals.

These more exacting design requirements of laboratories lead to increased costs of laboratory construction as well as requirements for additional space to house the complex equipment. But this increasing sophistication makes obsolete the research facilities designed in a time when the techniques of science were less complex. Forty percent of the present medical research facilities of the country are estimated to be more than 20 years old. Many of these facilities are inadequate for modern research.

The cost of meeting these needs will be great but the cost to the health of the American people of impeding the progress of medical research through inadequate facilities would be even higher. The continuation of this valuable program for 5 more years and the proposed authorization of \$400 million over that period are minimal and essential steps which must be taken to insure the continued progress of medical research.

So far as construction of research facilities for national and regional purposes is concerned, the present construction program needs new authority which would enable construction of research facilities urgently needed for important national or regional purposes and which are beyond the scope, capability, or function of individual institutions. Such a program must be free from rigid requirements for matching funds.

The experience of the National Institutes of Health in encouraging research in the important field of aging has led to the firm conclusion that the only way to mount a truly effective research program in this field will be through establishing a series of major National Laboratories on Aging. Productive research programs in this complex field must combine a number of scientific disciplines and research activities in a manner different from the usual departmental framework of a

university or medical school. We are convinced that the contributions of the several scientific disciplines involved in aging can be substantially increased by providing specially designed research facilities permitting their organization into a cohesive program of laboratory, clinical, and field studies. A research area such as that in aging, so important in its potential benefits, should not be dependent solely upon the initiative of non-Federal institutions or upon their access to matching funds.

The Department has long been concerned with the problem of enlarging the national research effort in the complex problems encompassed within the fields of toxicology and pharmacology which are so crucial to understanding the phenomena of adverse drug reaction, the effect of pesticides, and the broad problems of atmospheric and water contaminants. This is a research area which demands substantially greater effort than is possible within the present academic institutions engaged in this activity. We need to undertake the development, in association with universities, of several major research centers which can bring to bear the diverse capabilities resident in schools of medicine, pharmacy, agriculture, and veterinary medicine in a new, combined, scientific attack upon the solution of the complex problems involved in the effects of exogenous agents upon man. The development of these centers, since they are beyond the scope and capability of individual institutions, demands a national construction effort.

The Nation also needs to bring to bear its full potential toward solving the major problems of dental disease. Based on experience to date, achieving this objective will require full support for the construction and operation of several special purpose research centers. These centers—or Dental Research Institutes—will be located in major university complexes where basic scientists, across a broad range of disciplines, can cooperate in new approaches to the stubborn problems of oral disease. Only through this purposeful approach, on a national scale, will it be possible to create environments adequate to draw into this vital field outstanding men from outside the conventional disciplines of dentistry.

This proposed authority might also be appropriately used for the construction of facilities that could serve as a research resource for a number of institutions within a region. It does not seem reasonable to use a matching grant for such regional facilities for this would require a single institution to commit sizable amounts of its own funds to serve the needs of an entire region. The further advance of the biomedical sciences will certainly present additional needs to provide research facilities which are clearly beyond the capability or responsibility of individual institutions.

In order to provide flexible means for achieving such research objectives identified on the national or regional level, this bill contains authority to construct or to finance the construction of health research facilities without a rigid requirement for non-Federal matching funds when a determination is made that such construction cannot be effectively or appropriately financed through a matching grant. The authority also provides, by contract or otherwise, for the operation of such facilities or for contributions toward the cost of the operation of similar facilities already constructed. It would also authorize transfer of title of any facility constructed under this authority to any public

or nonprofit institution, subject to appropriate conditions for the protection of the national interest.

While authority of this type is new, similar authority has long been available to other major Federal research-supporting agencies including the National Science Foundation, the Department of Defense, and the Atomic Energy Commission. It is our firm conviction that the importance of research in the sciences related to health demands that the Department have available the same range of authority that has proven so useful in the conduct of other Federal research programs.

CONTRACTS FOR RESEARCH

The bill would also make available certain research contract authorities which are presently available to the Department of Defense, and comparable to those utilized by the Atomic Energy Commission and the National Aeronautics and Space Administration in the conduct of their research activities. The Public Health Service Act as it now stands does not provide authority for the making of research contracts in the conduct of the Service's research programs. The research contract authority utilized by the Public Health Service is based on "point-of-order" language which appears annually in the appropriation statute. Thus, authority is inadequate in the present-day circumstances under which research programs are being conducted.

Progress in the biochemical sciences now makes possible the undertaking of deliberate developmental and applied research activities. The development of vaccines for respiratory diseases, the furtherance of research in the viral etiology of cancer, and the design and development of artificial organs such as the mechanical heart and the artificial kidney are examples of the current direction of research activities which progress in the basic sciences has made possible. The conduct of programs of this character requires greater control over the course of the technical activity and access to new kinds of engineering and scientific talent. Broader contract authority is essential if the Department is to move effectively in this area and to make broad use of the competency of industry in expanding research and development in emerging new areas important to our health programs.

The first of these authorities would permit payment of the costs of construction determined to be necessary in the performance of a research contract. Some research contracts require highly specialized facilities as an integral part of the research program. A current example is the special protective facilities required for continued work with dangerous and infectious agents encountered in the important research effort investigating the cancer-virus relationship. Without such authority, these research contracts must be administered within restrictions based on superficial distinctions between "temporary" and "permanent" improvements. These artificial distinctions result in the expenditure of additional money with no productive effect on the performance of the contract.

The second authority requested would provide for the indemnification of contractors against claims which arise out of direct performance of the contract and which are the result of a risk which the contract defines as unusually hazardous. This type of contract provision is often required if a contractor is to be induced to undertake work

which involves the handling of live viruses or the exposure to poisonous compounds. As I mentioned before, this authority has been available to the Public Health Service for a number of years through point-of-order language in the appropriation act.

In our attack upon major health problems we are now moving toward new efforts to expand scientific inquiry into problems of community health activity, into the urgent dangers of growing environmental hazards and toward the realization of the national objectives so magnificently stated in the President's health message. The three portions of this bill which relate to research authority constitute essential enlargement of the capability of the Department to assure strong advance in these areas.

I come now to the community health services extension amendments of 1965, S. 510. This would carry out recommendations made by President Johnson in his health message of January 7, 1965, for extending and otherwise amending certain expiring provisions of the Public Health Service Act relating to community health services.

The current programs which S. 510 would extend are those relating to community immunization activities, health services for migratory workers, general public health services, and special project grants for community health services. I will discuss each of these programs briefly.

IMMUNIZATION PROGRAMS

For the past 3 years funds have been authorized and appropriated under section 317 of the Public Health Service Act to assist States and communities in carrying out community vaccination activities against poliomyelitis, diphtheria, whooping cough, and tetanus. The legislative authorization for this program expires June 30, 1965.

Substantial progress has been made under this program in achieving a higher level of immunization against these four diseases. In addition, community programs have been developed which will maintain this level. As a result of these and other programs, the number of cases of poliomyelitis in the United States was reduced from 910 in 1962 to 121 in 1964; diphtheria from 444 to 306 cases in 1964; and tetanus from 322 to 271 cases in 1964. During this period, an estimated 58 million people under age 50 received 3 doses of oral polio vaccine and 7 million children under age 15 were immunized against diphtheria, whooping cough, and tetanus.

S. 510 authorizes an extension of Federal financial assistance in support of such programs for an additional 5 years. Despite the progress that has been made, the maximum desirable level of protection against poliomyelitis, diphtheria, tetanus, and pertussis has not been realized.

However, the major purpose of the extended authorization is to undertake a nationwide program of immunization against measles, one of the most infectious and serious of the childhood diseases. Approximately 4 million cases of measles occur in the United States each year, resulting in at least 500 deaths, and in extensive and serious disability, such as measles encephalitis, mental retardation, pneumonia, and hearing disorders.

Safe and effective vaccines against measles have become available since the Vaccination Assistance Act was enacted in 1962. There is no longer any reason why measles should continue to take its toll.

S. 510 would make Federal grant funds available by adding measles to the list of diseases against which federally assisted immunization programs are specifically authorized during the next 5 years.

S. 510 also authorizes Federal grant assistance for vaccination programs directed against other serious infectious diseases for which effective vaccines or other preventive agents may become available during the 5-year period. This "standby authority" is specifically limited to infectious diseases which represent a major public health problem and which are susceptible of practical elimination through immunization programs. This provision in the bill would permit prompt action to achieve on a nationwide basis the advantages and opportunities of new vaccines which may be developed through medical research.

HEALTH SERVICES FOR MIGRATORY WORKERS

The second program which S. 510 would extend for an additional 5 years is the program of grants for family health service clinics and other health services for domestic agricultural migrants and their families. The 3-year authorization for this program expires June 30, 1965.

About 1 million persons including workers and family dependents move during each crop season in response to seasonal farm labor demand. They live and work for brief periods in nearly one-third of the Nation's counties. Their health needs are acute as a result of their low income, lack of education and understanding of good health practices, geographic isolation from communities and their health services, and customary ineligibility for the health care afforded indigent residents because they lack permanent resident status anywhere.

The Public Health Service has assisted 60 county or multicounty projects in 29 States and Puerto Rico. The projects vary from one locality to another in the nature and scope of their service. They provide medical treatment for illness or injury, immunizations, case-finding and treatment of communicable diseases, pre- and post-natal care, and other preventive and curative services. Family health service clinics to provide medical and, in some cases, dental care have been established in or near farm labor camps; public health nurses have been employed to visit families in the camps on a regular schedule; sanitarians have joined projects to work with the migrants themselves and with property owners to upgrade housing and environmental conditions; and health educators have been hired to work with the migrants to develop better understanding of modern medicine and good health practices.

In each of the first 2 years under the current authorization, the amounts required by applications approved for funding have exceeded the funds available. The amount available for grants in this final fiscal year is inadequate to fund all of the new applications on hand, as of January 1.

Major emphasis of the program will continue to be on early care to reduce the need for hospitalization. We do propose, however, making financial assistance available for costs of hospitalization in short-term general hospitals if—

- (a) documentation of a problem in meeting hospital care needs is furnished;
- (b) a mechanism for furnishing early outpatient services and other preventive measures is part of the project; and

(c) assurance that payments for general hospital care from Federal grant funds will be only for migrants.

GENERAL PUBLIC HEALTH SERVICES

S. 510 would extend through June 30, 1967, the provisions of section 314(c) of the Public Health Service Act which otherwise will expire on June 30, 1966. The Public Health Service now makes grants to States for the provision of general health services, mental health services, radiological health services, dental health services, and health services for the chronically ill and aged under this authority. Also, under this authority, financial assistance to the 12 schools of public health is provided.

The purpose of the 1-year extension of this authorization is to permit a thorough study of the programs carried out under this authorization and development of necessary legislative recommendations to increase their usefulness. In addition to studies, which are being undertaken within the Department, the Public Health Service is also undertaking a joint review of legislative needs with the Association of State and Territorial Health Officers and the State and territorial mental health authorities.

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

S. 510 would also extend the provisions of section 316 of the Public Health Service Act for an additional 1-year period through June 30, 1967, pending completion of the studies which I have just mentioned. Under this section, which was enacted as part of the Community Health Services and Facilities Act, in 1961, financial assistance is provided to States and other public or nonprofit private agencies to undertake studies, experiments, and demonstrations looking toward the development of new or improved methods of providing health services outside the hospital, particularly for chronically ill or aged persons.

Under this program, the Public Health Service has been able, over the past 3½ years, to make grants for 187 projects in 40 States. With your permission, Mr. Chairman, I should like to provide for the record a listing of the project grants which have been made under this program.

The CHAIRMAN. We will be happy to have that listing appear in the record.

Dr. DEMPSEY. Thank you.

(The material referred to follows:)

SUMMARY OF APPROVED COMMUNITY HEALTH PROJECTS

I. ADMINISTRATION OF COMMUNITY PUBLIC HEALTH PROGRAMS

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-37 A-63	University of Pittsburgh, Pittsburgh, Pa.; Joseph D. McEville.	May 1, 1963, to Apr. 30, 1966 (full funded).	\$221,602

A project to establish a model system for the collection, storage, and retrieval of information relating to drug prescriptions. Recorded information from patients' prescriptions will be placed on magnetic tape for rapid retrieval to permit statistical studies of drug utilization, actuarial studies, market research studies of a retrospective nature, and studies of individual consumption and expenditures for prescribed medication. A long-range objective of the project is to permit retrospective studies of adverse reactions as well as prospective studies on the health benefits and hazards of specific drugs within a known population.

PHS region	Project No.	Grantee and project director	Period	Amount
V.....	CH 24-10 A-64	United Community Services of Metropolitan Detroit, Detroit, Mich.; Mary K. Guiney.	June 1, 1964, to May 31, 1965... Tentative.....	\$79,420 79,703 73,956

A program to take maximum advantage of the interrelationship between health, morale, and independence of aging persons who are living in their homes will be demonstrated and tested. The project will seek to develop methods of helping aging people maintain physical health while living in their own homes and to prevent, as far as possible, the development of health crises. It will determine whether there is a close interrelationship for aging persons between physical well-being, social well-being, and economic well-being.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 51-7 A-64	Washington State Department of Health, Olympia, Wash.; Bernard Bucove, M.D.	Jan. 1, 1965, to Dec. 31, 1965... Tentative.....	\$32,478 32,432 33,661

The overall objective of this project is to demonstrate the value of epidemiologic services in improving chronic disease control programs in the State of Washington. The health department will establish a section on noncommunicable disease epidemiology which will conduct epidemiologic investigations designed to develop new and applicable knowledge, in response to requests from persons or agencies with chronic disease control program responsibilities. Project evaluation will be based mainly on the extent to which the work of the section can be shown to have made contributions to improved control programs.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH 55-11 A-64	Southern branch, APHA, Birmingham, Ala.; George A. Denison.	Apr. 15, 1964, to Apr. 14, 1965, (1 year only).	\$47,548

This is a 1-year planning program to develop a 3-year demonstration program of inservice training at the undergraduate level to increase the knowledge and skills of those without formal training already employed in public health. The purpose is to upgrade community health services especially for the chronically ill and aged. Methods and course material will be developed by the project. Plans developed should lead to sound methods for conducting effective inservice public health educational programs.

II. STUDIES OF PEOPLE'S ATTITUDES TOWARD HEALTH PROGRAMS

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-38 A-63 CH 40-38 B-64	Allentown Hospital Association, Allentown, Pa.; Charles P. Sell, M.D.	July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965... Tentative.....	\$24,050 7,600 2,000

A project for a coordinated home-care program throughout Lehigh County to be provided by the Allentown Hospital Association in cooperation with other community agencies. The primary objectives are to provide such care to urban and rural patients who have received their initial care in the hospital; to find out why physicians do or do not refer patients for home-care services; to train physicians and paramedical personnel through this program; and to provide home-maker services from the hospital staff nursing aids. Comprehensive services will include medical care, nursing, physical therapy, speech therapy, homemaking, nutrition consultation, medical social service, lab service, and transportation as indicated in each case.

III. TRAINING AND UTILIZATION OF PERSONNEL

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH 21-3 A-64	Bingham Associates Fund, Boston, Mass.; George J. Robertson, M.D.	July 1, 1964, to June 30, 1965... Tentative.....	\$62,705 82,826 64,122

In this project, an attempt will be made to upgrade medical care in the State of Maine through the use of open-circuit television. Television is a possible medium for bringing the teaching programs of university hospitals to the practicing physicians who do not take part in established postgraduate educational programs, but who are most active in out-of-hospital care; such as, home care, nursing home care, care of the aged, and the chronically ill and disabled. Educational TV facilities are available and can reach over 90 percent of Maine's physicians. A series of 16 one-half-hour presentations yearly is contemplated. Evaluation of television as a method of postgraduate education will be included as a research portion of the project.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 32-5 A-63	New Jersey Tuberculosis & Health Association and the hospital center at Orange, N.J.; Earl F. Hoerner, M.D.	Feb. 1, 1963, to Oct. 31, 1964 (full funded).	\$59,498

A project to demonstrate the feasibility of a comprehensive program of medical care and rehabilitation for unhospitalized patients with chronic respiratory disabilities. A regional teaching facility will be established to provide training opportunities for professional personnel in evaluation, treatment, and rehabilitation of the respiratory disabled. It is also proposed to demonstrate the value and adaptability of this program as a community service in other areas of New Jersey.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-2 A-62 CH 34-2 B-63..... CH 34-2 C-64	Montefiore Hospital, New York, N.Y.; George A. Silver, M.D.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965....	\$40,000 40,000 40,000

A project to demonstrate a comprehensive training program for planners and operators of coordinated home care programs. Through expansion of the home care program of the hospital, selected professional health personnel are to be trained in organizing and operating home care programs. Both short- and long-term training is made available for several types of trainees, including community leaders who are expected to stimulate and influence coordinated home care services. The chief focus of the training will be to orient the trainees in proper utilization of community resources to meet homebound patients' needs, with particular reference to home care services.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-14 A-63	Visiting Nurse Service, of New York, New York, N.Y.; Miss Anna Fillmore.	Nov. 15, 1962, to Dec. 31, 1963, (1 year only).	\$44,079

Support is given under this project for the production of an educational film to assist in preparing nurses for better understanding and improved care of the chronically ill and aged in their homes. The film will be produced by Vision Associates, Inc., New York, on a contract basis. Because of the increasing numbers of persons over 65 years of age with chronic illness and the trend toward caring for them in their homes, it is felt that the film will be of assistance to agencies which are expanding their programs or developing new programs on care of the sick and aged at home and to schools of nursing, both in hospitals and universities. The Visiting Nurse Service of New York will be responsible for promoting wide distribution of the film either through the American Nurses Association, National League for Nursing Film Service, or through some other channel.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-25 A-63 CH 34-25 B-64	Jewish Home and Hospital for the Aged, New York, N.Y.; Frederic D. Zeman, M.D.	Sept. 19, 1963, to Aug. 31, 1964. Sept. 19, 1964, to Aug. 31, 1965. Tentative.....	\$20,050 20,535 20,535

This project will establish a training center within the Home for Aged and Infirm Hebrews of New York to prepare qualified health professionals to handle special problems of the aged and aging. Courses will be offered by the institution's professional staff as well as a group of invited faculty instructors utilizing other community agencies for demonstration purposes. Evaluation will be based on the enthusiasm with which the program is received by the personnel being trained.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-30 A-63 CH 34-30 B-64	Henry Street Settlement, New York, N.Y.; Mrs. Marion Kron.	July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965... Tentative.....	\$42,200 53,940 47,810

In this project, a small professional staff will recruit, train, and supervise approximately 100 volunteers in a variety of health-assistance tasks. Referrals for service will come from nearby clinics and hospitals, public housing management, the department of welfare, private agencies, and individuals. Help will be given to the homebound with light housekeeping, shopping, and meal planning. Escort service will be provided in connection with outpatient treatments, and home visits will be paid to convalescents and incapacitated. A participant-observer will record and analyze referral and training procedures and evaluate services rendered. An advisory council representing area agencies, will review progress and guide activities.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-43 A-64 CH 40-43 B-65	Montefiore Hospital Association of Western Pennsylvania, Pittsburgh, Pa.; Mrs. Celia R. Moss.	Jan. 1, to Dec. 31, 1964..... Jan. 1, to Dec. 31, 1965..... Tentative.....	\$39,215 42,845 39,671

This project will establish a training and information center for home care and related community services for the chronically ill for planning, developing, conducting, and evaluating a series of educational experiences toward providing

orientation in the establishment, operation, and improvement of coordinated home care programs and related out-of-hospital services. The program will be geared to multidisciplinary groups as well as individual professions. Methods will include courses in teaching specifics, planned institutes, seminars, and workshops.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-44 A-64	University of Pittsburgh, Pittsburgh, Pa.; Frances L. Drew, M.D.	Oct. 1, 1964, to Jan. 31, 1966... Tentative.....	\$24,677 25,049 25,420

Because the medical student's horizon of illness is being increasingly limited to the clinic or hospital setting surrounding a patient, the objective of this project is to improve the understanding of these students about certain aspects of chronic disease. The medical student usually has little appreciation of the fact that patients return to a social setting which may importantly influence the course of the disease; he often delegates to the social worker the job of agency referral, often never discovering which agencies were chosen and why, nor what agency functions and limitations may be; and while he has the opportunity to study the diagnostic and therapeutic aspects of chronic disease, its social, financial, and epidemiologic aspects are ignored. Training will consist of observations of various community health problems and programs, field placement, and a written report of a study conducted during the training period. Evaluation will be based on the number of students seeking training, the content of the training experience, the quality of the student projects, and the amount of service performed for various community agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 09-3 A-63 CH 09-3 B-64 CH 09-3 C-65	George Washington University, Washington, D.C.; Frederick H. Gibbs.	Jan. 15, 1963, to Jan. 14, 1964... Jan. 15, 1964, to Jan. 14, 1965... Jan. 15, 1965, to Jan. 14, 1966...	\$74,958 83,914 77,669

The university will develop criteria and text material for a program of instruction of nursing home administration personnel by correspondence. The general purpose will be to develop courses which can be undertaken in many locations throughout the Nation with an aim to providing students with administrative understanding which might help them meet the standards required by the States in which they are located. Also to be developed is a screening test for applicants which will give an inclination of the level of instruction which should be offered, and a methodology for evaluating the text used and the instructional methods employed.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 41-3 A-63 CH 41-3 B-64 CH 41-3 C-65	University of Puerto Rico, San Juan, P.R., L. E. McKelvey.	Feb. 1, 1963, to Jan 31, 1964... Feb. 1, 1964, to Jan. 31, 1965... Feb. 1, 1965, to Jan. 31, 1966...	\$73,047 66,123 57,819

This project will investigate and evaluate the dental health care requirements of the people of Puerto Rico and formulate an effective plan to provide such services. It will be a pilot project to be used as an example to establish like facilities and procedures in all municipalities in Puerto Rico. Personnel will be trained at the University of Puerto Rico and will then form the nucleus to staff succeeding facilities.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 52-10 A-65	West Virginia State Department of Health, Charleston, W. Va., Eugene J. Powell.	Jan. 1, to Dec. 31, 1965... Tentative.....	\$17,910 15,100 11,200

This project will be a study to improve the quality of emergency transportation and immediate care available to the sick and injured, the study to cover all 55 counties of West Virginia. The first phase will determine the current status of emergency transportation, the second phase will consist of a training program to be developed and conducted by the staff of West Virginia University Medical Center in cooperation with the sponsor and other nonofficial organizations to raise the training level of ambulance drivers and crews. The third phase will consist of continuing educational efforts and development of a demonstration program for emergency services in a well-organized community selected on the basis of the survey.

PHS region	Project No.	Grantee and project director	Period	Amount
IV.....	CH 45-8 A-65	Outlook Nashville, Inc., Nashville, Tenn., Mrs. Elsa T. Ellis, A.C.S.W.	Nov. 1, 1964, to Oct. 31, 1965... Tentative.....	\$30,402 29,130 29,525

This project will recruit and train nonprofessional teenagers and adults to provide appropriate homemaker services to persons who are handicapped. Basic and advanced training courses will be standardized, with a flexible outline of content which can be adjusted to community resources as well as to range of age, intellectual and cultural levels of understanding of the trainee. The prime objective is to help the trainee feel more comfortable around persons who are physically, mentally or emotionally "different," through development of a greater understanding and acceptance of the individual as a person, with the disability being seen in its proper perspective. The ultimate goal of the project is to demonstrate the value to a community when trained nonprofessionals are made available to all handicapped persons who might benefit from their services.

PHS region	Project No.	Grantee and project director	Period	Amount
V.....	CH 24-4 A-63 CH 24-4 B-64 Supplement B-65	University of Michigan, Ann Arbor, Mich., Vlado A. Getting, M.D.	Apr. 1, 1963, to May 1, 1964... May 2, 1964, to Apr. 30, 1965... Tentative.....	\$30,824 29,447 2,000 32,007

This project will establish a training program in home care as a joint endeavor of the University of Michigan School of Public Health and the Visiting Nurse Association of Detroit. The training program will consist of four 4-day institutes in each of 3 years. Materials developed will be published, and later developed into a training manual which should be of value to communities interested in developing home-care services in the future.

PHS region	Project No.	Grantee and project director	Period	Amount
V.....	CH 37-21 A-65	University Hospitals of Cleve- land, Cleveland, Ohio, Dr. Malcolm S. Mackenzie, Mrs. Mary F. B. Mohammed, R.N.	Award not issued as of Dec. 31, 1964.	\$43,916 36,322 25,544

The project objective is to write programed instructional material for persons with diabetes mellitus, administer it to a selected group of patients, and evaluate its effect on diabetes control, patient learning, and patient attitude. The proposed programed instructions will incorporate the actual performance of the desired behavior as an integral part of its structure in the expectation that this may lead to improved self-care and control of the diabetes, as well as to an in-

creased knowledge of the facts about diabetes. Evaluation of the programmed course will be through trial use, item analyses, and revisions.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 53-4 A-65	Wisconsin State Board of Health, Madison, Wis.; Milton Feig, M.D.	Oct. 1, 1964, to Sept. 30, 1965... Tentative.....	\$48,091 51,741 44,435

The Wisconsin State Board of Health will develop and conduct a 4-month course to train certified occupational therapy assistants as activity program directors in nursing homes. The course will follow guidelines established by, and will seek the approval of, the American Occupational Therapy Association. Priority for admission will be given persons presently functioning as activity program directors, with second and third priority given other employees of nursing homes and unemployed persons, respectively. After thorough evaluation of the project, if a need for continuation of the course has been demonstrated, it will become an integral part of the State board of health program activities.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH 27-1 A-62 CH 27-1 B-63 CH 27-1 C-64	Jewish Hospital of St. Louis, St. Louis, Mo.; Franz U. Steinberg.	Sept. 1, 1962, to Aug. 31, 1963... Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965...	\$45,367 49,173 45,656

The project will establish a demonstration training center for home care and other out-of-hospital services to train members of the health professions and related groups in the principles of organization and operation of the out-of-hospital health care programs that serve the long-term patient. It will also collect and exchange information about organized out-of-hospital services, and report on research in programing, administering, and evaluating these services. The training program is designed to offer a variety of training opportunities geared to the total area of home care.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH 20-1 A-63 CH 20-1 B-64 CH 20-1 C-65	Louisiana State University, Baton Rouge, La.; Dr. Clara Tucker.	Oct. 1, 1962, to Sept. 30, 1963... Oct. 1, 1963, to Sept. 30, 1964... Oct. 1, 1964, to Sept. 30, 1965...	\$18,274 22,518 17,133

This project will demonstrate methods of training homemakers using home economics teachers and will develop curriculums for training homemakers in different kinds of communities. Special training workshops will be established for home economics teachers selected to teach community training classes for homemakers who are adaptable and willing to give homemaking services in families seeking assistance in the care of the aging or the chronically ill. After 3 years of the project, it is estimated that 125 home economics teachers will be trained for leadership responsibilities in community training programs of homemakers, and more than 125 communities will have had opportunity to experience and appraise these programs. Contributions of trained homemakers are hoped to alleviate the personnel shortage in nursing homes and hospitals and in providing medical, nursing, and welfare services.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII-----	CH 28-1 A-65	Montana State Board of Health, Helena, Mont.; Mary E. Soules, M.D.	Oct. 1, 1964, to Sept. 30, 1965... Tentative.....	\$19,585 13,300

The first phase of this project will evaluate the present level of emergency medical services in the State. By appropriate community education, the grantee hopes to stimulate and continue public awareness to the needs in emergency medical services, and to provide training for those persons from a community involved in emergency medical services. Reevaluation of the emergency medical services after proper training has been instituted will determine if the level of service has been raised

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 05-40 A-64 Supplement A-65	Stanford University, Palo Alto, Calif.; Lucille Daniels.	Sept. 1, 1964, to Aug. 31, 1965.. Tentative.....	{ \$34,520 924 34,026 43,547

The purpose of this project is to provide opportunities for students in the basic curriculum and the graduate programs in physical therapy to develop the knowledge and skills at their level of competence to function effectively in a multi-disciplinary out-of-hospital program. Through the cooperative efforts of the grantee and the associate community agencies, the student will be provided learning situations in a correlated and integrated didactic and clinical training program. Opportunities for out-of-hospital patient care in conjunction with other medical disciplines will be included in the student's training. Teaching aids and materials will be developed and designed for this area.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH 55-10 A-63	Community Research Associates, Inc., New York, N. Y.; Donald B. Glabe.	Sept. 1, 1963, to Aug. 31, 1966 (full funded).	\$268,122

An inservice training program to produce workers with a combined knowledge of the health problems and social problems of the people they serve. A basic operational pattern for staff development and inservice training will be developed through the combined efforts of key training personnel from the State and county welfare departments. The knowledge and techniques developed will be applied and tested through the public welfare agencies, and a report will be prepared which will deal with the substance and methods of inservice training in health and welfare agencies focusing on the prevention and control of community problems through the use of systematic classificational and rehabilitative procedures.

V. HOME CARE, HOMEMAKER SERVICES, AND NURSING CARE

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH 07-1 A-62	Hartford Health Department, Hartford, Conn.; Leonard F. Menzler, D.D.S., M.P.H.	Apr. 15, 1962, to Apr. 14, 1963 (1 year only).	\$2,875

The project will add a dental component to a community home care program which has been in operation for 6 years. It is designed to provide such dental service as needed commensurate with the patient's physical and emotional tolerance and needs. The project is expected to supply information on dental services in home care programs which will broaden the base of experience that can be utilized in initiating similar programs elsewhere. PHS support is being used primarily for equipment for the dental care program.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 23-8 A-63	Boston City Hospital, Boston, Mass.; Julius Abramson, M.D.	June 1, 1963, to May 31, 1964...	\$34,344
	CH 23-8 B-64		June 1, 1964, to May 31, 1965...	41,134
			Tentative.....	23,229

The applicant will initiate a home care program for pregnant cardiac patients to avoid development of congestive heart failure and also reduce hospitalization. Care of such patients at Boston City Hospital has been successful but long hospitalization and the emotional and financial cost to the patient and her family has often been great. It is hoped the program will establish a pattern which could be followed by other agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 42-5 A-63	Family Service, Inc., Providence, R.I.; Edward M. Kenly.	July 1, 1963, to Mar. 31, 1965...	\$21,836
			Tentative.....	42,964 48,688

This project will demonstrate a method of organization for providing homemaker service which will have applicability in sections or localities set off by geographic and other conditions as entities and which have, in combination, urban, suburban, and/or semirural characteristics. The demonstration will combine centralized administration and decentralized service units under the sponsorship of a family counseling service which already offers homemaker service as an integral part of its program of casework service.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 32-8 A-63	East Orange Health Department, East Orange, N.J.; J. Robert Lackey.	Sept. 1, 1963, to Aug. 31, 1964...	\$37,680
	CH 32-8 B-64		Sept. 1, 1964, to Aug. 31, 1965...	37,315
			Tentative.....	37,784

This project will coordinate the efforts of the VNA's of the Oranges and Maplewood, the East Orange General Hospital, and the East Orange Department of Health to provide improved continuity of health services for the chronically ill and aged who are outpatients or discharged hospital patients. It will demonstrate the improvement in health care services that can result from the establishment of a collaborating team made up of members of the staff of a hospital, visiting nurse association, and a health department. Periodic evaluation will be made covering number of persons served, review of services provided, and review of financial statistics to determine cost per patient cared for.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-7 A-62	Rip Van Winkle Foundation, Hudson, N.Y.; Caldwell Blakeman Esselstyn, M.D.	July 1, 1962, to June 30, 1963...	\$60,000
	CH 34-7 B-63		July 1, 1963, to June 30, 1964...	60,000
	CH 34-7 C-64		July 1, 1964, to June 30, 1965...	60,000

The purpose of this project is to establish a comprehensive program to meet the out-of-hospital needs of the chronically ill and aged in a rural community which has a high proportion of chronically ill and aged persons. It is expected this project will demonstrate how a countywide organization, by mobilizing and coordinating all resources, can best approach the problem of providing continuity of service and a direct comprehensive health care program in a rural area. Data will be provided as to the kinds and numbers of services required in such a program and costs of services.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-21 A-63 CH 34-21 B-64 CH 34-21 C-65	Visiting Nurse Service of New York, New York, N.Y.; Mrs. Ione Carey.	Dec. 1, 1962, to Feb. 29, 1964... Mar. 1, 1964, to Feb. 28, 1965... Mar. 1, 1965, to Feb. 28, 1966...	\$161,404 180,012 130,000

This project will demonstrate the feasibility of providing a visiting home aid service to the chronically ill and aged in conjunction with the visiting nurse services. The "home aid" as used in this project is a person oriented toward work in homes with chronically ill or aged patients when no family member is available to care for the home and the patient's personal needs. A nurse supervises the aid and evaluates the patient's and the family's need for services. The sponsor plans to determine the extent of the need for home aid service in the Visiting Nurse Service of New York caseload of the chronically ill and aged in Queens; the types of workers required to meet the needs of the patients and families served and the possibility for recruiting these workers; and the cost of home aid services. Also, the sponsor will determine the effect on the nursing service by addition of the aid program.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-22 A-63 CH 34-22 B-64	Visiting Nurse Association of Brooklyn, Inc.; Patricia Hughes.	Mar. 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965... Tentative.....	\$43,045 42,822 39,854

This project will demonstrate the effectiveness of adding home visiting aids to the health team of the VNA. They will work as members of the nursing team and be supervised by the professional staff members and the project director, assisting with personal care and doing simple household tasks. It is expected to determine the feasibility of adding such a group to the VNA team as well as to determine the best method for training them.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-29 A-63 CH 34-29 B-64	District Nursing Association of Northern Westchester County, Mount Kisco, N.Y.; Sybil P. Bellos.	Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965... Tentative.....	\$46,000 44,840 27,130

This project will develop a corps of nonprofessional workers to be known as health aids who will assist in the care of chronically ill patients in their homes. It will demonstrate the distinctive roles and the types of professional activity required of the professional social worker and the public health nurse in initiating and maintaining a quality health aid service, and ascertain which personal services and housekeeping duties can be performed by a trained health aid in the person's home under direct supervision of the project PHN. It will also make a study of the cost of such a service in a highly rural community. The project will utilize the existing Social Service Department of Northern Westchester Hospital, the nursing and consultant services of the Westchester County Department of Health, and will be an integrated part of the DNA of northern Westchester.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-33 A-64 CH 34-33 B-65	Council of Social Agencies of Rochester & Monroe Co., Inc., Rochester, N.Y.; Grace B. Chilman, R.N.	Mar. 1 1964 to Feb. 28, 1965... Mar. 1, 1965 to Feb. 28, 1966... Tentative.....	\$20,005 21,310 22,533

32 PUBLIC HEALTH GRANTS—HEALTH RESEARCH FACILITIES

The purpose of this project is to demonstrate the effectiveness of a minimal cost foster family care program for a select group of aged and infirm persons for whom this type of care is appropriate. The value of such a program should result in: (a) maintenance of independence for a longer period of time; (b) prevention of premature or inappropriate placement in other care settings; and (c) prevention of premature mental and physical deterioration.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-48 A-64 Supplement A-65	St. Luke's Hospital, New York, N.Y.; Dr. Paul R. Torrens.	Sept. 1, 1964 to Aug. 31, 1965... Tentative.....	{ \$46,227 5,730 48,714 50,670

Morningside Gardens is a group of middle-income cooperative apartments in New York City. The purposes of this project are: To determine the need for and utilization of various health and health-allied services among the residents of such a housing project; to determine the ability of this group to meet the needs for these services by utilizing volunteer workers drawn from the group itself; and to determine the feasibility of establishing a prepaid, self-supporting insurance plan to provide those services which cannot be provided by the volunteer workers. Periodic evaluations will be made.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 40-1 A-63 CH 40-1 B-64	Pennsylvania Department of Health, Harrisburg, Pa.; Miss Margaret K. Murphy.	Nov. 1, 1963 to Oct. 31, 1964... Nov. 1, 1964 to Oct. 31, 1965... Tentative.....	\$12,055 6,719 6,461

The purpose of this project is to prove that the addition of licensed practical nurses to the nursing staff for home nursing care is economical and permits better care of more people. It is the opinion of the sponsor that many of the services required by chronically ill persons could be given as well by practical nurses, and this project will make job studies and judgmental analyses of nurse functions in new areas of service in order to determine the level of preparation necessary for the various aspects of care, and to determine whether those tasks which do not require public health or professional nursing competence can be grouped so as to make such differential assignment feasible and safe. Quantitative and qualitative analyses will be made of the effect of using such practical nurses.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 40-14 A-62 CH 40-14 B-63 CH 40-14 C-64	Phoenixville Community Nursing Service, Phoenixville, Pa.; Miss IdaMae Siegfried.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965... (2 years only.)	\$12,790 10,182 7,800

The sponsor is making a 3-year study of the feasibility of providing physical rehabilitation services at home for the chronically ill and aged. It is expected to demonstrate that a visiting nurse in a small community can provide good physical rehabilitation care in the home and to document the value of home rehabilitation with statistics based on this program. The experience gained should be of value as a guide for VNA's elsewhere.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 40-21 A-62 CH 40-21 B-63	Visiting Nurse Association of Allegheny County, Inc., Pittsburgh, Pa.; Alice K. deBenneville, R.N., M.P.H., Betty Jane McWilliams, Ph. D.	May 15, 1962, to May 14, 1963. May 15, 1963, to May 14, 1964. (2 years only.)	\$24,960 23,905

This project will demonstrate the extension of services of the VNA to include services to patients with special defects, particularly those resulting from cerebral accident, spasticity, and other neurological center speech defects. These services are provided in the home by a full-time speech clinician who guides public health nurses in providing supportive services to patients. Staff of the University of Pittsburgh Speech Department are assisting in developing and evaluating the program. The results of the demonstration could make a worthwhile contribution to the total rehabilitation plan for the patient and also could be beneficial in improving the emotional health of the patient and his family.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 40-52 A-64	Jefferson Medical College & Medical Center, Philadelphia, Pa.; Joseph F. Rodgers, M.D.	June 1, 1964, to May 31, 1965... Tentative-----	{ \$44,493 44,493 44,493

A home care program will be established to provide coordinated medical and nursing care to chronically ill patients who are essentially homebound. The program will be hospital based; all activities, including physicians' services, laboratory services, X-rays, medications, etc., will be coordinated by the grantee. Paramedical services will be purchased from Community Nursing Service of Philadelphia and other existing agencies in the city. Coordination of services will provide needed medical services to a segment of the population often neglected and will also greatly improve the efficiency of bed utilization by decreasing the hospital stay and preventing unnecessary hospitalization.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 22-4 A-63	Talbot County Health Department, Easton, Md.; Louis S. Welty, M.D., M.P.H.	Feb. 1, 1963, to Apr. 30, 1964 (project canceled after 1st year of operation).	\$23,444

A project to demonstrate the value of using public health nurses to assist in discharge planning for patients released from the memorial hospital in Easton. It will measure the effect of the planning on length-of-stay and readmission rate of those patients who were admitted for hospitalization at State expense. Because the area is one with limited financial resources and facilities, it is felt that the result of the study will be of benefit to other areas with similar characteristics.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 35-8 A-63	Durham County Health Department, Durham, N.C.; Dr. O. L. Ader.	July 1, 1963, to June 30, 1965 (full funded).	\$21,630

The department has designed a program to determine the value of home followup care on patients with congestive heart failure. In this program, the services of a nurse are utilized in bridging the gap between the physician and the dietitian in established medical facilities and the patient and his family at home. The department plans to determine: Whether better control of congestive heart failure can be obtained by followup home care of this type; whether the frequency and length of hospitalization for recurrent congestive heart failure can be decreased; and what the comparison of total money spent for the care of congestive heart failure, in the control and home followup groups, is.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 49-1 A-62 CH 49-1 B-63 CH 49-1 C-64	Fairfax County Health Department, Fairfax, Va.; Harold Kennedy, M.D., M.P.H.	Aug. 1, 1962, to July 31, 1963... Aug. 1, 1963, to July 31, 1964... Aug. 1, 1964, to July 31, 1965...	\$33,434 45,502 37,536

The objective of the project is to establish a coordinated home care program and to demonstrate the value of this type of service for the medical, social, and psychological adjustment of the patient and the family to problems of the chronically ill and aged patient in the home. The local health department will coordinate the activities of a number of other community resources for delivery of a wide variety of home care services. It is expected to add homemaker services to the program.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 52-2 A-63	Family Service Association, Morgantown, W. Va.; Mrs. Leonard Sizer.	Jan. 1 to Dec. 31, 1963.....	\$38,904
	CH 52-2 B-64		Jan. 1 to Dec. 31, 1964.....	47,250
	CH 52-2 C-65		Jan. 1 to Dec. 31, 1965.....	54,275

The project will provide, for the first time in Monongalia County, a county-wide visiting homemaker service which will be aimed primarily at the chronically ill and aged. Its purpose is to enable such persons to remain in their own homes, if possible, or to reduce their length of stay in hospitals. It will supplement the work of the bedside nursing program of the county health department, and will develop a continuing demonstration and evaluation program to test the efficiency of such a service.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 52-4 A-63	The Children & Family Service Association, Inc.; Manuel J. Viola.	Mar. 1, 1963, to Feb. 29, 1964...	\$20,972
	CH 52-4 B-64		Mar. 1, 1964, to Feb. 28, 1965...	23,112
	CH 52-4 C-65		Mar. 1, 1965, to Feb. 28, 1966...	21,808

A project to determine whether home care for the chronically ill and aged through homemaker services will prevent unnecessary hospitalization for this group, and whether the homemaker can provide basic services; or will it be necessary to use other services such as meals-on-wheels, volunteers, and other community resources. The project will be carried out in cooperation with the VNA of Ohio County who will provide a physical therapist as well as visiting nurses.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 52-5 A-63 CH 52-5 B-64	Visiting Nurse Association of Ohio County, Inc., Wheeling, W. Va.; Regina C. Griffith, R.N.	Aug. 1, 1963, to July 31, 1964...	\$19,197
			Tentative.....	{ 21,561 19,521

This project will provide support for the Visiting Nurse Association which is working in conjunction with the Children and Family Service Association and the local health department in providing homemaker services. The need for such services will be defined, and an analysis of the homemaker's job in relation to the agency best fitted to administer the service will be made. Emphasis will be placed on the utilization and evaluation of individual methods of referral and better utilization of health and welfare resources. The sponsor will also study and evaluate the contribution of a physical therapist and licensed practical nurse to the public health nursing program.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 01-2 A-62	Visiting Nurse Association, Birmingham, Ala.; Mrs. Helen Lloyd.	July 1, 1962, to June 30, 1963..	\$35,349
	CH 01-2 B-63		July 1, 1963, to June 30, 1964..	37,313
	CH 01-2 C-64		July 1, 1964, to June 30, 1965..	37,311

The association will study the effect of communitywide homemaker activities in health care programs for the chronically ill and aged in Jefferson County. The sponsor plans to experiment in the use of male homemakers for certain types of situations; determine the cost of providing such services; and identify the needs of the chronically ill and aged and study how many of these can be met through homemaker services. Homemakers are given training prior to assignment to give services in the home. A variety of community resources representing several professional disciplines will be used in teaching the homemaker course. It is expected a teacher's guide will be developed. Other community participation includes the selection and appointment of an advisory committee from representative community agencies supporting the project and possibly using the services.

PHS region	Project No.	Grantee and project director	Period	Amount
V.....	CH 37-19 A-65	Community Chest & Council of the Cincinnati Area, Cincinnati, Ohio; Mrs. Mary H. Little.	Jan. 1, to Dec. 31, 1965..... Tentative.....	\$42,850 70,300 67,200

This project is a demonstration of home aid service for chronically ill patients and feeble aged persons in a large metropolitan area covering five counties in two States. The main objectives are: To learn how to give such service in a large area; to delineate more clearly the characteristics of such a service as distinguished from traditional homemaker services; to learn how to relate such service to a protective program for older people; and to learn how best to correlate the service with a home medical care program. One of the aims of the project is the determination of auspices under which the service can best be given.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 18-1 A-63 CH 18-1 B-64	University of Kansas Medical School, Kansas City, Kans.; Charles E. Lewis, M.D.	July 1, 1963, to June 30, 1964 .. July 1, 1964, to June 30, 1965 .. Tentative.....	\$58,227 61,019 63,304

This project will establish a combination service and training program in home care and community health, coordinating services of the sponsor, local health departments, and the VNA of Kansas City. It will provide services for certain indigent medical patients in the community through various community agencies. Student nurses and other students will rotate through this program in addition to various other community health projects. The program will provide for teaching and demonstration, as well as service, and will demonstrate the feasibility of such integrated care in a metropolitan area and the need for coordinated effort by both official and voluntary health agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 18-2 A-64 CH 18-2 B-65	Cloud County Health Department, Concordia, Kans.; Elta M. Kennedy, R.N.	Jan. 1 to Dec. 31, 1964..... Jan. 1 to Dec. 31, 1965..... Tentative.....	\$13,844 12,548 16,510

The Cloud County Health Department will determine the need for, demonstrate, and ascertain the additional cost of providing for citizens of all ages and at all economic levels, nursing care of the sick at home. This particular type of rural nursing care in the home has not been successfully demonstrated in this county, and in some surrounding States, and the achievement of the objectives should contribute to the extension of public health and visiting nursing in rural communities.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH 27-17 A-63 CH 27-17 B-64	Department of Health and Hospitals, St. Louis, Mo.; Bernard T. Garfinkle, M.D.	July 1, 1963, to June 30, 1964 .. July 1, 1964, to June 30, 1965 .. Tentative.....	\$17,350 17,000 16,850

This program will be directed toward the control of recurrences of congestive heart failure and reduction of multiple hospital admissions for this group of patients by the use of paramedical personnel in an organized followup program. The program will incorporate regular home visits by visiting nurses, diet counseling for the patients, and medical social worker consultation for correction of socioeconomic problems. It is hoped that such services will lessen the problems commonly arising in congestive heart failure patients which tend to bring on recurrences, and regular visits by a nurse will detect early changes in the patient's condition which warrant outpatient therapy and thereby prevent rehospitalization.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH 27-23 A-64	Catholic Charities of St. Louis, St. Louis, Mo.; Rev. Robert P. Slattery, M.S.W., A.C.S.W.	Sept. 1, 1964, to Aug. 31, 1965 .. Tentative.....	{ \$104,480 146,335 150,580

This project will develop a method of providing comprehensive home care services to meet the total physical, social, and emotional needs of aged and/or chronically ill persons within the scope (including the cost factor) of individual and community resources. This would be an organizational model which can be duplicated in other communities or parts of this community. It will identify services currently available, identify patient characteristics which enhance or detract from a person's acceptance or rejection of comprehensive home care services, and establish a cost accounting system to determine the unit costs of providing home care services. It will also utilize the training potential in the project to develop course outline, curriculum, and training objectives for training of paramedical personnel, case aids, and neighborhood volunteers.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH 36-1 A-62 CH 36-1 B-63 CH 36-1 C-64	Fargo City Health Department, Fargo, N. Dak.; D. H. Lawrence, M.D.	July 1, 1962, to June 30, 1963 .. July 1, 1963, to June 30, 1964 .. July 1, 1964, to June 30, 1965 ..	\$6,953 7,418 7,164

A project to extend official public health nursing services to provide home nursing care for the chronically ill and aged and show the value of therapeutic nursing services as a part of a health department nursing program. Also, it is to provide clinical experience for nursing students from the college of nursing. It is expected that such a demonstration will be of value to other communities in North Dakota and in neighboring States in planning for home nursing care in rural areas.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH 38-4 A-62 CH 38-4 B-63 CH 38-4 C-64	University of Oklahoma, Norman, Okla.; Charles McDaniel.	July 1, 1962, to June 30, 1963 .. July 1, 1963, to June 30, 1964 .. July 1, 1964, to June 30, 1965 ..	\$21,470 18,650 16,156

A project to demonstrate and evaluate a method of establishing homemaker services in small communities in Oklahoma, to increase the rate of development of homemaker services, especially in medium-sized and smaller communities, and to develop a method of insuring an increasing supply of persons available to

A study to determine the contributions a dental hygienist can make to improve the dental health status of the chronically ill and handicapped individuals who are confined to nursing homes or are homebound. The hygienist is to develop a program of casefinding and screen and refer those needing the services of a dentist to appropriate dental resources. Further, the chronically ill and handicapped are to be taught how to maintain adequate oral hygiene, and instructions in proper oral hygiene procedures are to be given to those caring for patients in the home.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH 47-1 A-64	Salt Lake Community Nursing Service, Salt Lake City, Utah; Maxine A. Thomas	Apr. 1, 1964 to Mar. 31, 1965... Tentative.....	\$27,346 26,890 18,000

This project will organize and administer a visiting homemaker service as a division of the Salt Lake Community Nursing Service and establish a pattern for the development of similar service in other communities in Utah. The aim is to assist the chronically ill and aged in the community to attain independent living in a home environment. Training courses have been prepared for "certified home assistants, and emphasis will be placed on developing competency in the homemaker to teach clients or their families the activities of daily living and home management.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 05-7 A-62 CH 05-7 B-63 CH 05-7 C-64	Homemaker Service of Pasadena Area, Inc., Pasadena, Calif.; Mrs. Cerna S. Hirsch, Mrs. Wilma K. Jordan (3d year).	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$49,643 33,096 16,547

This project is designed to help determine the nature of and extent to which a homemaker service can play a supporting role in the care and treatment of chronically ill or aged patients outside of the hospital on a professionally adequate but economical basis. The project is to be conducted in the Pasadena area. It will more accurately identify the nature and extent of the need for homemaker services; establish and maintain valid methods of securing reliable program service statistics; establish and maintain a cost accounting system that will provide accurate cost factors; validate methods of organization and administration of homemaker service in a large metropolitan area; and establish criteria for the referral and acceptance of patients for homemaker service.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 05-10 A-62 CH 05-10 B-63	Contra Costa County Health Department, Martinez, Calif.; Joseph F. Whiting, Ph. D.	Nov. 15, 1962, to Nov. 14, 1963... Nov. 15, 1963, to Feb. 28, 1965 (2 years only).	\$59,375 80,346

Through this study the health department expects to determine whether a new method of providing home health services to the chronically ill and aged and their families (by use of a new type of home visitor and community worker) meets their personal health needs better and more economically than current practices. A further objective is to identify the kinds of skills needed to provide these services, and to begin work with the institutions of higher learning to develop educational preparation with attention to costs. A demonstration is to be set up and records are to be kept to enable comparisons between the new services, functions, costs, and outcome and the services traditionally given. Attention is also to be directed to the organization for rendering these services.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 05-33 A-64	Family Service Association, San Diego, Calif.; Mrs. Eula Hamman.	July 1, 1964, to June 30, 1965...	\$53,640
			Tentative-----	{ 52,440 47,130

This demonstration will show how a selected group of incapacitated adults can be cared for effectively in their homes by a homemaker service with a public health nurse added. The objectives are to develop a new pattern of collaboration between a homemaker agency and a visiting nurse association to meet the changing needs of chronically ill and aged individuals who cannot remain in their homes without some community intervention; to identify individuals who can use this service effectively; and to evaluate the program's effectiveness in meeting the needs of incapacitated adults and referral agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 05-42 A-64	San Francisco Homemaker Service, San Francisco, Calif.; Miss Brahma Trager.	Aug. 15, 1964, to Aug. 14, 1965...	\$87,855
			Tentative-----	{ 153,010 173,925

This demonstration of a health-centered program which will provide in-home services to the chronically ill and aged of the community will add social workers, public health nurses, homemakers, home health aids, and attendants to the staff of three health centers in the community and will provide orientation, training, and supervision directed toward the development of counseling and referral, health maintenance, supervision of in-home plans utilizing homemakers and home health aids, maximum utilization of community resources and coordination of appropriate services. The use of the health center as the base for these services is intended to demonstrate the function of the health department in a chronic disease program. Although volume statistics will be available after the third year for evaluation of the project, of particular concern will be how certain interrelated variables influence success or failure in satisfactorily maintaining the patient at home.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 13-1 A-62	St. Francis Hospital, Honolulu, Hawaii; Sister M. Aileen, R.N.	Apr. 1, 1962, to Mar. 31, 1963...	\$51,382
	CH 13-1 B-63		Apr. 1, 1963, to Dec. 31, 1964 (2 years only).	46,178

This project establishes a communitywide hospital based program through which team health services and intermediate equipment are supplied to the chronically ill and aging regardless of their economic level. One hospital, with agreement of the other two, operates a coordinated program for all three hospitals. The study proposes to determine the feasibility of a program of continuity of care from hospitals to homes and homes to hospitals within a designated geographical area in Honolulu. Out-of-hospital needs of patients in terms of staff, equipment, and facilities will be studied, with demonstration of methods for meeting these needs. Further, opportunities will be explored for provision of educational experiences for patients and their families, interested community groups, and medical and paramedical personnel.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 30-1 A-62	Nevada Tuberculosis & Health Association, Reno, Nev.; Mrs. Elaine Walbroek.	July 1, 1962, to June 30, 1963...	\$34,302
	CH 30-1 B-63		July 1, 1963, to June 30, 1964...	66,149
	CH 30-1 C-64		July 1, 1964, to Dec. 31, 1965...	68,122

The sponsor will establish a homemaker service in a rural, sparsely populated area where there are almost no medical or social services. The project is to demonstrate that multicounty, multiagency cooperation can make possible the operation of such a service where limited facilities and resources in any one of the counties would prohibit its initiation. Further, it will provide information as to how best to develop homemaker services in a sparsely populated area and one with different cultural groups, as well as the feasibility of the establishment of such services in rural areas.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 39-2 A-63	Harvey E. Rinehart Memorial Hospital, Wheeler, Oreg.; Mrs. Genevieve W. Smith, RN.	Mar. 1, 1963, to Feb. 29, 1964...	\$19,442
	CH 39-2 B-64		Mar. 1, 1964, to Feb. 28, 1965...	19,448
	CH 39-2 C-65		Mar. 1, 1965, to Feb. 28, 1966...	22,395

The project will provide visiting nurse services to residents within a 20-mile radius of the hospital using the hospital nursing staff. Patients will be referred by the medical staff, and home visits will carry out treatment as ordered by the doctor under the supervision of a nurse coordinator. Evaluation will be based on demands and use for service, checking expenses against income, and consideration of staffing problems.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 39-3 A-63	Eugene - Springfield Area Homemaker Demonstration & Research Project, Inc., Eugene, Oreg.; Donald L. England, M.D.	Feb. 1, 1963, to Jan. 31, 1964...	\$27,500
	CH 39-3 B-64		Feb. 1, 1964, to Jan. 31, 1965...	30,250
	CH 39-3 C-65		Feb. 1, 1965, to Jan. 31, 1966...	29,680

A homemaker demonstration and research project for the Eugene-Springfield area, one with limited resources, for home care service which will research the cost of not providing homemaker services to the chronically ill and aged. The results of the research will be made available to other communities which may wish to establish or modify homemaker services.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 51-1 A-63	King County Hospital System, Seattle, Wash.; K. K. Sherwood, M.D., and Kenneth N. Anderson, M.D.	Dec. 1, 1962, to Nov. 30, 1963...	\$56,879
	CH 51-1 B-64		Dec. 1, 1963, to Nov. 30, 1964...	62,200
	CH 51-1 C-65		Dec. 1, 1964, to Nov. 30, 1965...	62,200

This project combines a rehabilitation team with an established home care program. It is known that the long hospitalization and accompanying cost for rehabilitation therapy prevents many patients from being rehabilitated. If such therapy could be given in the home, many more patients could receive the benefit of rehabilitation therapy. Studies are needed to find better and more economical methods of meeting this need. The sponsor will conduct a controlled study to demonstrate that many patients could be discharged to their homes much earlier by receiving physical therapy treatment, plus necessary medical and nursing care, in the home; when sufficiently recovered, they will be transferred to the outpatient physical therapy department of the hospital for continued care. It is hoped to prove that the methods developed will result in the same degree of recovery of the patient, as compared to the hospitalized patient, at much less cost.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 51-4 A-63	King County Hospital System, Seattle, Wash.; Richard A. Warren.	Aug. 1, 1963, to July 31, 1964...	\$46,834
	CH 51-4 B-64		Aug. 1, 1964, to July 31, 1965 (2 years only).	95,558

Through this program, dietetic therapy will be extended into the home under the home-care-for-the-aged plan. This project results from the knowledge of past experience that many patients on the hospital extension service do not receive adequate nutritional therapy. The program will include dietetic instruction and preparation and delivery of therapeutic diets prescribed by doctors and planned by dietitians.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH 55-5 A-62 CH 55-5 B-63 Supplement B-65	National Council on Aging, New York, N.Y.; Mary F. Champlin.	Aug. 1, 1962, to July 31, 1963 Aug. 1, 1963, to Dec. 31, 1964 (2 years only).	\$39,343 26,626 7,100

The project proposes to make a study of the services now offered by current portable meals programs, how they are operated, the inadequacies, and the difficulties of operating such a program; to enlist the help of professional and technical persons in solving the practical problems of furnishing portable meals; and to recommend guidelines for portable meals programs. It is expected the study will provide information which will be useful to community health and welfare agencies and other organizations in planning and coordinating out-of-hospital services for the chronically ill and aged.

VI. EXTENSION AND IMPROVEMENT OF FACILITIES AND SERVICES FOR CHRONICALLY ILL AND AGED, INCLUDING NURSING HOMES

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 23-12 A-63 CH 23-12 B-64	Florence Heller Graduate School, Waltham, Mass.; Howard E. Freeman.	June 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965... Tentative-----	\$118,140 132,430 112,846

This project provides for a study of the role of the nursing home in the provision of care for the aged. It will seek to describe the posthospital experiences of patients discharged to nursing homes, and compare these experiences with those of patients who return to their homes or other community settings. It will (1) provide a description of current nursing home care, (2) suggest ways to modify current practices in the care of nursing home patients, and (3) formulate plans for more effective and efficient ways of utilizing nursing homes within the medical care system.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-47 A-64	United Hospital Fund of New York, New York, N.Y.; Helen M. Gossett.	June 1, 1964, to May 31, 1965... Tentative-----	\$53,230 58,130 58,130

The main objectives of this project are to assess the types of social problems of chronically ill and elderly patients in nursing homes, assess the extent of service needed, and provide supportive services to residents of these homes and their families. Casework in the nursing homes will be provided by social workers under the supervision of the project director, and continuity of help to patients transferred from hospitals will also be given, thus effecting speedier hospital discharges.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 40-47 A-64	Visiting Nurse Association of Allegheny County, Pitts- burgh, Pa.; Mrs. Alice K. de Benneville.	Apr. 1, 1964, to Mar. 31, 1965... Tentative-----	\$30,900 30,325 23,230

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Public health nurses find that for some stroke patients care at home is no longer providing the necessary motivation for self-help and that a need exists to develop new ways of helping them retain physical gains and participate again in community life. Under the direction of the VNA and an Association of Neighborhood Houses, a group work program for stroke patients and their families will be established in four to five settlement houses to demonstrate a method for contributing to the rehabilitation of stroke patients through a coordinated approach.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 09-10 A-65	District of Columbia Department of Public Health, Washington, D.C.; Murray Grant, M.D.	Jan. 1 to Dec. 31, 1965----- Tentative-----	\$116, 028 85, 606 62, 574

This project is designed to improve the standards of nursing homes and patient care in nursing homes in the city. It will offer multidisciplinary services to the patients of nursing homes, introducing these services through a screening of the patient and of the home. Training of nursing home personnel will be provided. Knowledge of and utilization of community resources available to nursing homes will be promoted.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 22-9 A-64 CH 22-9 B-65	Baltimore City hospitals, Baltimore, Md.; H. Glenn Waring, D.D.S.	Dec. 1, 1963, to Nov. 30, 1964.. Dec. 1, 1964, to Nov. 30, 1965.. Tentative-----	\$77, 316 59, 889 46, 922

This project will develop appropriate administrative patterns which will make the provision of dental care an integrated part of the program of the chronically ill patients in Maryland. It will provide dental services to the chronically ill and aged in the Baltimore City hospitals, nursing home system, and private foster homes, by the expansion of present hospital dental service through the extension of out-of-hospital services.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 37-20 A-64	Toledo District Board of Health, Toledo Ohio; Gladys M. Spear.	Aug. 1, 1964, to July 31, 1965... Tentative-----	\$17, 399 16, 546 16, 562

This is a demonstration of improvement of the management of dietary service in nursing homes through shared professional service and selective training of food service personnel. The project is designed to acquaint administrators of nursing homes and related facilities with the regular, part-time assistance of professional dietitians and with the full-time vocationally trained food service supervisors. Regular dietary consultation will be given to selected nursing homes and related long-term care facilities on a voluntary basis. After a period of demonstration of professional assistance, the consultant employed will recruit, orient, and assist with the placement of professional dietitians in those facilities which wish to employ them. Administrators will be requested to submit evaluation and progress reports periodically which will give the consultant an opportunity to appraise the long-range effects of the demonstration as well as the attitude of the administrator toward providing adequate food service for patients.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 53-1 A-62-----	Milwaukee Health Department, Milwaukee, Wis.; Gertrude Mulaney.	June 18, 1962, to May 1, 1963 (1 year only).	\$22, 184

This project is directed to the quantitative measurement of the amount of nursing service needed in nursing homes and subjective evaluation of the quality of nursing care provided. The study entails identification of all nursing procedures utilized in the direct care of patients and a recording of the units of time consumed in carrying out each procedure. In addition, determination is to be made as to the quality of patient care rendered and an evaluation made of nursing home personnel best capable of carrying out each procedure.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 18-3 A-65....	Kansas State Department of Health, Topeka, Kans.; Conie C. Foote.	Award not made as of Dec. 31, 1964.	\$24,517 27,389 16,092

In this project professionally qualified dietitians will develop a training program for food service personnel in adult care homes and demonstrate to administrators of such homes how trained food service supervisors and professional dietary consultation service can help them with food service management. Locally recruited dietitians will be employed in the homes under the supervision of project staff. Training programs to be developed in cooperation with the State vocational and adult education programs will be continued beyond the project.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH 38-3 A-62....	Oklahoma State Department of Health, Oklahoma City, Okla.; Forest R. Brown, M.D.	Aug. 1, 1962, to July 31, 1963..	\$31,396
	CH 38-3 B-63....		Aug. 1, 1963, to July 31, 1964..	54,675
	CH 38-3 C-64....		Aug. 1, 1964, to July 31, 1965..	51,989

This project is concerned with the development of a training program which will equip nursing homes to meet the nutritional, occupational, and social needs of the patient. It also proposes to develop training materials such as food service manuals, guidelines on the use of volunteers, and a handbook for volunteers which could be used by other nursing homes. Demonstrations of the training program will be made to nursing home personnel, to local health departments, and to the community at large.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH 38-9 A-65	University of Oklahoma, Oklahoma City, Okla.; Dr. Claude M. Bloss, Jr.	Oct. 1, 1964, to Sept. 30, 1965.. Tentative.....	\$52,653 51,554 51,554

The principal objective of this project is to contribute to the overall improvement of care in nursing homes in Oklahoma through the provision of physical therapy services to patients in such homes. It will establish and test a method of providing physical therapy services in 149 Oklahoma nursing homes, demonstrate to nursing home administrators and the consumer public the value of adding these services, and encourage practicing physical therapists to provide services to the geriatric patient on a part-time basis.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH 06-5 A-64	Colorado State Department of Public Health, Denver, Colo.; John Lichty, M.D.	Mar. 1, 1964, to Mar. 31, 1965.. Tentative.....	\$148,947 151,634 162,546

Because of the large increase in the number of chronically ill, aged, and physically disabled who require rehabilitation services but do not need hospitalization, this project will attempt to find satisfactory means to meet this need as eco-

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nominally as possible. Intensive rehabilitation services will be provided to two groups of patients—one in a home or nursing home, the other in a clinic setting, and the results achieved in the two settings compared. Evaluation will include a comparison of initial prognosis with final level of rehabilitation reached, and comparison of the two treatment groups in order to determine which is the more effective.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH 06-6 A-64	Colorado State Department of Public Health, Denver, Colo.; John A. Lichty, M.D.	July 1, 1964, to June 30, 1965 (1 year only).	\$12,500

The grantee will produce a 20-minute color training film concerning food service in nursing homes which will fill a gap in materials now available for training courses for all types of nursing home personnel. The purpose of the film will be to identify to nursing home personnel what good food service is, what it can mean to patients, and how such service can be obtained. A contract will be awarded to a commercial firm with professional consultation provided by the grantee.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII.....	CH 14-3 A-64....	Idaho Department of Health, Boise, Idaho; Richard D. Adams.	July 1, 1964, to June 30, 1965... Tentative.....	\$27,876 15,745 16,200

The department of health will demonstrate in nursing homes, boarding homes, and related facilities the effectiveness of comprehensive fire and accident prevention programs for reducing hazards and improving patient morale and sense of security. Two technically qualified fire and accident consultants will provide consultation and educational services. Each facility will be surveyed to evaluate fire safety as applicable to current regulations, and after the initial survey will be revisited to assist in developing fire evacuation plans, etc. The program will be evaluated on the basis of requests for consultation and educational programs to be conducted.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 51-3 A-63 CH 51-3 B-64	Washington Dental Service, Seattle, Wash.; Howard B. Henderson, D.M.D.	Apr. 1, 1963, to Mar. 31, 1964... Apr. 1, 1964, to Mar. 31, 1965 (2 years only).	\$50,036 39,161

This project will conduct an analysis of needs, utilization, and cost of dental services for nursing home residents, to be rendered in and out of nursing homes by private practitioners through the administration of a dental service corporation. Administrative and clinical policies, standards, and procedures will be developed and evaluated and the actual costs for the demonstration group and estimated costs for the nursing home population of the State will be determined.

VII. CENTRAL REFERRAL AND INFORMATION SERVICES

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH 23-4 A-62 ¹	Harvard University School of Public Health, Boston, Mass.; Leonid S. Snegireff, M.D.	Aug. 1, 1962, to July 31, 1965 (full funded).	\$51,957
	CH 23-4 B-64 CH 23-4 C-65	Brandeis University, Waltham, Mass.; Howard E. Freeman, Ph. D.	Aug. 1, 1963, to July 31, 1964... Aug. 1, 1964, to July 31, 1965...	16,330 21,390

¹ This project transferred at the end of the 1st year to CH 23-4 B-64 and CH 23-4 C-65.

A project to set up and test a procedure for coding case records of selected agencies providing services for the chronically ill. Data will be analyzed for the purpose of studying and evaluating these services. Detailed information will be obtained on the caseload, areas of unmet need, and problems of interagency relationships. Factors will be explored affecting utilization of community services; service methods and practices will be evaluated in terms of their meeting needs of the chronically ill and aging. It is also hoped to identify additional areas of needed research relating to community services for the chronically ill and to utilize the study as a training opportunity for graduate students at Harvard.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 23-7 A-63 CH 23-7 B-64	Massachusetts Association for the Adult Blind, Boston, Mass.; Richard V. McCann.	May 1, 1963 to Apr. 30, 1964... May 1, 1964, to Apr. 30, 1965... Tentative.....	\$45,661 59,145 59,145

This project will demonstrate a method of referral, consultation, and education to provide generalized health and welfare services to the adult blind. It will attempt to combine a program of assessment and referral to the patient and a program of consultation and education directed to the agencies providing the services. In this way it is hoped to overcome the tendency of the blind to rely on special, segregated services, and to develop techniques for making all community services available to them.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 23-10 A-63 CH 23-10 B-64	Massachusetts Health Research Institute, Inc., Boston, Mass.; Hugh L. C. Wilkerson, M.D.	Dec. 1, 1962, to Nov. 30, 1963... Dec. 1, 1963, to Nov. 30, 1965...	\$70,381 80,659

The sponsor proposes to determine the role of a geriatric hospital in the development of appropriate out-of-hospital services for the chronically ill and aged in its service area. This project is to be accomplished by establishment of a closely integrated evaluation unit consisting of nine members, who will study the mechanism by which chronically ill persons can be kept in their own environment or hospitalized for restoration and return to their communities as soon as possible. The basic objective is to define better methods of evaluation, referral, and continuity of care applicable to the growing geriatric problems of sickness and attending needs. These methods will show how existing institutional and community facilities can be most efficiently utilized in care of the geriatric patient. It is felt that the findings of this study could serve as a model not only to other communities in Massachusetts but to the country as a whole.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-6 A-62 CH 34-6 B-36 CH 34-6 C-64	Medical & Health Research Association of New York City, Inc., New York, N.Y.; Jules E. Vandow, M.D., M.P.H.	May 15, 1962, to May 14, 1963... May 15, 1963, to May 14, 1964... May 15, 1964, to May 14, 1965...	\$175,695 184,804 214,239

The primary objective of this project is to study and demonstrate how the health resources of New York City can be brought to bear on the health problems of selective service rejectees and to determine how volunteers from this group of rejectees can most effectively be referred to appropriate sources for medical care. Other objectives include the development of practical working relationships with a number of cooperating agencies and health resources, the identification of the causes for medical rejection, and the extent to which local health resources can provide remedial and rehabilitative services to rejectees. In addition, the demonstration is expected to identify the causes for delay in the discovery of

medical defects prior to preinduction examination and to examine the patterns of the rejectee's voluntary response to the offer of counseling and referral services.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-34 A-63 CH 34-34 B-64	Visiting Nurse Service of Rochester and Monroe County, Rochester, N.Y.; Elisabeth C. Phillips.	Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965... Tentative.....	\$20,045 21,745 26,325

This project will build an additional type of community service to prevent unnecessary building of institutional beds and to make it safer and more desirable for a larger number of elderly and chronically ill persons to remain at home or to return home following group care. Using a personalized professional approach, it will attempt to identify needs of patients which have bearing on their mental and physical health. Through consultation, referral, and followup, it will utilize all appropriate existing community agencies in meeting these needs, and it will also develop additional services which are not available to the homebound. Volunteers will be used under professional direction and supervision.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-52 A-65	State Charities Aid Association, New York, N.Y.; Edward G. Lindsay.	Oct. 1, 1964, to Sept. 30, 1965... Tentative.....	\$39,985 39,985 39,985

The establishment of a statewide information and consultation service in New York under this project will demonstrate how such a program can assist at the State level in bringing together official and voluntary agencies in a coordinated manner to identify gaps in services and plan jointly to fill the gaps. It will take necessary action at both State and local levels and directly assist local communities in appraising the needs of the chronically disabled, developing plans to meet the needs, and acting to implement such plans.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-16 A-62 CH 40-16 B-63 CH 40-16 C-64	Philadelphia Health Research Fund, Philadelphia, Pa.; Alfred S. Bogucki, M.D.	Aug. 1, 1962, to July 31, 1963... Aug. 1, 1963, to July 31, 1964... Aug. 1, 1964, to July 31, 1965...	\$73,033 67,911 67,425

The project is designed to demonstrate the value of a system of referral and field followup of selective service rejectees, with the local health department as the key coordinator, making maximum use of existing community resources by means of a variety of administrative devices. In addition, it is proposed to attempt to obtain insight into the attitudes toward health and illness and toward opportunities provided for correction of defects. It is expected the project will provide a pattern for use in many other localities throughout the country.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-34 A-63 CH 40-34 B-64	Visiting Nurse Association of York & York County, York, Pa.; Mrs. Anna B. Leibfried, R.N.	July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965... (2 years only).	\$9,399 5,045

This project is designed to provide better nursing care and thus to promote the health and welfare of patients and their families, particularly the aging, by utilizing the services of a public health nurse supervisor who will work as a coordinator in the various departments of the hospital and outpatient department planning for referrals on the basis of individual patient needs to promote continuity of care.

This will result in a more coordinated use of community resources which will be revealed in better care to more people.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-40 A-63 CH 40-40 B-64	The Arthritis & Rheumatism Foundation, Eastern Pennsylvania Chapter, Philadelphia, Pa.; Harold R. Snyder.	Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965 (2 years only).	\$30,250 33,000

Increasing evidence indicates that there are a great many chronically ill arthritic persons who do not require institutional care, but whose physical, social, and emotional health would be improved by guidance and motivation into normal cultural and social programs in a community. This project will develop and demonstrate a community recreation referral system for such persons. Two recreational professionals will be assigned to the sponsoring agency and will become the liaison persons between that agency, the recreation department, and the community. Patients will be evaluated medically, socially, and emotionally throughout the 2 years.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 09-8 A-64	District of Columbia Department of Public Health Washington, D.C.; Dr. Murray Grant.	July 1, 1964, to June 30, 1965... Tentative.....	\$75,301 78,616 56,965

This project will create a central registry of all diagnosed cases of rheumatic fever and rheumatic heart disease on record for the last 5 years, obtaining records from the District of Columbia Health Department, the six large cooperating hospitals, and from cooperating private physicians. Followup service will be provided to assure that those on the registry remain under medical supervision. Drugs for secondary prophylaxis for indigent and medically indigent patients on the registry will be provided. An adult rheumatic fever clinic for the medically indigent will be established. Phase II of the project will conduct an intensive study of delinquent cases of rheumatic fever to determine why people have stopped prophylaxis and have been lost to medical supervision.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 19-5 A-64 CH 19-5 B-65	Information Center for the Chronically Ill, Louisville, Ky.; Ruth M. Dalton.	Dec. 1, 1963, to Nov. 30, 1964... Dec. 1, 1964, to Nov. 30, 1965...}	\$46,015 47,525 40,282

The main objective of this project is to demonstrate that an information, consultation, and referral center can administer efficiently and economically a home aid program. It will demonstrate that such a center can become a research and demonstration agency focusing on the needs of the chronically ill and on the development and improvement of necessary community resources and that it can successfully promote and administer a new and needed program in the community. It will also study administrative costs for home aid programs when attached to a centralized service such as an information and referral center.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 35-1 A-62 CH 35-1 B-63 CH 35-1 C-64	Chronic Illness & Rehabilitation Foundation, Inc., of Guilford County, Greensboro, N.C.; Mrs. Sue S. McClellan.	Sept. 1, 1962, to Aug. 31, 1963... Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965...}	\$38,375 45,264 38,375

The foundation is to provide a coordinated home care and information and referral service for the chronically ill and aged in Guilford County which includes two urban communities and a rural population. It is designed to reach those who are able to pay all or part of the cost of care and those who cannot pay anything. The county health department and the county welfare department as well as other local organizations are cooperating in the project. The project will demonstrate an approach to bring communities together into a single program to study their problems and needs, plan to meet these needs, and activate a program of coordinated services.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 49-5 A-65	Health - Welfare - Recreation Planning Council, Norfolk, Va.; George F. Rice.	Mar. 1, 1965, to Feb. 28, 1966... Tentative.....	\$35,511 33,400 35,001

This project will institute a new program in southeastern Virginia designed to demonstrate the value of a comprehensive approach in the distribution of health information through a health information-referral planning center within the largest metropolitan area of the State. The council will centralize current information and disseminate it to the general public and providers of health services, and through an economical and efficient method of compiling data proposes to set up an approach for the planning of community health services to be used areawide.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 10-5 A-63 CH 10-5 B-64 CH 10-5 C-65	University of Florida College of Nursing, Gainesville, Fla.; June G. Remillet.	Dec. 1, 1962, to Nov. 30, 1963... Dec. 1, 1963, to Nov. 30, 1964... Dec. 1, 1964, to Nov. 30, 1965..	\$21,936 22,462 23,869

This project is directed to the development of a method of communication which will assure continuity of patient care following discharge from the hospital into the patient's home, either as an in-patient or out-patient. It is expected to demonstrate how a statewide referral service can work on a routine basis and evaluate its usefulness and effectiveness.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 24-8 A-64 CH-24-8 B-65	Commission on Professional and Hospital Activities, Ann Arbor, Mich.; Vergil N. Slee M.D.	Mar. 1, 1964, to Feb. 28, 1965... Mar. 1, 1965, to Feb. 28, 1966... Tentative.....	\$84,277 83,890 86,663

The purpose of this study is to develop an integrated information system for local community health departments using the computer facility of the sponsor in cooperation with the Washtenaw County Health Department. Information will be collected and reported only once, and the electric computer system will process, compile, and rearrange this information in as many different ways as might be useful to community, county, State, Federal Government, and other interested agencies. Thus more information can be provided in readily assessable form and with greater economy of effort in accumulating.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 37-17 A-64	Toledo Council of Social Agencies, Toledo, Ohio; Miss Mary Hayes, B.S., M.P.H.	Apr. 1, 1964, to Mar. 31, 1965... Tentative.....	\$25,580 25,580 26,580

The primary objective of this project is to assist the community in making more effective use of its health, welfare, and recreational facilities through an information, counseling and referral center. The program will be under the administration of the Toledo Council of Social Agencies and expects to eliminate duplication of services by several agencies, give short-term counseling by social casework method, and disclose a significant number of individuals with unmet needs. Such a center will be able to interpret available services provided by agencies, and will promote a coordinated effort by all agencies to meet needs of the community.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH 27-12 A-63 CH 27-12 B-64	Regional Health and Welfare Council, Kansas City, Mo.; Edward H. Tuttle.	Aug. 1, 1963, to Sept. 30, 1964... Oct. 1, 1964, to Sept. 30, 1965... Tentative.....	\$63, 589 61, 144 63, 983

Through this project an information, counseling and referral center will be set up in the Kansas City metropolitan area. This will be a voluntary organization of citizens who will plan and coordinate services in health and welfare for the area. The funds will be used to provide information to those serving the chronically ill and aging, to provide advice to the patient, or his family, concerning the appropriate agency or institution for his problem, and to test whether such a center can be of use in coordinating out-of-hospital care.

PHS region	Project No.	Grantee and project director	Period	Amount
VII-----	CH 38-5 A-63 CH 38-5 B-64 CH 38-5 C-65	Oklahoma State Department of Health, Oklahoma City, Okla.; Forest R. Brown, M.D.	Mar. 1, 1963, to Feb. 29, 1964... Mar. 1, 1964, to Feb. 28, 1965... Mar. 1, 1965, to Feb. 28, 1966...	\$43, 642 27, 541 28, 538

This project will demonstrate how a State Department of Health in a rural State can provide leadership and service in combating the effects of chronic illness and aging by means of an information, referral and consultative service. A statewide survey of resources in the 77 counties of the State will be conducted with all social agencies, organizations, health and welfare units, etc., being contacted. Information gathered will be used to provide and maintain a file on all resources in the State for the chronically ill and aged. Field consultants will report health and social problems from which a central index will be compiled. Local planning bodies may then be able to determine the extent and kind of services required in various communities and make referrals.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII-----	CH 06-2 A-62 CH 06-2 B-63	Colorado State Department of Public Health, Denver, Colo.; John A. Lichty, M.D.	June 1, 1962, to May 31, 1963... June 1, 1963, to May 31, 1964 (2 years only).	\$11, 500 12, 228

This project is a demonstration to the community and its social agencies, and to the patients themselves, of the leadership a local health department can assume in resolving the complexity of health-related problems of the chronically ill and their families. This will be accomplished by setting up a central referral, coordination, and consultation service in the local health department. Where multiple needs exist, services are to be coordinated. This service is staffed by a medical social worker and a part-time clerk to whom health problems can be referred from any source in the community for either direct service or consultation.

PHS region	Project No.	Grantee and project director	Period	Amount
VIII-----	CH 06-7 A-65----	Colorado State Department of Public Health, Denver, Colo.; Valentin E. Wohlaer, M.D.	Oct. 1, 1964 to Sept. 30, 1965... Tentative.....	\$57, 644 61, 131 63, 690

Because of the apparent need of men rejected from the Armed Forces for medical reasons for health counseling, guidance, and referral, the Colorado Department of Public Health will operate a statewide project to carry out such a service. Each person rejected for medical reasons will be referred to the health referral center by the staff at AFES. Professional personnel will make a determination as to the possibilities of rehabilitation, cure and/or paramedical benefits in the fields of psychiatry, physical medicine, and dentistry. The rejectee for whom such assistance is believed to be in order will be referred to the proper agency or persons who can help him in making arrangements for the necessary services and followup. Evaluation will compare the differences of the problems and programs as they exist in a primarily rural area with those in completely urban areas.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 03-11 A-65	Community Council (Maricopa County), Phoenix, Ariz.; Milton Gan, M.S.W.	Nov. 1, 1964, to Oct. 31, 1965...	\$36,919 29,387 35,097
			Tentative.....	

This project will establish and maintain a central service which will provide information and/or referral to individuals and agencies with regard to the extent and availability of all health services in the area. It will also experiment with methods and procedures for systematically collecting, maintaining, and using information on the variety of agency policies regarding referrals and admissions. Experimentation will also be made as to what happens to people once they are referred and how such data can be used in helping the community to remodel its structure and program of services.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 05-18 A-63 CH 05-18 B-64	United Community Fund of San Francisco, San Francisco, Calif.; Martha Burt.	Mar. 1, 1963, to Oct. 31, 1964...	\$32,150 34,461 21,091
			Nov. 1, 1964, to Oct. 31, 1965...	
			Tentative.....	

The project will organize and administer a central medical social service bureau for private patients on referral from physicians, on a fee-for-service basis, with the objective of improving the personal relationships and environmental factors of patients under the care of private physicians. It will be established to serve institutions where it does not presently exist and will attempt to prove the value of medical social work to hospitals which do not now maintain this type of patient service. It is expected that at the end of a 5-year period the program will be self-supporting.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 05-22 A-63 CH 05-22 B-64	San Mateo County Department of Public Health and Welfare, San Mateo, Calif.; Pierre Salmon, M.D.	July 1, 1963, to June 30, 1964...	\$61,567 76,276 64,268
			July 1, 1964, to June 30, 1965...	
			Tentative.....	

The primary objective of the sponsor is to establish a satisfactory system of patient classification for those patients in need of long-term supportive and remedial care. Patients who are currently receiving long-term medical or nursing care under the auspices of the department of public health and welfare will be initially deployed, and their placements reviewed at intervals of 3 to 4 months for appropriateness. A referral system for nonindigent patients needing long-term care is also planned.

VIII. PUBLIC EDUCATION AND COMMUNICATION

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 32-1 A-62 CH 32-1 B-63 CH 32-1 C-64	The United Hospitals of Newark, Newark, N.J.; Howard R. Jones.	July 16, 1962, to July 15, 1963... July 16, 1963, to July 15, 1964... July 16, 1964, to July 15, 1965...	\$15,100 15,450 14,891

This project is directed to the development of integrated hospital-community educational services for chronically ill patients in the community through a hospital-based health education program. The sponsor proposes to determine the educational interest and needs of chronically ill patients and their families prior to and following hospitalization, assess hospital and community resources for meeting these needs, and measure the effectiveness of educational services in reducing relapse and readmission rates.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 09-7 A-63 CH 09-7 B-64	Health & Welfare Council of the National Capital Area, Washington, D.C.; Everett S. Cope.	July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965... Tentative.....	\$32,800 46,070 46,175

The purpose of this project is to deliver existing medical knowledge and health services to the low-income families living in today's urban neighborhoods. Three indigenous neighborhood health aids who are familiar with the way of life of the people of the area will be hired and trained. They will serve as a bridge between professional and lay patterns of language, health attitudes and practices. They will be supervised by the medical personnel of the department of public health and will work in conjunction with a project nurse. Intake and evaluation plans will be coordinated into the existing casework program which includes research consultation.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 11-8 A-64	Ferst Research Center, Piedmont Hospital, Atlanta, Ga.; Mary Sue Pritchett.	June 1, 1964, to May 31, 1965... Tentative.....	\$39,560 41,100 40,000

The shortage of qualified, trained medical personnel cannot meet the educational demand presented by an ever-increasing population unless better methods of communication are employed to speed up the process of education and thereby more fully utilize the talents and extend the capabilities of the limited number of educators. In a selected group of community health agencies, a study will be made of the basic communications problems in order to develop low-cost, simple communications aids (audio, visual, and audiovisual materials and devices) to fit particular teaching situations which affect community health—patient and family education, personnel training, liaison between agencies, etc.

PHS region	Project No.	Grantee and project director	Period	Amount
National	CH 55-9 A-63	American Pharmaceutical Association, Washington, D.C.; George B. Griffenhagen.	June 1, 1963, to Aug. 31, 1964 (1 year only).	\$100,800

This project is designed to determine the effectiveness of the community pharmacy as a community health education center. Racks displaying printed material on health matters will be installed in a sample of community pharmacies across the Nation. Changes in attitudes and opinions of patrons of these pharmacies and in the pharmacists themselves will be evaluated to determine the effectiveness of the program.

IX. ORGANIZATION TO PROVIDE HEALTH SERVICES

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 07-2 A-62 CH 07-2 B-63 CH 07-2 C-64	Connecticut State Department of Health, Hartford, Conn.; Mrs. Norma Lundquist.	Sept. 1, 1962, to Aug. 31, 1963... Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965...	\$26, 794 25, 325 24, 222

The State health department will demonstrate the value of nursing supervision in upgrading public health nursing services and show how one supervisor can supervise the nurses of several small agencies. Another objective is to demonstrate the value of generalized public health nursing services, especially out-of-hospital nursing care of the sick in rural areas, and motivate community leaders in the State to make provision for this service.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 07-3 A-63 CH 07-3 B-64 CH 07-3 C-65	Dental Clinic Society of New Haven and the Gerontological Committee of the Connecticut State Dental Association, New Haven, Conn.; Gerald L. St. Marie, D.D.S.	Aug. 13, 1962, to Aug. 12, 1963... Aug. 13, 1963, to Aug. 12, 1964... Aug. 13, 1964, to Aug. 12, 1965...	\$29, 762 30, 795 31, 904

The sponsor is developing a community dental care program for homebound and chronically ill and aged persons. Study will be made of the actual costs of providing dental services and ascertain its economic feasibility as a community health service. Dental services will be provided in the home, community clinic, or private office, depending on the extent of the patient's disability as determined by the physician or facility or both. Charges will be made for the services. However, the project is designed so that no person will be refused service because of inability to pay.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 07-4 A-62 CH 07-4 B-63 CH 07-4 C-64	Connecticut State Health Department, Hartford, Conn.; Harold S. Barrett, M.D.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$65, 545 58, 521 46, 094

This project involves three major areas: organization for and financial assistance in developing homemaker services; the design of courses, preparation of materials and exhibits for use in training homemakers and the holding of seminars, institutes for supervisors, directors, and other personnel; and the evaluation of organized homemaker services. The project will develop guidelines and criteria for homemaker programs, at both State and local levels, and provide new information and identify the role of a State health department in homemaker programs useful on a regional or national basis.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 07-11 A-65	Yale University, New Haven, Conn.; Roy M. Acheson, D.M.	Nov. 1, 1964, to Oct. 31, 1965... Tentative.....	\$92, 991 135, 096 112, 003

This project will define a group of people in five socioeconomic classes in the city of New Haven who are suffering debilitation from joint diseases. It will measure the severity and causes of disability arising from joint disease, measure

the source and effectiveness of medical care being provided, and plan future medical services in new Haven for such people.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 07-12 A-65	City of New Haven Department of Public Health, New Haven, Conn.; Carter Marshall, Jr., M.D., M.P.H.	Sept. 15, 1964, to Sept. 14, 1965... Tentative.....	\$57,348 58,052 58,448

This project is one unit of the HEW-PHA concerted services program, a program conceived as an approach to intervening in and destroying the cycle of dependency and poverty. It will be conducted in the Elm Haven housing project, and will develop techniques of identifying and interpreting health needs, develop an action program which will arrange for the delivery of appropriate health programs, provide the appropriate public health services, and provide assistance to project residents in recognizing their family's health needs and help them make the most appropriate use of services available to them. Evaluation will be by the project staff with the help of the Yale University Department of Epidemiology and Public Health.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 23-18 A-64	Berkshire Rehabilitation Center, Pittsfield, Mass.; Dr. Vincent T. Barnaba.	May 1, 1964, to Apr. 30, 1965... Tentative.....	\$56,150 43,350 42,450

The project will incorporate into the medical care of a semirural area the concepts and skills of modern rehabilitation of persons with chronic illnesses of all kinds regardless of the person's age, income or medical location. It will define and distinguish those aspects of medical rehabilitation which should be provided by secondary rehabilitation centers, general practitioners or other specialists in the course of their regular care of patients, or an affiliated primary rehabilitation center. It will also study the amounts and patterns of medical rehabilitation services provided in this area by a psychiatrist and by other categories of professional staff of a secondary rehabilitation center.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 23-19 A-64	Age Center of Worcester Area, Inc., Worcester, Mass.; Samuel Bachrach, M.D.	June 1, 1964, to May 31, 1965... Tentative.....	\$49,831 55,590 57,481

The age center will demonstrate the use and usefulness of a community-sponsored multiservice center for the aging which will provide for and coordinate a variety of necessary health and social services for older people well enough to come to the center and chronically ill residents of nursing homes. It will provide consultant service in the fields of nursing, nutrition, and social work to nursing homes requesting it, and physical therapy and recreation therapy services to patients living in certain nursing homes with which contract agreements have been made. It will also provide for the systematic training of volunteers willing to serve as "friendly visitors," recreation aids, staff members of nursing homes, and students seeking careers in health and social work professions.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 31-5 A-63 CH 31-5 B-64 CH 31-5 C-65	New Hampshire State Council on Aging and Claremont General Hospital, Claremont, N.H.; Garner C. Goodwin.	Mar. 1, 1963, to Feb. 29, 1964... Mar. 1, 1964, to Feb. 28, 1965... Mar. 1, 1965, to Feb. 28, 1966...	\$10,000 7,000 5,000

This project will sponsor and establish an outpatient diagnostic and treatment clinic for persons 60 years of age and over which will serve as a detection and prevention medium for conditions leading to disability. It hopes to establish the value of such a clinic by determining whether or not the clinic will be used by the older citizens of the area; through the use of hospital and casework records determine that the clinic is in fact providing a medical service which would not have been provided otherwise; and gather information on the amount of known and unknown disease and disability found through contact with the clinic.

PHS region	Project No.	Grantee and project director	Period	Amount
I.....	CH 42-1 A-62	Rhode Island Department of Health, Providence, R.I.; John T. Tierney, M.S.	July 1, 1962, to June 30, 1963....	\$13,724
	CH 42-1 B-63		July 1, 1963, to June 30, 1964....	13,178
	CH 42-1 C-64		July 1, 1964, to June 30, 1965....	12,930

The purpose of this project is to establish a rehabilitation council—under the coordinating sponsorship of the State health department—as a principal planning agency for health services in the State. Establishment of such a council is the first step in the long-range planning program to integrate rehabilitation services now supplied by various rehabilitation agencies so that a more effective approach can be made to meet the needs of the chronically ill and aged. The State health department provides staff for the council which serves as the main body for interpretation of rehabilitation to the community and to special services related to rehabilitation.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-1 A-62	The Patient Care Planning Council of Monroe County, Rochester, N. Y.; Miss Jane Robertson.	Mar. 1, 1962, to Feb. 28, 1963..	\$8,000
	CH 34-1 B-63		Mar. 1, 1963, to Feb. 29, 1964..	8,225
	CH 34-1 C-64		Mar. 1, 1964, to Feb. 28, 1965..	8,600

Project grant funds are being used to help finance a study of health needs of the chronically ill and aged and utilization of existing facilities and services by the Patient Care Planning Council of Monroe County which makes recommendations to appropriate governmental and non-governmental bodies on development of home care, ambulant, and institutional patient care services and facilities. On the basis of the results of this study, the council will make recommendations as to a balanced program of institutional and home care services and facilities for appropriate patient care.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-3 A-62	Medical & Health Research Association of New York City, Inc., New York, N.Y.; Nicetas Kuo, M.D., M.P.H.	Apr. 2, 1962, to Apr. 1, 1963....	\$85,295
	CH 34-3 B-63		Apr. 2, 1963, to Apr. 1, 1964....	123,202
	CH 34-3 C-64		Apr. 2, 1964, to Apr. 1, 1965....	124,272

A project to further develop a pilot program of health and medical care for the elderly initiated in a public housing project. Through this program, it is planned to identify the health and medical needs of an elderly population living in a public housing project; develop a system acceptable to the group for meeting these needs through coordinated efforts of cooperating agencies; to integrate this system into regular ongoing programs in effect; to maintain as long as possible the ability of these older people to live independently and as active members of their community; and to make an evaluation of the overall program and its component parts. Services will be centered in the health maintenance clinic of the housing project but will, when indicated, be offered in the hospital outpatient department, or through the hospital home care program, or any combination of these.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-8 A-62 CH 34-8 B-63 CH 34-8 C-64	Monroe County Department of Health, Rochester, N.Y.; Margaret L. Rathbun, M.D., M.P.H.	Aug. 1, 1962, to July 31, 1963... Aug. 1, 1963, to July 31, 1964... Aug. 1, 1964, to July 31, 1965...	\$28,498 34,393 26,481

The sponsor will study whether the assignment to hospitals of qualified public health nursing personnel might shorten the hospital stay and improve the medical, nursing, and social management of patients requiring home care by advance planning for the proper level of care and services required. The nursing personnel would be under the administrative control and guidance of the county health department. In addition, the study is to determine whether this method of screening, evaluation, and planning for patient care at home is effective. Three nurses are assigned in three different hospitals in the county to participate in the functions planned, with a fourth nurse assigned to followup of patients for purposes of the study.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-18 A-63	Health Association of Niagara County, Inc., Niagara Falls, N.Y.; Lawrence T. Snyder.	July 1, 1963, to June 30, 1965... Tentative.....	{ \$16,825 16,825 { 16,825

This project will document the expansion of an information and referral service now existing through the utilization of an administrative assistant to complement the social worker. Roles of a medical consultant and a public health nursing consultant in the service will be identified. It is hoped, through such a service functioning within the framework of a voluntary health agency, to bring about greater coordination and improved utilization of existing out-of-hospital services, thereby aiding physicians, agencies, patients, and their families.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 40-31 A-63 CH 40-31 B-64 CH 40-31 C-65	Home for Crippled Children, Pittsburgh, Pa.; Miss Katherine Patton.	Mar. 1, 1963, to Feb. 29, 1964... Mar. 1, 1964, to Feb. 28, 1965... Mar. 1, 1965, to Feb. 28, 1966...	\$41,350 45,620 47,820

This project will demonstrate the effectiveness of rehabilitation services by continued followup of patients. It plans to develop, test, improve, and demonstrate procedures and techniques with patients which will result in earlier diagnosis and evaluation, and a reduction in the length of the inpatient treatment period. It will also develop an on-going case record for periodic reevaluation of patients to determine the effectiveness of the services provided.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 40-53 A-64 Supplement A-65	Allegheny County Medical Society Foundation, Pittsburgh, Pa.; Florence Marcus, M.D.	May 1, 1964, to Apr. 30, 1965... Tentative.....	{ \$62,070 9,100 { 60,850 74,150

A health care team composed of a general practitioner, a social worker, a public health nurse and office personnel will be located in a public housing community of 5,000 population to provide health care services coordinated with other health as well as welfare services in the community. The project will demonstrate that, by making family health care services easily and quickly available in an otherwise "medically isolated" community, the health level of the population can be more

effective and efficiently utilized. The project will also determine the costs of such health care and the degree to which such care can become self-supporting, or the amount of community subsidy it requires for continuation.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 19-6 A-64 CH 19-6 A-65	Kentucky State Department of Health, Frankfort, Ky.; Russell E. Teague, M.D.	Jan. 15, 1964, to June 30, 1965... July 1, 1964, to June 30, 1965....	\$327, 100 77, 000

A demonstration project will be established which will show how a comprehensive screening, evaluation and followup program can be operated in a chronically depressed rural area in which transportation is a major problem. Two screening teams plus an evaluation team will coordinate their activities with existing programs and facilities. Families and groups of people will be transported to the screening areas and to the diagnostic center as needed. Emphasis will be placed on referring all cases where a diagnosis has been established to the most appropriate source of treatment.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 22-5 A-63 CH 22-5 B-64	Baltimore City Health Department, Baltimore, Md.; Mason Lord, M.D., Matthew Tayback, Sc. D.	Jan. 1, 1963, to Mar. 31, 1964... Apr. 1, 1964, to Mar. 31, 1965... Tentative.....	\$44, 925 70, 182 47, 804

Under this project a coordinating office of community services for chronic disease will be established which will attempt to coordinate for the chronically ill the use of home, office, and clinic care; general hospital care; chronic disease hospital care; and nursing home or foster home care. It is believed that the lack of such coordination results in excessive demands for chronic disease hospital care and nursing home care. A team, consisting of a physician, social worker, and public health nurse, will demonstrate the manner in which it can function to provide preadmission patient evaluation and postdischarge planning and case supervision.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 35-5 A-63 Supplement A-65	North Carolina Hospital Education and Research Foundation, Raleigh, N.C.; Robert R. Cadmus, M.D.	Apr. 1, 1964, to Mar. 31, 1965 (full funded).	\$56, 713 3, 100

The purpose of this project is to study the organization of ambulance service in the State, using a questionnaire technique. Lack of appropriate transportation often complicates treatment of home care patients, and it is expected from the data collected and evaluated in this study to develop guidelines for community action for studying and meeting the patient transportation problem in this and other States.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 41-2 A-63 CH 41-2 B-64 CH 41-2 C-65	Puerto Rico Department of Health and Welfare, San Juan, P.R.; Raul A. Munoz.	Dec. 1, 1962, to Nov. 30, 1963... Dec. 1, 1963, to Nov. 30, 1964... Dec. 1, 1964, to Nov. 30, 1965...	\$46, 550 88, 205 115, 200

The basic objective of the project is to provide information for use in planning and evaluating health programs in Puerto Rico through a continuing master sample survey. This survey will seek to identify and characterize the dimensions

and magnitude of chronic illness and other health problems as they prevail among family units, as well as individuals. It will also seek to indicate the effect of the health and welfare programs created to deal with these problems, and thus provide a sounder basis for decisions as to priorities and allocations of scarce resources of money and personnel.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 41-7 A-65	University of Puerto Rico, San Juan, P.R.; Norman O. Harris, D.D.S.	Oct. 1 to Dec. 31, 1965----- Tentative-----	\$21,666 18,998 4,701

This project will demonstrate the value and operational feasibility of a preventive dentistry school program, utilizing a new rapid methodology for accomplishing a prophylaxis with a stannous fluoride paste. It will verify the anti-cariogenic effectiveness of a twice-a-year rapid prophylaxis-stannous fluoride procedure accomplished within a school, using first- and second-grade children, and will determine the professional manpower and supporting facilities which would be necessary to accomplish needed treatment under a referral system.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 01-1 A-62 CH 01-1 B-63 CH 01-1 C-64 Supplement C-65	Jefferson County Health Department, Birmingham, Ala.; Polly Ayers, D.D.S.	June 1, 1962, to May 31, 1963... June 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965...	\$33,012 30,640 30,384 2,082

This project is to demonstrate how a dental school (University of Alabama) and a health department (Jefferson County Department of Health) can cooperate in providing services for the chronically ill and aged by establishing a special center for training students in the techniques of providing such services for both ambulatory and nonambulatory individuals. Plans call for establishment of a two-chair dental clinic in a health center. Two dental students will work either in this clinic or out from the clinic 5 half-days a week. A hygienist is to work half time with the students and half time with prophylaxes and X-rays for ambulatory patients. Also, a dental assistant is to work full time in the clinic. Existing equipment of the health center is being renovated for use on the project. The following services are to be rendered for chronically ill and aged patients: operative dentistry, full and partial dentures, edentulous radiographic surveys, cleaning of natural and artificial teeth, and oral hygiene instruction.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 10-1 A-62 CH 10-1 B-63 CH 10-1 C-64	Florida State Board of Health, Jacksonville, Fla.; Jean Jones Perdue, M.D.	June 1, 1962, to May 31, 1963... June 1, 1963, to May 31, 1964... June 1, 1964, to May 31, 1965...	\$49,677 47,607 46,098

A project to demonstrate that continuity of medical care and the rehabilitative needs of persons with chronic diseases can more adequately be met by existing community resources through advance planning and well-developed coordinated efforts. Patients for the project are selected from those referred to the Department of Welfare for continuing medical care. Evaluations are to be made to determine the medical, nursing, rehabilitative, and socioeconomic needs of these persons. Based on the evaluations and recommendations, a plan for continuing care will be formulated through case conferences. Comprehensive treatment plans are also formulated for each individual with followup provision. Representatives of cooperating agencies are invited to participate in formulating plans for cases in which they have particular interest. It is expected that the community agencies will continue the coordination of services as developed in the project.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 10-4 A-62	Florida State Board of Health, Jacksonville, Fla.; Mary K. Pratt, R.N., M.A.	July 1, 1962, to Sept. 30, 1964 (full funded).	\$84,917

The project is a study to determine the nature and magnitude of total extra-hospital nursing needs—those not normally met by hospitals and nursing homes—by conducting interviews and making observations in a representative sample of households in Pinellas County. The same methods as those applied in the Johns Hopkins University study conducted in Butler County, Pa., will be used, thereby testing the usefulness of the previous method as a means of obtaining data which will permit generalizations broadly applicable to other segments of the population. Interviews and observations are to be carried out by specially trained and experienced public health nurses. Analysis and evaluation will be made of the nurse interviewers-observers' judgments as to needs and detailed evidences as to household situations and problems.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 11-1 A-62 CH 11-1 B-63 CH 11-1 C-64	Emory University School of Nursing, Atlanta, Ga.; Miss Lillian Bischoff.	July 1, 1962, to June 30, 1963... July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965...	\$51,944 44,826 40,035

Through the establishment of a health district serviced by Emory University School of Nursing, the project sponsor will identify the nursing and related needs of persons in the middle or upper socioeconomic level who are chronically ill or aged, and demonstrate the contribution of high-quality public health nursing to meeting the needs of such persons on a fee basis. In addition, it will identify the need for additional services such as homemaker meals-on-wheels and occupational therapy and promote physician utilization of nursing and rehabilitation services in the home on a fee-for-service basis. This project represents a first attempt to study an entire community to identify nursing needs and needs for other related services of economically independent persons.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 11-9 A-64	Richmond County Department of Public Health and Augusta Area Tuberculosis Association, Inc., Augusta, Ga.; Frank P. Anderson, M.D.	Sept. 1, 1964, to Aug. 31, 1965... Tentative.....	\$71,335 79,431 89,273

This project will establish a coordinated community service to rehabilitate and educate patients with chronic pulmonary diseases in the Augusta area. Diseases included will be chronic bronchitis, chronic obstructive pulmonary emphysema, bronchiectasis, and chronic bronchial asthma. The service will provide treatment, using the group therapy approach; evaluate patients and provide services in forms of outpatient care; educate and train patients, their families, and the laity; and orient and educate professional individuals. Complete evaluations will be included.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 45-7 A-64	Meharry Medical College, Nashville, Tenn.; Eugenia L. Mobley, D.D.S., M.P.H.	July 1, 1964, to June 30, 1965... Tentative.....	\$55,708 73,357 72,904

This project is designed to develop a community dental care program for the chronically ill and aged. The sample population will consist of both institutionalized and noninstitutionalized indigent residents of Davidson County. Characteristics of this population will be measured in terms of the need for full-mouth rehabilitation, the extent to which patients can benefit from rehabilitation, the type, frequency, and cost of the dental services needed for their rehabilitation, and the effects of such rehabilitation on the community in social and economic terms. The project will determine the prevalence and incidence of dental health needs, evaluate the present methods and means by which these needs are being met, and establish the level of dental care in terms of past care and present need.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 24-11 A-65	University of Michigan, Ann Arbor, Mich.; Vlado A. Getting, M.D.	Jan. 1 to Dec. 31, 1965----- Tentative-----	\$88,962 94,440 98,472

The ultimate goal of this project is to improve the status of organization and finance of community health services in Michigan. It will test the extent to which systematic involvement of top decisionmakers in the analysis of the problems connected with provision of these services will lead to positive action to change the system for the better and result in actual and significant modifications of the current pattern of operations. The project will be under the direction of the University of Michigan with the Michigan Health Officers Association and the Michigan Department of Health as cosponsors. The working committee will be made up of 40 highly influential citizen leaders in the State.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 37-10 A-63 CH 37-10 B-64 CH 37-10 C-65	Mount Sinai Hospital of Cleveland, Cleveland, Ohio; Sidney E. Wolpaw, M.D.	Dec. 15, 1962, to Dec. 14, 1963-- Dec. 15, 1963, to Dec. 14, 1964-- Dec. 15, 1964, to Dec. 14, 1965--	\$58,816 49,986 51,309

This study is to demonstrate the feasibility, cost, and value of providing a full range of out-of-hospital health services to elderly residents of a public housing project. The findings are expected to contribute knowledge on the selection of those elements of health care that can economically be provided to elderly persons in a residential setting. Comparison will be made of the experience of residents in this project with an equivalent population in a nearby housing project without a medical program. This will make it possible to evaluate and document the usefulness and health value of specific out-of-hospital services. Such data would provide guidance to housing authorities, health agencies, and community planners on needs, facilities, cost problems, and cost solutions.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 37-11 A-63 CH 37-11 B-64	Welfare Federation of Cleveland, Cleveland, Ohio; Mildred C. Barry.	June 1, 1963, to May 31, 1964--- June 1, 1964, to May 31, 1965--- Tentative-----	\$25,000 34,550 25,000

This project will provide a means by which a group of the community's decision-makers can develop acceptable community health goals and a model of a health community; identify and reduce gaps between the present situation and goals; establish priorities; and set into motion a program of implementation. The study will be a departure from the traditional in that it starts with goal formulation and development of a model. It will be a total approach covering all aspects of health in a metropolitan community and utilize a new system of classifying health areas. It provides for extensive use of consultation service from outside and substantial involvement of community leaders.

PHS region	Project No.	Grantee and project director	Period	Amount
V.....	CH 37-14 A-64	Cleveland Health Foundation, Cleveland, Ohio; Glenn Wilson.	Jan. 1, 1964, to June 30, 1965...	\$100,000

This project is designed to demonstrate and evaluate the effectiveness and cost of a complex of health maintenance services, especially directed at the problems of aging and chronic illness, and organized in the setting of a consumer-sponsored comprehensive service, prepaid group practice program. Currently operating medical care plans have not found it financially or organizationally feasible to include significant health maintenance services within the regular benefit-premium structure. The need remains to test the feasibility of just such incorporation into the routine activities of a prepaid medical service program. This will be done in the environment of and with the cooperation of a university medical center.

PHS region	Project No.	Grantee and project director	Period	Amount
V.....	CH 37-18 A-64	Highland View Hospital, Cleveland, Ohio; Dr. Howard Barry Waldman.	May 1, 1964, to Apr. 30, 1965... Tentative.....	\$56,073 55,140 59,274

This project proposes to gain information and experience regarding the factors involved in providing dental care to the chronically ill and aging using an outpatient clinic to supplement existing available means, and establish a criteria for home versus out-of-home dental care for this group. The knowledge gained will be utilized to promote the integration of the dental care of this population with the existing community health agency activities and to investigate means to incorporate this program as a permanent service of the local community.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 25-3 A-62 CH 25-3 B-63 CH 25-3 C-64	St. Paul Outpatient Center, Inc., St. Paul, Minn.; Winston R. Miller, M.D., F.A.C.P.	Sept. 1, 1962, to Aug. 31, 1963... Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965...	\$115,732 111,050 117,829

A project to develop further the potential of a unique and significant experiment in the administration of out-of-hospital medical care. Among the objectives are the provision of comprehensive, coordinated out-of-hospital care for the medically indigent persons on a part-pay basis and the evaluation of this method of medical care administration and demonstration of its value to the public and the various health professions. Five private hospitals join to form an outpatient department and participate in its operation.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 25-11 A-64	Department of Public Health and Welfare, Rochester, Minn.; Viktor O. Wilson, M.D., M.P.H.	July 1, 1964, to June 30, 1965... Tentative.....	\$11,484 10,988 11,264

This project will develop a program utilizing community services to reduce the number of recurrences of congestive heart failure and to decrease the frequency of hospital admissions because of these recurrences. It is planned to accomplish this through the use of various paramedical professions at the community level as an adjunct to private physicians in the care of the patient. The program will incorporate regular visits of public health nurses to the home of congestive heart

failure patients; dietary counseling services; and the use of a social worker to assist in the correction of socioeconomic problems which might arise. A further objective of the project is to undertake an epidemiological study of congestive heart failure.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 27-7 A-63 CH 27-7 B-64	Health & Welfare Council of Metropolitan St. Louis, St. Louis, Mo.; Robert C. Linstrom.	Apr. 1, 1963, to Mar. 31, 1964... Apr. 1, 1964, to Mar. 31, 1965... Tentative.....	\$62,431 65,487 68,350

A project to determine the optimum method of providing homemaker-housekeeper services to the chronically ill and aged by working with voluntary and governmental health and welfare agencies. One of the issues to be resolved is the location of such services in the array of health and welfare services offered in the community. Another is whether homemaker-housekeeper services in the family or child welfare field are similar and should be related to the same services for the chronically ill and aged. It is expected to obtain pertinent information on such aspects of homemaker services as the effect of certain auspices on services and the possibility of providing certain centralized services.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH 46-7 A-64	Texas Institute for Rehabilitation and Research, Houston, Tex.; Marvin E. Mergele, D.D.S.	Apr. 1, 1964, to Mar. 31, 1965... Tentative.....	\$46,338 38,049 36,887

This project will evaluate the benefits of a multidisciplinary approach in providing dental care for the elderly, handicapped, disabled, and the chronically ill. Its aim is to accumulate field data about the special dental, physiological, personal, and social problems of these groups which will lead to better techniques and treatment, and utilize results from a prototype program which will demonstrate the need for programs of this type. It will establish a basis for determining the type of care needed plus a mechanism for delivery of such care.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH 46-8 A-65	Dallas Dental Public Health Division, Dallas, Tex.; E. W. Hornish, D.D.S.	Award not made as of Dec. 31, 1964.	\$38,307 36,412 31,776

This project will develop a program designed to provide complete dental services to the chronically ill, the aged, and the homebound living in nursing homes and private residences in Dallas, making the best use of local resources and demonstrating the value of continuing this project as a regular part of the total community health program.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 51-2 A-63 CH 51-2 B-64	University of Washington, Seattle, Wash.; Justus F. Lehmann, M.D.	July 1, 1963, to June 30, 1964... July 1, 1964, to June 30, 1965... Tentative.....	\$29,500 29,500 29,500

The purpose of this project is to aid the process of returning patients to the community and daily living. It will develop a series of nonhospital controlled environmental situations for the placement of chronically disabled patients in an attempt to integrate medical rehabilitation and the process of solving everyday

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problems, emotional and physical, which patients must meet once they have received maximum benefit from medical restoration. Evaluation will be concerned with functional performance of the patients in the program and in the attitudes toward working with the disabled.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH 55-4 A-62	Group Health Association of America, Inc., Washington, D.C.; W. Palmer Dearing, M.D.	June 15, 1962, to June 14, 1963...	\$62,300
	CH 55-4 B-63		June 15, 1963, to June 14, 1964...	73,034
	CH 55-4 C-64		June 15, 1964, to June 14, 1965...	76,700

This project is directed to collecting, analyzing, and disseminating nationwide basic medical care statistics on prepaid group practice programs. Such data will aid in planning and evaluating program operations. Uniform medical care statistics will also provide a basis for sound planning by labor and other consumer groups, community and professional groups, health institutions and government, which desire to establish comprehensive health care programs. Standards and methods will be developed for regular collection, analysis, and dissemination of statistical data.

X. SURVEYS OF HEALTH NEEDS, FACILITIES, OR PROBLEMS

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-28 A-63	Health Research, Inc., Albany, N.Y.; David B. Ast, D.D.S.	July 1, 1963, to June 30, 1965, (1 year only).	\$18,086

This project will determine the actual prevalence of physical handicapping malocclusion among 12- to 16-year-old schoolchildren in upstate New York, using a stratified sampling already prepared, and will, as a second objective, refine the HLD index as an objective tool to determine severity of malocclusion. As a result of the refinement of the index, preliminary screening can be performed by clerks, rather than dentists, which will result in lower cost.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 34-41 A-64	Medical & Health Research Association of New York City, Inc., New York, N.Y.; Lester J. Rosner, M.A., LL.B.	Apr. 1, 1964, to Mar. 31, 1965..	{ \$43,465 37,759 27,463
			Tentative.....	

The primary purpose of this project is to develop a school health team which will employ an optimum percentage of professional time for professional purposes. It will also develop methodology for studying public health personnel utilization patterns. It will be conducted in three phases. Phase I will be a utilization study of the present system of staffing. Phase II will be an analysis of the baseline data and experimentation with restructured staffing patterns, and phase III will be an appraisal of the restructured patterns.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-36 A-63	Philadelphia Health Research Fund, Philadelphia, Pa.; David A. Soricelli, D.D.S., M.P.H.	May 1, 1963, to Apr. 30, 1964..	\$30,748
	CH 40-36 B-64		May 1, 1964, to Apr. 30, 1965..	36,715
			Tentative.....	33,620

A project to determine how the dental needs of the chronically ill homebound patient can best be met. A representative sample of homebound patients will be made and a complete dental examination given to every patient included in the sample. Operative, surgical, prosthetic, periodontal, and oral hygiene care will be provided as indicated. Experience gained through providing treatment will hopefully spell out factors influencing decisionmaking criteria in this area. The study will be a joint project of the Division of Dental Health of the Philadelphia Department of Public Health and the Philadelphia County Dental Society.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 27-6 A-63 CN 27-6 B-64	Missouri State Division of Health, Jefferson City, Mo.; Dr. W. D. Bryant.	Apr. 1, 1963, to Mar. 31, 1964 .. Apr. 1, 1964, to Aug. 31, 1965 .. (2 years only).....	\$29, 215 30, 990

This project is a methodological study of mechanisms for collecting morbidity data from private physicians on a regular basis in an attempt to determine the extent to which valid and reliable data can be secured in this way, and the method which is best. Samplings of general practitioners, internists, pediatricians, and specialists will be selected and three methods of securing data will be tried. For one group of doctors, arrangements will be made to pay their nurses for recording the information; a second group will be asked to forward the names of patients and the study nurse will extract the necessary data from the doctor's records; and a third group will be asked to dictate the data to their secretaries who will forward the material to the study center. The reliability of the reporting will be assessed by comparing reports with physician records.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 39-1 A-62 CH 39-1 B-63 CH 39-1 C-64	Yamhill County Health Department, McMinnville, Ore.; Elton Kessel, M.D., M.P.H.	July 1, 1962, to June 30, 1963 .. July 1, 1963, to June 30, 1964 .. July 1, 1964, to June 30, 1965 ..	\$31, 550 22, 010 15, 979

The purpose of this project is the establishment on a demonstrative basis of a senior citizens' center by a county health department which serves a small town in a rural area where home health services are limited. The functions of the center are to include periodic health appraisal and maintenance, with home nursing and homemaker services. In addition, recreational and social activities are to be provided.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 13-5 A-64 CH 13-5 B-65	Hawaii State Department of Health, Honolulu, Hawaii; Paul T. Bruyere, M.D.	Dec. 1, 1963, to Nov. 30, 1964 .. Dec. 1, 1964, to Nov. 30, 1965 .. Tentative.....	\$15, 110 20, 023 20, 828

The objective of this project is health surveillance, by means of continuing monthly household interviews, to provide information needed in planning and evaluating health programs. Public health nurses will question a random sample of residents of Oahu Island to provide sensitive, up-to-date measures of morbidity, population characteristics, health attitudes, and information in the community. A record will be kept of how and to what extent survey results are used by units of the health department as well as by outside agencies.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH 55-2 A-62 Supplement A-65	American Public Health Association, New York, N.Y.; Dean W. Roberts, M.D.	July 1, 1962, to June 30, 1966... Tentative.....	\$400, 000 91, 553 100, 861

Funds have been made available to support the collection and study of facts about community health needs and practices and to promote the translation of this knowledge into effective community health services, particularly those needed by the chronically ill and aged. Through the establishment of a National Commission on Community Health Services, it is expected to define the characteristics and assess the current status of community health services and establish goals for strengthening, extending, and improving such services. In addition, attention will be directed to developing principles of organization and action for health agencies as well as standards for community health services and to focusing public attention on the goals established and plans for action.

XI. EVALUATION OF SPECIFIC TREATMENT PRACTICES OR TECHNIQUES

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 07-13 A-65	Hartford Hospital, Hartford, Conn.; Ralph F. Reinfrank, M.D.	Feb. 1, 1965, to Jan. 31, 1966... Tentative.....	\$31,144 21,273

This project will demonstrate within the setting of a large community hospital the application of recent advances in the automatic analysis and processing of electrocardiograms. Automatic EKG procedures will be introduced into the routine out-patient and emergency room services of the Hartford Hospital and results will be recorded on FM magnetic tape and transmitted over ordinary telephone lines to the cooperating computer center in Washington, D.C., where they will be interpreted. Diagnoses will be either mailed back or can be teletyped back within minutes after receipt of the tracings. Appropriate quality control studies documenting the accuracy of computed diagnoses will be conducted.

PHS region	Project No.	Grantee and project director	Period	Amount
I-----	CH 23-6 A-63 CH 23-6 B-64 CH 23-6 C-65	The Age Center of New England, Inc., Boston, Mass.; Hugh Cabot.	Nov. 1, 1962, to Oct. 31, 1963... Nov. 1, 1963, to Oct. 31, 1964... Nov. 1, 1964, to Oct. 31, 1965...	\$108,917 131,789 131,667

The main objective of this project is to test the interrelations of health and social dependency in people 65 or over and to study a method of dependency prevention in a random, stratified urban sample. The Age Center of New England, in a 7-year research study on over 1,000 older men and women, has developed a method for the prevention of dependency in later years. This study will attempt to determine in detail the degree to which the method can be fully effective in another urban area. Through an interviewing and counseling program by trained staff, the study will introduce intervention in an attempt to reverse the trend toward illness and social dependency in late age by modifying older people's perception and understanding of their own aging and evaluating carefully the social and health changes which occur after a year has elapsed. It is the intent of the study to test and document the age center method of dependency prevention to the point where it can be introduced to health and social agencies as a tool in their ongoing work.

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-35 A-64 CH 34-35 B-65	St. Luke's Hospital, New N.Y.; York, Dr. Theodore Van Itallie.	Jan. 1, 1964, to Dec. 31, 1964... Jan. 1, 1965, to Dec. 31, 1965... Tentative.....	\$30,051 33,606 25,551

This project is directed toward the control of recurrence of the symptoms of congestive heart failure through the use of paramedical personnel at the community level. It will incorporate comprehensive medical care in the clinic, home visits by public health nurses, dietary counseling and social service assistance as

needed. It hopes to demonstrate that the addition of close supervision of congestive heart failure patients in the home can reduce the recurrence rate and readmission rate to the hospital by 50 percent.

PHS region	Project No.	Grantee and project director	Period	Amount
II.....	CH 40-46 A-64	Pennsylvania State College of Optometry, Philadelphia, Pa.; William G. Walton, Jr., O.D.	Apr. 1, 1964, to Mar. 31, 1965 (1 year only).	\$11,691

The sponsor will conduct a multiphasic investigation of the visual problems of institutionalized out-of-hospital aged in an attempt to develop improved and more efficient visual care programs. The study will concern itself with (1) examination of aged patients, (2) study of the adaptation of examining procedures to the unique visual problems of the aged, (3) demonstration and study of the benefits to aged patients of optometric services, and (4) standardization of criteria for referral of patients for medical care. Data collected will be continuously studied and analyzed and periodic reports prepared.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 09-4 A-63	District of Columbia Tuberculosis Association and District of Columbia Department of Public Health, Washington, D.C.; William Beque.	Oct. 1, 1962, to Sept. 30, 1963....	\$13,816
	CH 09-4 B-64		Oct. 1, 1963, to Sept. 30, 1964....	27,848
	CH 09-4 C-65		Oct. 1, 1964, to Sept. 30, 1965....	32,154

The objectives of this project are to diagnose the alcoholism of individuals with tuberculosis and to supply continuing treatment for alcoholic tubercular patients on an outpatient basis. Patients at Glenn Dale Hospital with possible diagnosis of alcoholism are now referred to the Alcohol Rehabilitation Center during their treatment for tuberculosis. Funds are requested in this project for the hiring of a psychiatric social worker who will serve on a full-time basis with the Alcohol Rehabilitation Division of the District of Columbia Department of Public Health and as liaison between the Division's clinic staff and the staff at Glenn Dale Hospital. Treatment of both tuberculosis and alcoholism will be continued on an outpatient basis after the patient's release from Glenn Dale. It is expected that a wealth of clinical data will be accumulated which will provide a basis for subsequent research.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 19-3 A-64	University of Kentucky, Lexington, Ky.; Kurt W. Deuschle, M.D., and Sylvester A. Shaffer, M.D.	Mar. 1, 1964 to Feb. 28, 1965 (1 year only).	\$86,286

The major objective of this project is to demonstrate how a tuberculosis eradication program can be established and carried out in a rural Appalachian county of eastern Kentucky, using the program as an initial technique to win family acceptance, to be followed by delivery of comprehensive health services. Although the demonstration is built around tuberculosis, it will be a prototype for the development of a comprehensive out-of-hospital service program for a rural, depressed area.

PHS region	Project No.	Grantee and project director	Period	Amount
III.....	CH 19-9 A-65.....	Lynch Medical Services, Harlan, Ky.; Beatrice Elrod Cope, R.N.	Dec. 1, 1964, to Nov. 30, 1965... Tentative.....	{ \$18,435 17,985 17,485

This project will demonstrate maximum utilization of scarce health manpower in an Appalachian coal mining community. It expects to stimulate the adult community, particularly the parents of preschool and school-age children, to take a positive interest in basic oral hygiene and dental health in behalf of their children. Demonstration of incremental dental care services and a planned program of oral hygiene education for students of the Lynch Independent School District, Harlan County, Ky., is expected to raise the health standards, educational achievements, and economic opportunities of the residents of an economically depressed coal mining town in Appalachia.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 35-6 A-63	Duke University Medical Center, Durham, N.C.; Morton D. Bogdonoff, M.D.	July 1, 1963, to Sept. 30, 1964..	\$94,309
	CH 35-6 B-64		Oct. 1, 1964, to Sept. 30, 1965..	102,535
			Tentative.....	112,526

This project is designed to evaluate a specific type of health care management—termed the “health team approach”—upon the health status and course of ambulatory patients with chronic illness. This approach is characterized by continuity of care, planned assessment of the patient’s feelings and attitudes and their specific utilization during long-term care, and expanded and more singular roles of activity for the allied health care personnel. The characteristics of the patient’s course and health status will be evaluated through study of symptomatic response, physiologic response, and functional role change.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 49-2 A-62	Bureau of Public Health, Lynchburg, Va.; John T. T. Hundley, M.D.	July 1, 1962, to June 30, 1963 (project canceled and funds returned to PHS).	\$11,360

Funds have been made available to the bureau of health to test and demonstrate a new and comprehensive program of out-of-hospital services coordinated with inpatient services, using the resources of a uniquely combined local health and welfare department. A chronic disease evaluation and treatment clinic will be established, with followup services to assure adequate care is maintained, to provide social services, and to determine final disposition of the patient.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 52-9 A-64	Lawrence Frankel Foundation, Inc., Charleston, W. Va.; Willard Pushkin, M.D.	Nov. 15, 1964, to Nov. 14, 1965.	\$54,000
	CH 52-9 B-65		Nov. 15, 1964, to Mar. 31, 1965.	12,000

This project will assess the effect of a supervised and graded physical exercise program as a therapeutic device for patients with coronary heart disease to determine (1) its feasibility, (2) the rehabilitative effect of the exercise, (3) the capacity of a continued conditioning exercise program for maintaining physical and vocational fitness, and (4) the prophylactic efficacy on the natural course of the disease following its stabilization. Two groups of at least 100 patients each will be used, one as a control group. Evaluation will also be made of physician participation in such a community-oriented project.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 01-4 A-65	Alabama Tuberculosis Association, Birmingham, Ala.; K. W. Grinley, George A. Danison, M.D.	Nov. 16, 1964, to Nov. 15, 1965. Tentative.....	\$113,524 91,080 63,178

This project will conduct on a demonstration basis throughout the State of Alabama a program of case finding, case supervision, physical restoration and therapy and vocational rehabilitation where indicated, for victims of chronic pulmonary diseases. Operations will include first a survey unit for preliminary screening of individuals, and a second unit which will consist of a field laboratory to provide both confirmatory tests for diagnosis as well as for continuing followup of patients during their course of treatment.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 11-6 A-64 CH 11-6 B-65	Georgia Department of Public Health, Atlanta, Ga.; Joseph A. Wilber, M.D.	Jan. 1, to Dec. 31, 1964----- Jan. 1, to Dec. 31, 1965-----	\$11,821 16,262

The objective of this project is to define and delineate those areas and techniques whereby public health agencies can contribute to the management of hypertensive patients on a community basis. Patients who have been identified as hypertensives will be divided into two groups, the first to be offered an intensive 2-year program of medical education regarding hypertensive disease, with facilities available for the treatment of indigent patients free of charge. The second group will serve as a control group. At the end of 2 years both groups will be resurveyed and compared.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 45-3 A-64	University of Tennessee, Memphis, Tenn.; L. W. Diggs, M.D.	May 1, 1964, to Apr. 30, 1965--- Tentative-----	\$7,474 7,622 7,770

This project is concerned with the home study and care of sickle cell disease. The present knowledge concerning it has been obtained from patients in a hospital environment. The project will assign a full-time experienced registered nurse to periodically visit selected families with sickle cell disease in their homes. This nurse will serve as a liaison between the patient in the home and the "sickle cell center" at the university where basic and clinical research on hospital patients is in progress. It is hoped that the home study of patients in painful crises will furnish information regarding trigger mechanisms, seasonal incidence, manner of onset, location and migration of pain, periodicity, duration, variability in severity, association with infections, exanthema, weather and barometric conditions. Home remedies and experimental drugs will be tested. Normal individuals and those with sickle cell trait will serve as controls.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 37-12 A-63	Public Health Federation of the Cincinnati Area, Cincinnati, Ohio; Sewall O. Milliken.	June 1, 1963, to May 31, 1966 (full funded).	\$96,885

This project will develop, test, and evaluate criteria of effective utilization of community health services serving the chronically ill, including criteria useful to the private physician, to a coordinated home care project, to a health department, to a visiting nurse association, and to an information and referral service, in planning comprehensive care and continuity of care for chronic illness patients. It will identify present patterns of utilization of current services, and attempt to improve these patterns through use of the criteria developed, tested, and evaluated in the project.

PHS region	Project No.	Grantee and project director	Period	Amount
VI-----	CH 25-14 A-65	Mount Sinai Hospital, Minneapolis, Minn.; Jerome T. Grismer, M.D.	Nov. 1, 1964, to Oct. 31, 1965. Tentative-----	\$70,340 70,635 72,071

This project will establish in the community a diagnostic unit which will perform comprehensive clinical physiologic tests of the cardiovascular and pulmonary systems either individually or simultaneously. The unit will provide easily available consultative service for private physicians, laymen, industrial physicians, and community agencies interested in the prevention, diagnosis, treatment, and rehabilitation of cardiopulmonary disease.

PHS region	Project No.	Grantee and project director	Period	Amount
VI.....	CH 27-16 A-63 CH 27-16 B-64	The Jewish Hospital of Saint Louis, St. Louis, Mo.; Franz U. Steinberg, M.D.	Sept. 1, 1963, to Aug. 31, 1964.. Sept. 1, 1964, to Aug. 31, 1965.. Tentative.....	\$31,663 29,833 29,833

The need for a liaison unit between hospital and home for congestive heart failure patients has been demonstrated by patients who respond to rest and medical treatment during their hospital stay but return to failure when they go back to their homes inadequately prepared for the physical exertions and emotional tensions which are part of their daily living. The grantee will establish such a unit for the rehabilitation of such patients. This unit will be part of the hospital's Department of Rehabilitation and Chronic Disease where patients can be hospitalized as long as necessary, and in it will be graduated from almost complete rest to increasing activities, using specialized clinical observations and calorie expenditure tests as a guide. Evaluation will be made using a control group and comparing number of readmissions to the hospital, total number of days spend in the hospital during these readmissions, and number of days of incapacity and/or loss of work.

PHS region	Project No.	Grantee and project director	Period	Amount
VII.....	CH 04-3 A-64	Arkansas State Board of Health, Little Rock, Ark.; Bryant S. Swindoll, M.D.	Feb. 1, 1964, to Jan. 31, 1965, (one year only).	\$13,758

Two nursing homes in Arkansas will (1) determine through laboratory tests the durability and flame retardancy of wearing apparel, bedclothing, and decorator fabrics after normal usage and washing, (2) compare the wearing qualities and service life of the articles with and without fire retardant properties, (3) determine the aesthetic acceptability of articles which are fire retardant, and (4) obtain medical observation as to dermatological acceptability of flame retardant materials.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 05-1 A-62 CH 05-1 B-63 CH 05-1 C-64	California Medical Education & Research Foundation, San Francisco, Calif.; Murray Klutch.	June 1, 1962, to May 31, 1963.. June 1, 1963, to May 31, 1964.. June 1, 1964, to May 31, 1965..	\$14,700 26,131 43,113

The purpose of this project is to develop and test a number of methods and techniques by which local medical societies throughout the State of California can establish and maintain a continuous form of evaluation of services, primarily out-of-hospital, rendered by physicians in private practice. The sponsor is an operating arm of the California Medical Society. The first phase of the project involves a conference with leading representatives of all county medical societies for a 1-day presentation, discussion, and workshop centered around four experts in the field. Following this, meetings are planned with at least 10 medical societies interested in developing programs of evaluation, assisting them in initiating such a program and in conducting pilot tests of procedures developed. Subsequent evaluation of the several types of programs initiated will enable the sponsor to recommend adoption of one or more types to all county medical societies for continuing use after the 3-year project has been completed.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 51-8 A-64	Lee House for Senior Citizens, Inc., Seattle, Wash.; Lorena Peterson.	July 1, 1964, to June 30, 1965... Tentative.....	\$37,531 39,175 41,053

The objectives of this project are to identify the physical, social, and related health needs of senior citizens who come to a traditional-type day center, develop a diagnostic method for evaluating these needs, and develop a method for determining the effectiveness of a nurse-social work team approach in meeting them. The first phase of the study will develop procedures, the second will be concerned with the collection of data, and the third will evaluate it. It is anticipated that the findings of this study will make a significant contribution to others planning day centers for older citizens.

XII. SCREENING

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-49 A-65	Buffalo & Erie County Tuberculosis & Health Association, Inc., Buffalo, N.Y.; V.J. Sallak, Ed. D.	Nov. 1, 1964, to Oct. 31, 1965... Tentative.....	\$79,300 72,100 57,100

The objective of this project is the demonstration of community services to identify chronic respiratory disease, to provide diagnostic facilities, and to direct patients for adequate medical care. It will use mobile clinic facilities to screen approximately 15,000 apparently healthy adults annually to find chronic respiratory abnormalities. Subjects with significant respiratory disease will be referred to their private physicians or to other treatment facilities.

PHS region	Project No.	Grantee and project director	Period	Amount
III-----	CH 09-1 A-62 CH 09-1 B-63 CH 09-1 C-64	Howard University, Washington, D.C.; Dorothy D. Watts, R.N., M.P.H.	May 15, 1962, to May 14, 1963... May 15, 1963, to June 14, 1964... May 15, 1964, to May 14, 1965...	\$24,954 38,823 41,868

The project will demonstrate the use of trained lay volunteers for door-to-door health and social problem screening in a lower class neighborhood. Individuals in need of services are brought to a health center for intensive diagnosis and for coordinated social casework and medical treatment. The sponsor will work toward improving physician-patient relationships in a coordinated service for low income groups and explore the possibility of organizing and using the resources of physicians in the area for more preventive medical services.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 37-9 A-63	Western Reserve University, Cleveland, Ohio; Jack R. Leonards, M.D.	Oct. 15, 1962, to Oct. 14, 1963 (1 year only).	\$34,582

The sponsor proposes to develop an accurate method of utilizing finger blood as a method of mass screening for diabetes, to test this method as a more effective technique for community screening for the early detection of diabetes by pilot studies, and to evaluate the use of such a method for widespread diabetes detection in an urban community. A mobile trailer unit is being used for the study. Support is given for only the first phase of the study.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 37-16 A-64 CH 37-16 B-65	Western Reserve University, Cleveland, Ohio; Gerald T. Kent, M.D., and Jack R. Leonards, M.D.	Oct. 1, 1963, to Dec. 31, 1964... Jan. 1, to Dec. 31, 1965..... Tentative.....	\$125,718 105,764 109,192

This is a continuation of the pilot study of finger blood as a method of mass screening for diabetes. (See project CH 37-9 A-63.) The sponsor has developed a new technique which has been used successfully in testing personnel on a community basis in a mobile unit and personnel of industrial plants. It is now planned to carry this method into the entire community, an area with a total population of 1,800,000 people. Funds were also requested for development of a new type of automatic glucose analyzer, but were not approved in the current award.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 05-8 A-62 CH 05-8 B-64 CH 05-8 C-65	Kaiser Foundation Research Institute, Oakland, Calif.; Morris F. Collen, M.D.	Sept. 1, 1962, to Aug. 31, 1963... Sept. 1, 1963, to Aug. 31, 1964... Sept. 1, 1964, to Aug. 31, 1965...	\$224,267 301,087 364,088

This project is designed to evaluate the effectiveness of multiphasic screening and to develop automated screening techniques, machine diagnostic techniques, and a framework for research in medical care. It is expected that the project will demonstrate how improved, automated techniques will effectively and economically furnish periodic health appraisals to large numbers of individuals. The computer furnish periodic health appraisals to large numbers of individuals. The computer storage of data on over 25,000 adults annually will permit extensive epidemiological research especially directed toward the preventive aspects of chronic disease. Plans call for development of refined and improved methods of procedure during the first year; the installation and operation of an expanded program in enlarged facilities during the second year; and the further accrual of research data and beginning of statistical analyses in the third year.

XIII. OTHER

PHS region	Project No.	Grantee and project director	Period	Amount
II-----	CH 34-44 A-65	State University of New York, Albany, N.Y.; Eli A. Friedman, M.D.	Sept. 1, 1964, to Aug. 31, 1965... Tentative.....	\$191,954 202,288 203,929

Patients suffering end-stage renal failure due to a variety of diseases will be subjected to chronic peritoneal and hemodialysis in order to study the relative efficacy of these two approaches to chronic life prolongation.

PHS region	Project No.	Grantee and project director	Period	Amount
IV-----	CH 01-3 A-65	University of Alabama Medi- cal Center, Birmingham, Ala.; H. Walker Brown.	Dec. 1, 1964 to Nov. 30, 1965... Tentative.....	\$211,509 177,486 191,420

This project will initiate a 5-bed 15-patient intermittent dialysis facility in a well-controlled environment (the university medical center) in order to attempt to duplicate the success of the Seattle project, which other competent investigators using similar techniques have failed to do. It will investigate methods of improving the technique and initiate a comprehensive study of the effects of prolonged intermittent dialysis on the patient.

PHS region	Project No.	Grantee and project director	Period	Amount
V-----	CH 24-6 A-63 CH 24-6 B-64	Saginaw County Hospital, Saginaw, Mich.; V. K. Volk, M.D.	June 1, 1963, to May 31, 1964... June 1, 1964 to May 31, 1965... Tentative.....	\$65,439 80,287 51,057

This project will establish and evaluate a day care rehabilitation program in which out-of-hospital patients will receive medical and allied services at the hospital by being brought daily, or as necessary, by bus. Evaluation will seek to establish that such a program will reduce the hospital stay and insure continuity of care and that it will reduce readmissions and lower the overall cost of care of the long-term patients. Research in the project will be administered through the University of Michigan.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 05-2 A-62 CH 05-2 B-63	University of Southern California, Los Angeles, Calif.; Frederick J. Moore, M.D.	July 1, 1962 to June 30, 1963... July 1, 1963 to Jan. 31, 1964, (2 years only).	\$14,179 50,626

Through this project the records systems of certain health and welfare agencies in the Los Angeles region will be automated with a view toward coordinating these and other systems in a central records index. The coordinated electronic central file is to service the needs of health practice, research, and teaching. Identity files are to be mechanized from the county general hospital and bureau of public assistance as well as major districts of the county health department, units of the bureau of hospitals, and the Los Angeles District Office of Vocational Rehabilitation Services. Preliminary work has been done as a basis for the mechanization of these records. Grant funds will aid in the actual development of the center for the storage and retrieval of personal health information data.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 05-20 A-63	University of California, Los Angeles, Calif.; Olive G. Johnson.	Apr. 1, 1963, to Aug. 31, 1965 (full funded).	\$47,225

This project will make a study of the need for records and reports in local health departments for patient service and for planning and evaluating programs. It will appraise existing records and reports in relation to stated needs and current usage, and it will design systems for recording, processing, and maintenance that will assure availability of required data. It will also study the application of high-speed data processing to health department records.

PHS region	Project No.	Grantee and project director	Period	Amount
IX-----	CH 13-6 A-64	State Department of Health, Honolulu, Hawaii; Paul T. Bruyere, M.D.	Aug. 1, 1964, to July 31, 1967 (full funded).	\$50,355

The major purpose of the project will be to provide a thorough 55-year record and analysis of the mortality experience of the major ethnic groups in Hawaii as a guide in public health practice and research. Major emphasis will be on causes of death. A sample of Hawaii death records from 1908-62 will be coded, punched, tabulated, and analyzed to delineate differences in causes of death and trends among the various ethnic groups of Hawaii. Such data will aid health agencies in program planning and supply the bases for epidemiological and genetics research, and will also add materially to the demographic history of Hawaii's ethnic groups.

PHS region	Project No.	Grantee and project director	Period	Amount
IX.....	CH 51-6 A-63	Seattle Artificial Kidney Center, Seattle, Wash.; John S. Murray, M.D.	July 1, 1963, to June 30, 1966 (full funded).	\$307,271

This project will enlarge the current 3-bed center to a 10-bed facility to reduce and study the costs of the treatment of patients with chronic uremia by periodic hemodialysis. It will demonstrate that this form of treatment is worthy of community support, and will work out with appropriate agencies in the area a pattern of long-term community support which will include a method of determining what each patient's own contribution should be. The facility will also be used for demonstration and training purposes for groups from other communities who plan similar facilities.

PHS region	Project No.	Grantee and project director	Period	Amount
National.	CH 55-12 A-64	American Public Health Association, New York, N.Y.; Henrik L. Blum, M.D.	Feb. 1, 1964, to Jan. 31, 1965 (1 year only).	\$23,249

This project will develop and publish a handbook which will describe in detail the major concepts of the public health approaches to control of chronic disease, including a detailed presentation of information about specific diseases, assembled for ready reference. Part I of the book will be devoted to major concepts of the public health approaches to control of chronic disease; part II more detailed presentation of information about specific diseases. Utilization will be promoted through the channels of the APHA.

Dr. DEMPSEY. Mr. Chairman, this concludes my prepared statement on S. 512 and S. 510. The provisions of these two bills deserve your careful consideration and we hope that early and favorable action upon them will be taken by the Congress.

My associates and I shall be glad to answer any questions which you or other members of the subcommittee may have.

The CHAIRMAN. Doctor, you have certainly brought us a splendid statement. We very much appreciate your statement. It is very fine indeed.

There is one provision in one of the bills for the creation of three assistant secretaries in the Department of Health, Education, and Welfare.

Mr. Miles, will you address yourself to that provision?

STATEMENT OF RUFUS E. MILES, ASSISTANT SECRETARY FOR ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. MILES. Yes. Mr. Chairman, I do not have a prepared written statement, but I would like to make a brief oral statement and then respond to any questions which you may have.

In the 12 years since the Department of Health, Education, and Welfare was created, it has been the fastest growing department of the the U.S. Government. It has grown from a Department which had appropriations from general funds in 1953, when it was created, of \$1.9 billion and from social security trust funds of a little over \$3 billion—\$3.4 billion—to a Department which, in the 1966 budget,

calls for expenditures from the general funds of over \$7 billion and trust fund expenditures—social security trust fund expenditures—of approximately \$20 billion. So it has grown from over \$5 billion to about \$27 billion in total expenditures in 1956.

This growth has been accompanied by the creation of a large number of interrelated programs. The 88th Congress, as you are very well aware, Mr. Chairman, did a remarkable job of adding to the duties of the Department of Health, Education, and Welfare, and I would just like to refresh your recollection of the highlights of the legislative additions to the functions of the Department of Health, Education, and Welfare provided by the 88th Congress alone: The Health Professions Education Assistance Act; the Maternal and Child Health and Mental Retardation Planning Amendments of 1963; the Mental Retardation Facilities and Community Mental Health Construction Act of 1963; the Higher Education Facilities Act of 1963; the Clean Air Act; the Vocational Education Act of 1963; the Manpower Development and Training Amendments of 1963; the Library Facilities and Construction Act; the Civil Rights Act of 1964; the Juvenile Delinquency and Youth Offenses Control Amendments; Medical Care for Self-Employed Commercial Fishermen; Hospital and Medical Facilities Amendments of 1964; the Economic Opportunity Act of 1964, which included certain functions for the Department of Health, Education, and Welfare; the Graduate Public Health Training Amendments of 1964; the Nurse Training Act of 1964; the National Defense Education Act Amendments of 1964; Foster Care for Dependent Children; and the OASDI and other amendments to the Social Security Act and Internal Revenue Act of 1964.

These were the principal new legislative enactments of a single Congress. I could enter for the record, if you wish to have me, the enactments of previous Congresses which have added to the responsibilities of the Department of Health, Education, and Welfare.

The CHAIRMAN. I wish you would provide that for the record and have it appear in the record at the conclusion of your remarks.

Mr. MILES. I shall be glad to.

(Legislation referred to appears beginning p. 4.)

Mr. MILES. These responsibilities, as you will imagine, have many interrelationships between the component parts of the Department of Health, Education, and Welfare, between the Public Health Service, and Office of Education, between the Vocational Rehabilitation Administration and the Public Health Service, between the Public Health Service and the Welfare Administration, and so on.

We also have many interdepartmental relationships with other departments and agencies of the Government, with the Labor Department and with the Office of Economic Opportunity, with the Department of the Interior, and many other departments. These interrelationships, many of them, are of a high level of responsibility and are of a policy character. They require top level persons who can represent the Secretary in performing these functions.

Since the Department was created, there has been practically no change made in the top level staffing of the Department. We have two assistant secretaries who were appointed subject to Senate confirmation. We have a position of Assistant Secretary for Administration, the one which I hold, which is a position not subject to Senate confirmation, but is the top general administrative position within

the Department; and we have a Special Assistant to the Secretary for Health and Medical Affairs.

This bill would create two new assistant secretaries. Although it seems to create three, in fact, it creates two and converts one position from the Special Assistant to the Secretary for Health and Medical Affairs to an assistant secretary. This position was always intended to be a position which would rank with the assistant secretary positions and in fact would be better described as an assistant secretary, and it is our desire and intent to convert that position to one which is labeled assistant secretary instead of Special Assistant to the Secretary for Health and Medical Affairs.

The existing top representatives of the Department are currently extremely overburdened and the Secretary feels very strongly the need for two new assistant secretaries and the conversion of the Special Assistant to the Secretary for Health and Medical Affairs to an assistant secretary.

I will be glad to answer any questions.

The CHAIRMAN. There has been a tremendous growth in the duties, responsibilities, obligations, and programs of the Department of Health, Education, and Welfare, hasn't there?

Mr. MILES. I would say that is very true, Mr. Chairman—very true.

(The material referred to previously follows:)

*Major legislation affecting the Department of Health, Education, and Welfare,
1953-62*

Public Law No.	Brief description	Date enacted
83d Cong:		
217-----	Amends Federal Food, Drug, and Cosmetic Act by providing certain authority for factory inspection.	Aug. 7, 1953
246-----	Adds titles III and IV to Public Law 815, 81st Cong., to provide temporary program of assistance in construction of minimum school facilities in areas affected by Federal activities.	Aug. 8, 1953
248-----	Amends Public Law 874, 83d Cong., to make improvements in its provisions and extends its duration for a 2-year period.	-----do-----
335-----	Amends secs. 401 and 701 of the Federal Food, Drug, and Cosmetic Act so as to simplify the procedures governing the establishment of food standards.	Apr. 15, 1954
355-----	Amends Public Health Service Act to authorize the care and treatment at facilities of the Public Health Service of narcotic addicts committed by the U.S. District Court for the District of Columbia.	May 8, 1954
482-----	Medical Facilities Survey and Construction Act of 1954 (amends title VI of the Public Health Service Act).	July 10, 1954
518-----	Amends Federal Food, Drug, and Cosmetic Act with respect to residues of pesticide chemicals in or on raw agricultural commodities.	July 22, 1954
565-----	Vocational Rehabilitation Amendments of 1954 (amends the Vocational Rehabilitation Act so as to promote and assist in the extension and improvement of vocational rehabilitation services, provide for more effective use of available Federal funds, and otherwise improve the provisions of that act).	Aug. 3, 1954
531-----	Authorizes cooperative research in education.	July 26, 1954
532-----	Authorizes establishment of National Advisory Committee on Education.	-----do-----
568-----	Transfers the administration of health services for Indians and the operation of Indian hospitals to the Public Health Service.	Aug. 5, 1954
761-----	Amends the Social Security Act and the Internal Revenue Code to extend coverage under the old-age and survivors insurance program, increase the benefits, preserve the insurance rights of disabled individuals, and increase the amount of earnings permitted without loss of benefits.	Sept. 1, 1954
84th Cong.:		
61-----	Amends Federal Property and Administrative Services Act of 1949 to improve the administration of the program for the utilization of surplus property for educational and public health purposes.	June 3, 1955
159-----	Provides research and technical assistance relating to air pollution control.	July 14, 1955
182-----	Mental Health Study Act of 1955 (providing for an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness; adds sec. 304 to Public Health Service Act).	July 28, 1955
382-----	Amends Public Laws 815 and 874, 81st Cong.	Aug. 12, 1955
377-----	Poliomyelitis Vaccination Assistance Act of 1955.	Do.
497-----	Provides for the procurement of medical and dental officers of the armed services and Public Health Service.	Apr. 30, 1956

Major legislation affecting the Department of Health, Education, and Welfare,
1953-62—Continued

Public Law No.	Brief description	Date enacted
84th Cong.—Continued		
569	Dependents' Medical Care Act	June 7, 1956
597	Library Services Act	June 19, 1956
655	Amends Federal Property and Administrative Services Act of 1949 regarding donations for civil defense purposes.	July 3, 1956
660	Water Pollution Control Act Amendments of 1956	July 9, 1956
652	National Health Survey Act (adds sec. 305 to Public Health Service Act)	July 3, 1956
672	Amends sec. 406 of the Federal Food, Drug, and Cosmetic Act relating to oranges.	July 9, 1956
764	Dangerous Drug Control Act for the District of Columbia (secs. 302 and 303 affect Public Health Service care of narcotic addicts).	July 24, 1956
732	Increases authorization for facilities of National Institute of Dental Research.	July 19, 1956
830	Alaska Mental Health Enabling Act (amends title III of the Public Health Service Act).	July 28, 1956
881	Servicemen's and Veterans' Survivor Benefits Act (includes officers of Public Health Service; also amends title II of the Social Security Act).	Aug. 1, 1956
835	Health Research Facilities Act of 1956 (adds title VII to Public Health Service Act).	July 30, 1956
905	Amends secs. 401 and 701(e) of the Federal Food, Drug, and Cosmetic Act to simplify procedures governing the prescribing of regulations under certain provisions of such act.	Aug. 1, 1956
937	Amends sec. 4(a) of the Vocational Rehabilitation Act.	Aug. 3, 1956
941	National Library of Medicine Act (amends title III of Public Health Service Act).	Do.
813	To assist States in the establishment of State committees on education beyond the high school.	July 26, 1956
871	Health Amendments Act of 1956 (to assist in increasing the number of adequately trained professional and practical nurses and professional public health personnel, assisting in the development of improved methods of care and treatment in the field of mental health).	Aug. 2, 1956
922	Authorizes wider distribution of books and other special instructional material for the blind, increases the appropriations authorized for this purpose.	Do.
949	Extends until June 30, 1958, the programs of financial assistance under Public Laws 815 and 874, 81st Cong., and makes certain other changes in such provisions.	Aug. 3, 1956
886	Social Security Amendments of 1956 (provides disability insurance benefits for certain disabled individuals who have attained age 50, reduces to 62 the age on the basis of which benefits are payable to certain women, provides for child's insurance benefits for children who are disabled before reaching age 18, and further extends coverage).	Aug. 1, 1956
85th Cong.:		
109	Amends title II of Social Security Act to extend the period during which an application for a disability determination is granted full retroactivity.	July 17, 1957
110	Amends public assistance provisions of the Social Security Act to provide for a more effective distribution of Federal funds for medical and other remedial care.	Do.
151	Authorized funds available for construction of Indian health facilities to be used to assist in the construction of community hospitals which will serve Indians and non-Indians.	Aug. 16, 1957
161	Makes Public Law 815, 81st Cong., applicable to Wake Island	Aug. 21, 1957
198	Amends secs. 4(a) and 7(a) of the Vocational Rehabilitation Act (training provisions).	Aug. 28, 1957
250	Amends sec. 304(d) of the Federal Food, Drug, and Cosmetic Act re disposition of certain imported articles which have been seized and condemned.	Aug. 31, 1957
229	Amends Social Security Act to facilitate the provision of coverage for State and local employees under certain retirement systems.	Aug. 30, 1957
238	Amends title II of the Social Security Act to make inapplicable in the case of survivors of certain members of the Armed Forces, the provisions which prevent the payment of benefits to aliens who are outside the United States.	Do.
226	Amends title II of the Social Security Act to permit any instrumentality of 2 or more States to obtain social security coverage, under its agreement, separately for those of its employees who are covered by a retirement system and who desire such coverage, to include Alabama, Georgia, New York, and Tennessee among the States which may obtain social security coverage for policemen and firemen in positions covered by a retirement system on the same basis as other State and local employees, and extends the period during which State agreements for social security coverage of State and local employees may be made retroactive.	Do.
227	Amends title II of the Social Security Act to include California, Connecticut, Minnesota, and Rhode Island among the States which are permitted to divide their retirement systems into 2 parts so as to obtain social security coverage, under State agreement for only those State and local employees who desire such coverage.	Do.
239	Extends the time within which a minister may elect coverage as a self-employed individual for social security purposes and permits such a minister to include, for social security purposes, the value of meals and lodging furnished him for the convenience of his employer and the rental value of the personage furnished to him.	Do.

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*Major legislation affecting the Department of Health, Education, and Welfare,
1953-62—Continued*

Public Law No.	Brief description	Date enacted
85th Cong.— Continued		
267-----	Extends for 1 year Public Law 815, 81st Cong., add subsection (f) to sec. 305, and adds sec. 312.	Sept. 2, 1957
544-----	Amends sec. 314(c) of the Public Health Service Act to authorize grants-in-aid for the support of public or nonprofit educational institutions which provide training and services in the fields of public health and in the administration of State and local public health programs.	July 22, 1958
589-----	Authorizes loans for the construction of hospitals and other facilities under title VI of the Public Health Service Act.	Aug. 1, 1958
620-----	Amends Public Law 815 and 874, 81st Cong., to make permanent the programs providing financial assistance in the construction and operation of schools in areas affected by Federal activities, insofar as such programs relate to children of person who reside and work on Federal property, to extend such programs until June 30, 1961, insofar as such programs relate to other children, and to make certain other changes in such laws.	Aug. 12, 1958
798-----	Amends title II of Social Security Act to provide that a widow or former wife divorced who loses mother's insurance benefits by remarriage may again become entitled if her husband dies within 1 year of such remarriage, and to provide that interstate instrumentalities may secure coverage for policemen and firemen in positions under a retirement system of the instrumentality.	Aug. 28, 1958
785-----	Amends sec. 403 of the Social Security Amendments of 1954 to provide social security coverage for certain employees of tax-exempt organizations which erroneously but in good faith failed to file the required waiver certificate in time to provide such coverage.	Aug. 27, 1958
786-----	Amends title II of the Social Security Act to provide that the exception from "wages" made by sec. 209(l) of such act shall not be applicable to payments to employees of a State or a political subdivision thereof for periods of absence from work on account of sickness.	Do.
787-----	Amends title II of the Social Security Act to include Massachusetts and Vermont among the States which are permitted to divide their retirement systems into 2 parts so as to obtain social security coverage, under State agreement for only those State and local employees who desire such coverage and to permit individuals who have decided against such coverage to change their decisions within a year after the division of the system.	Do.
908-----	White House Conference on Aging Act	Sept. 2, 1958
840-----	Social Security Amendments of 1958 (increases benefits under OASDI, improves actuarial status of the trust funds, amends the public assistance and maternal and child health and welfare provisions of the Social Security Act).	Aug. 28, 1958
864-----	National Defense Education Act of 1958	Sept. 2, 1958
881-----	Relieves the Surgeon Generals of the Army and Navy of certain responsibilities outside the Department of Defense (amends sec. 351(d) of the Public Health Service Act).	Do.
875-----	Requires the Commissioner of Education to encourage, foster, and assist in the establishment of clubs for boys and girls especially interested in science.	Do.
929-----	Food Additives Amendment of 1958 (amends Federal Food, Drug, and Cosmetic Act to prohibit the use in food of additives which have not been adequately tested to establish their safety).	Sept. 6, 1958
905-----	Provides in the Department of Health, Education, and Welfare for a loan service of captioned films for the deaf.	Sept. 2, 1958
926-----	Grants to institutions of higher learning and to State educational agencies for expansion of teaching in the education of mentally retarded children.	Sept. 6, 1958
86th Cong.:		
2-----	Amends the Federal Food, Drug, and Cosmetic Act re coloring of oranges.	Mar. 17, 1959
121-----	Amends act of Aug. 5, 1954, re Indian sanitation facilities.	July 31, 1959
284-----	Provides additional time within which certain State agreements under sec. 218 of the Social Security Act may be modified to secure coverage for nonprofessional school district employees, and permits the States of California, Kansas, North Dakota, and Vermont to obtain social security coverage, under State agreement, for policemen and firemen in positions covered by a retirement system.	Sept. 16, 1959
354-----	Amends the Federal Credit Union Act.	Sept. 22, 1959
365-----	Extends for 4 years the air pollution control law and adds sec. 8.	Do.
415-----	Public Health Service Commissioned Corps Personnel Act of 1960.	Apr. 8, 1960
442-----	Amends Social Security Act regarding determination of quarters of coverage in certain cases.	Apr. 22, 1960
449-----	Civil Rights Act of 1960 (title V amends Public Law 874, 81st Cong., re education of children of members of Armed Forces when local authorities close schools).	May 6, 1960
493-----	Authorizes PHS study of effects of the discharge of substances into the atmosphere from exhausts of motor vehicles from the standpoint of human health.	June 8, 1960
537-----	Amends the Federal Food, Drug, and Cosmetic with respect to label declaration of the use of pesticide chemicals on raw agricultural commodities which are the produce of the soil.	June 29, 1960
546-----	Makes the uniform law relating to the record on review of agency orders (Public Law 85-791) applicable to the judicial review of orders issued under the Federal Aviation Act of 1958 and the Food Additives Amendment of 1958.	Do.

Major legislation affecting the Department of Health, Education, and Welfare,
1953-62—Continued

Public Law No.	Brief description	Date enacted
86th Cong.— Continued		
571-----	Provides for the hospitalization, at St. Elizabeths Hospital or elsewhere, of certain nationals of the United States adjudged insane or otherwise found mentally ill in foreign countries.	July 5, 1960
613-----	Federal Hazardous Substances Labeling Act-----	July 12, 1960
618-----	Color Additive Amendments of 1960 (amending the Federal Food, Drug, and Cosmetic Act).	Do.
612-----	International Health Research Act of 1960-----	Do.
679-----	Amends Library Services Act.	Aug. 31, 1960
720-----	Amends title III of Public Health Service Act to authorize project grants for graduate training in public health.	Sept. 8, 1960
798-----	Amends Public Health Service Act to authorize grants-in-aid to universities, hospitals, laboratories, and other public or nonprofit institutions to strengthen their programs of research and research training in sciences related to health.	Sept. 15, 1960
778-----	Social Security Amendments of 1960 (extends and improves coverage under OASDI and removes hardships and inequities, improves the financing of the trust funds, and provides disability benefits to additional individuals under such system, provides grants to States for medical care for aged individuals of low income, amends the public assistance and maternal and child welfare provisions).	Sept. 13, 1960
87th Cong.:		
19-----	Food Additives Transitional Provisions Amendment of 1961-----	Apr. 17, 1961
22-----	Amends title II of the Vocational Education Act of 1946, relating to practical nurse training.	Apr. 24, 1961
31-----	Amends title IV of the Social Security Act to authorize Federal financial participation in aid to dependent children of unemployed parents; also includes Federal payments for foster home care of dependent children, 1-year extension of appropriation authorization for training grants for public welfare personnel, and increases maximum medical care expenditures (in behalf of old-age assistance recipients) with respect to which there will be Federal participation.	May 8, 1961
64-----	Social Security Amendments of 1961-----	June 30, 1961
94-----	Amends the Federal Property and Administrative Services Act of 1949, as amended, to authorize the use of surplus personal property by State distribution agencies.	July 20, 1961
88-----	Federal Water Pollution Control Act Amendments of 1961-----	Do.
262-----	Establishes a teaching hospital for Howard University; transfers Freedmen's Hospital to the university.	Sept. 21, 1961
274-----	Juvenile Delinquency Control Act of 1961-----	Sept. 22, 1961
294-----	Authorizes wider distribution of books and other special instruction materials for the blind and increases the appropriation for this purpose.	Do.
276-----	To make available teachers of the deaf and other specialists for individuals with speech and hearing impediments.	Do.
344-----	Extends for 2 additional years Public Laws 815 and 874, 81st Cong., and provides for the application of such laws to American Samoa.	Oct. 3, 1961
395-----	Assists in expanding and improving community facilities and services for the health care of aged and other persons.	Oct. 5, 1961
400-----	Amends title II of the National Defense Education Act with respect to the periods for which loans under that title are made.	Do.
415-----	Manpower Development and Training Act of 1962-----	Mar. 15, 1962
447-----	Authorizes \$32,000,000 over a 5-year period to assist in the construction of educational television facilities.	May 1, 1962
510-----	Authorizes the President to carry on a program of aid to refugees in the Western Hemisphere (Cuban refugee program).	June 28, 1962
543-----	Public Welfare Amendments of 1962-----	July 25, 1962
692-----	Amends title III of the Public Health Service Act to provide Federal assistance for health services to the nearly 1,000,000 domestic migrant workers and their families who are employed annually to produce and harvest our agricultural crops.	Sept. 25, 1962
715-----	Captioned films for the deaf-----	Sept. 28, 1962
761-----	Air Pollution Act (extends the existing legislation for 2 years, until June 30, 1966, retaining the \$5,000,000 annual ceiling of the present act. The Surgeon General is given additional authority to conduct special studies of the problem of automobile exhaust fumes).	Oct. 9, 1962
781-----	Drug Amendments of 1962 (amends the Federal Food, Drug, and Cosmetic Act to assure the safety and effectiveness of drugs, authorize standardization of drug names, and clarify and strengthen existing factory inspection authority with respect to drugs).	Oct. 10, 1962
786-----	Permits the donation of surplus Federal property to schools for the mentally retarded and handicapped, educational television and radio stations and libraries.	Do.
838-----	Establishes new Institutes for Child Health and Human Development, and General Medical Sciences, at the National Institutes of Health.	Oct. 17, 1962
868-----	Vaccination Assistance Act of 1962 (authorizes project grants by the Public Health Service to States and local communities for intensive community vaccination programs).	Oct. 23, 1962

The CHAIRMAN. Dr. Terry, do you have any comment you want to make?

Dr. TERRY. I don't have anything particularly to say at this time, Mr. Chairman. Of course, I will be happy to answer any questions.

The CHAIRMAN. Dr. Sessoms, Deputy Director of the NIH?

Dr. SESSOMS. I have nothing to add to the testimony, Mr. Chairman, unless there are questions.

The CHAIRMAN. Dr. Dempsey, let me ask this question: Have you estimates of cost for the construction of research facilities of national and regional importance? Could you provide estimates of cost for the next 5 years? We have the estimates for the matching program, which is \$400 million for the 5-year period, I believe.

Dr. DEMPSEY. The estimates of this are necessarily somewhat insecure, Mr. Chairman, as one reaches into the future years. It is proposed, I think, to begin the program at a level of \$5 million in 1966 and for it to escalate as required by the development of the program and by the exigencies of the budgetmaking processes in the coming years. It is not, however, envisioned as a large part of the total construction program.

The CHAIRMAN. Now, you will probably recall the primate research centers that we established. Are they examples of what you contemplate in terms of regional and national health research facilities?

Dr. DEMPSEY. They are, indeed. They represent facilities which are specialized, which are highly necessary for the conduct of modern research, which are probably outside the capability of most single institutions to manage and which therefore have significance for entire regions, indeed for the entire Nation. There are other kinds of animal facilities that are equally important; the use of many large animals and the use of some of the exotic animals that normally are difficult to care for in ordinary laboratory circumstances, but which are vital for the prosecution of certain kinds of diseases, related research could also be provided on a national or on a regional basis in such institutions as we have proposed.

The CHAIRMAN. These primate research programs have proved themselves in the field of research, have they?

Dr. DEMPSEY. That is my impression. They have not yet had an opportunity to demonstrate their full effectiveness. The building and developing and staffing of programs of this size takes time. Those that are in full functioning at the moment already have demonstrated the wisdom of their creation, in my judgment.

The CHAIRMAN. Doctor, in the research facility construction program where Federal funds are matched on a 50-50 basis, have you given any thought or consideration to making the matching provisions more flexible?

Dr. DEMPSEY. There has been a considerable amount of consideration given to it, Mr. Chairman, and as in many situations, one can find all shades of opinion represented in this consideration. In general, there seems to be emerging a notion that the 50-50 matching principle is not bad in situations in which the primary function of the matching institution is being served, such as the creation of teaching facilities or of research facilities in a university, the prime purpose of which is to do teaching and research.

The further one gets away from the primary objective or the primary scope of the institution, however, as one does when he asks a university to undertake services outside the normal geographic or intellectual range of the institution, then the more appropriate it seems to enlarge the proportion provided by the Federal Government as may be necessary in order to bring the facility into being.

The CHAIRMAN. Doctor, you gave us some interesting figures in reference to polio and the other communicable diseases for the last year or two. Could you go back a little further and give us a figure, say, for as far back as 10 years ago? Or can you provide them for the record?

Dr. DEMSPEY. I can certainly provide them for the record. Do we have them here, Dr. Terry?

Dr. TERRY. Mr. Chairman, I think one of the startling figures one could point out is that back in 1952 we had over 50,000 cases of poliomyelitis in this country in contrast to 1964, when there were 121 cases, and of those, only 94 were paralytic, so there were less than 100 paralytic cases of poliomyelitis in the United States during 1964.

Now, we have not had comparable decline in the other diseases which are particularly mentioned in this proposal before you. On the other hand, we have had a very significant decline. If you would like, Mr. Chairman, I would be glad to supply for the record detailed figures on all of these diseases, say over a period of the last 10 years.

The CHAIRMAN. If you would do that, we will be happy to have those figures and put them in the record.

Dr. TERRY. I think one of the most significant points I could mention is that our reporting of the cases of poliomyelitis over the last 10 or 15 years has been quite reliable. On the other hand, the reporting of many of the other diseases has not been nearly so reliable; therefore, one can place less confidence in the figures, particularly of a few years ago.

The CHAIRMAN. If you will give us the figures as best you have them, we would appreciate it.

Dr. TERRY. We will be happy to.

(The material referred to follows:)

Detailed figures on various diseases, 1950-64

Year	Diphtheria		Tetanus		Pertussis		Polio (total)		Paralytic polio		Measles	
	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality
1950	5,796	410	486	326	120,718	1,118	33,300	1,994	(1)	279	319,124	468
1951	3,983	302	506	394	98,487	961	28,886	1,551	(1)	2106	530,118	683
1952	2,960	217	484	360	68,687	402	37,879	3,145	(1)	2110	683,077	618
1953	2,355	156	506	327	37,123	270	33,692	1,450	(1)	1,090	449,146	462
1954	2,044	145	524	322	60,886	373	38,476	1,368	(1)	1,046	682,720	518
1955	1,934	150	462	306	32,786	267	28,985	1,043	(1)	800	555,156	345
1956	1,668	103	488	246	31,732	267	16,140	1,066	(1)	440	611,936	530
1957	1,218	81	447	219	38,298	159	2,485	221	(1)	2,489	486,799	389
1958	1,918	74	445	303	32,148	159	3,787	255	(1)	3,697	763,094	385
1959	934	72	445	283	40,405	249	8,525	454	(1)	3,228	406,102	385
1960	918	69	368	231	14,806	118	3,190	230	(1)	100	441,703	380
1961	617	68	379	242	11,468	71	1,312	90	(1)	988	423,919	434
1962	444	41	322	215	17,760	88	910	60	(1)	702	481,950	408
1963	314	(1)	325	(1)	17,135	(1)	449	(1)	(1)	396	385,156	(1)
1964 ³	300	(1)	271	(1)	(1)	(1)	121	(1)	(1)	94	490,660	(1)

¹ Not available.

² Late effects of acute poliomyelitis.

³ Preliminary figures.

The CHAIRMAN. Senator Yarborough?

Senator YARBOROUGH. Yes, I have some questions.

Dr. Dempsey, the legislation of the 88th Congress in the field of medical and educational research has been mentioned. I direct your attention to the Health Professions Educational Assistance Act of 1963, signed into law by President Kennedy on September 24, 1963. That has been some year and 4 months ago. That provided for \$175 million aggregate for matching grants over 3 years for the construction or rehabilitation of teaching facilities at medical schools. What amount of that \$175 million has been expended to date?

Dr. DEMPSEY. Can you provide the figures, Dr. Terry?

Dr. TERRY. Senator, I can provide the detailed figures for you later. I would like to make one or two remarks, if I may, with regard to that.

Though this authorization was passed in 1963, the 1st session of the 88th Congress, no funds were made available for this program until our regular appropriation bill was signed into law by the President on September 19, 1964.

Senator YARBOROUGH. You mean it was a year before you got any actual money?

Dr. TERRY. That is right, sir. So, I think you should appreciate that the program has been in operation for only about 6 months. Furthermore, this authorization is broken down into yearly authorizations, so that I believe in the construction field we have had available through this fiscal year a total of about \$105 million of the authorized amount. I don't have the exact figures on the allocation of these funds with me, but I would be glad to supply them for the record. Roughly, I think one could say that more than half but not—probably not as much as three-quarters of the funds available for this year have already been allocated.

Projects approved and funded

Project and location	Type of school	Type of construction	Approved Federal share	Total cost
University of the Pacific, San Francisco, Calif.	Dental.....	Expansion and replacement.	\$3, 805, 785	\$7, 438, 987
Loyola University, New Orleans, La.....	do.....	do.....	3, 060, 043	5, 783, 715
University of Michigan, Ann Arbor, Mich.....	do.....	do.....	5, 034, 265	9, 101, 721
Western Reserve University, Cleveland, Ohio.	do.....	do.....	3, 229, 679	6, 576, 123
University of Pennsylvania, Philadelphia, Pa.	do.....	do.....	619, 416	1, 238, 833
Do.....	do.....	do.....	56, 200	112, 400
University of Pittsburgh, Pittsburgh, Pa.....	do.....	do.....	1, 084, 226	4, 087, 766
University of Nebraska, Lincoln, Nebr.....	do.....	do.....	2, 545, 000	4, 550, 000
University of Southern California, Los Angeles, Calif.	do.....	do.....	2, 003, 500	4, 007, 000
University of California, Los Angeles, Calif.	do.....	New school.....	1, 232, 127	7, 791, 822
University of California, Berkeley, Calif....	Medical.....	Expansion and replacement.	757, 502	1, 422, 405
Do.....	do.....	do.....	68, 784	129, 160
Loyola University, Chicago, Ill.....	do.....	do.....	7, 964, 973	15, 003, 700
University of Kansas, Kansas City, Kans.....	do.....	do.....	878, 022	1, 756, 045
University of New Mexico, Albuquerque, N. Mex.	do.....	New school.....	1, 705, 336	2, 558, 005
University of Utah, Salt Lake City, Utah.....	do.....	Equipment.....	235, 125	470, 250
Columbia University, New York, N. Y.....	do.....	Expansion and replacement.	1, 052, 300	2, 104, 600
University of California, Los Angeles, Calif.	do.....	do.....	4, 000, 000	14, 534, 200
University of Colorado, Denver, Colo.....	do.....	do.....	1, 723, 728	3, 241, 612
University of Bridgeport, Bridgeport, Conn.	Nursing.....	do.....	330, 833	595, 500
Illinois Wesleyan University, Bloomington, Ill.	do.....	do.....	158, 278	250, 000
Loyola University, Chicago, Ill.....	do.....	do.....	684, 922	1, 153, 842
D'Youville College, Buffalo, N. Y.....	do.....	do.....	612, 783	1, 021, 303
Western Reserve University, Cleveland, Ohio.	do.....	do.....	1, 170, 204	2, 054, 668
St. Xavier College, Chicago, Ill.....	do.....	do.....	100, 500	180, 000
Alverno College, Milwaukee, Wis.....	do.....	do.....	563, 460	962, 000
Johns Hopkins University, Baltimore, Md.	Public health.....	do.....	2, 666, 658	3, 555, 545
University of Pittsburgh, Pittsburgh, Pa.....	do.....	do.....	1, 500, 000	2, 000, 000
University of California, Los Angeles, Calif.	do.....	do.....	3, 023, 797	4, 031, 730
Total.....	51, 867, 446	107, 721, 932

Senator YARBOROUGH. They have been allocated and—

Dr. TERRY. Yes.

Senator YARBOROUGH. I know in my own State, there was a provision for a new medical school at San Antonio to be run by the University of Texas. And the people of San Antonio and the State legislature together appropriated \$11 million as their part of the matching grant but have been unable to get any Federal money to match that so they can build the new school. I wish you would look into that and see why the Federal moneys have not been allocated.

Dr. TERRY. We have been watching that situation very closely and working with the people at the University of Texas, so we are not unaware of it at all.

Senator YARBOROUGH. There is a great need for it, not only for the medical doctors, but in that region for the type of diseases that are treated there.

Dr. DEMPSEY. If I could add a comment to Dr. Terry's—

Senator YARBOROUGH. Certainly.

Dr. DEMPSEY. We shall appear later before you, I think, in support of an amendment to the Health Professions Assistance Act which you mentioned, and the information about the current status of the program we had hoped to include in the testimony in support of that, rather than in the support of the present bills.

Senator YARBOROUGH. They had voted that other bill before this law was signed into law in 1963. I hope you do not make them eat at the second table after you pass the other bill 3 years later.

In the student loan provision of this act of 1963, it provided for \$5.1 million in fiscal 1964 and \$15.4 million in fiscal 1966. What portion of that has been loaned to medical students; of the amounts authorized?

Dr. DEMPSEY. In general, again, you have anticipated our testimony in support of the program on that act. In general, most of that has been placed. This has been largely substituted for the funds, the loan funds that have previously been available through the National Defense Education Act.

Senator YARBOROUGH. This is very important to these students, because a larger loan is authorized to a medical student under this act than he could have obtained under the Defense Education Act. That is true, isn't it? A medical student is eligible for a larger loan than NDEA offers? And this releases more money that can be used by the student than under the National Defense Education Act and very often, two nonmedical students may be sustained for a year on what would take to sustain a medical student. So I think this could be liberally applied to the medical student to keep him in school, so that drain won't be on the NDEA.

I don't have this detail before me, but if you fail to lend all the money authorized under 1 year, that can be carried over and loaned in the next year, can it not, fiscal year? That is not a cutoff amount?

Dr. TERRY. I think this is correct, sir.

Senator YARBOROUGH. In other words, you did not get the \$5.1 million in 1964 in time?

Dr. TERRY. That is right, but a total of \$10,200,000 was appropriated for fiscal year 1965.

Senator YARBOROUGH. I hope that was carried over—I believe it could be, under the act, could it not, and made available to students in fiscal 1965?

Dr. TERRY. That is true. In that respect, Senator Yarborough, I would like to call your attention to the fact that the authorization for this loan program is such that, for instance, a medical school can either apply and qualify under this program or under the NDEA, and most of the medical schools have given up the NDEA for this provision under the new law. As a result of it, in a few unfortunate circumstances, schools have less funds available for loans under this provision than they did under NDEA. So, I think it very clearly indicates that there is a greater need than has been provided, at least to the present time.

Senator YARBOROUGH. I am willing to vote for more funds for that purpose, Doctor.

Dr. TERRY. Thank you, sir.

Senator YARBOROUGH. You have a willing vote right here. In fact, when we passed the National Defense Education Act in 1958, the bill was before the Education Subcommittee and supported by the distinguished chairman of the full committee, and the subcommittee had introduced outright grants to students rather than loans. We lost on the floor of the Senate by one or two or three votes and it was changed to a loan provision, instead of a scholarship. I will support an increased amount so these schools not only will not be prejudiced,

but they will have more money, because the National Defense Education Act money is there. I have had students tell me, "I know 15 applied in my dormitory and there is not enough money to go around." I am not speaking now of medical schools.

Dr. DEMPSEY. In your statement, you say heart diseases, cancer, and stroke alone produce a great burden, more than \$30 billion on our society.

Are you referring there to the cost of treatment of those, or are you taking out the productivity capacity of the people who suffer from it?

Dr. DEMPSEY. Both. The total cost of treatment for heart diseases alone, as I remember the figure, is in the area of \$3.5 billion.

Senator YARBOROUGH. Just for treatment alone, for 1 year?

Dr. DEMPSEY. And the loss of productivity of patients with heart diseases amounts to \$18 billion per year, and similar breakdowns are available for cancer and for stroke as well. The total is in the order of \$35 billion a year, direct costs plus loss of productivity of the patient.

Senator YARBOROUGH. I assume in that loss of productivity, you are counting only those people who are in their working years of life? And you have not assumed any loss for retired people or those not in their productivity years?

Dr. DEMPSEY. That is right. Women, housewives, are also excluded. Although their productivity is measurable, it is perhaps not measurable in dollars.

Senator YARBOROUGH. I see you have something in the succeeding pages about research facilities. Are they located only on the campuses or adjacent to campuses of medical schools?

Dr. DEMPSEY. Yes, sir.

Senator YARBOROUGH. What percentage of the funds go to pay the salaries of teachers in medical schools?

Dr. DEMPSEY. I am sorry, sir, I missed your question.

Senator YARBOROUGH. I said, what part of the moneys expended under that would go to pay the salaries of teachers in medical schools?

Dr. DEMPSEY. Under the provisions of this bill?

Senator YARBOROUGH. Yes.

Dr. DEMPSEY. None.

Senator YARBOROUGH. Then you have certain research funds that are used to pay salaries, though?

Dr. DEMPSEY. I beg your pardon; you mean for paying the operational cost of the regional centers which we are proposing?

Senator YARBOROUGH. Let me state this another way. Not limited to this one bill, but under the National Institutes of Health, the medical research that goes on in some medical schools, is it not true that over half of the salaries of the teachers are paid out of Federal funds?

Dr. DEMPSEY. Yes, sir.

Senator YARBOROUGH. I am not criticizing that, because without that, the state of medical education would have declined to a minimal or deplorable extent. I know some of those medical schools where that is taking place constantly denounce Federal aid to education, where they are paying half their salaries for medical teaching out of Federal funds.

Dr. DEMPSEY. This is true. It is also true, however, that those people spend more than half of their time and energy doing research rather than specifically teaching. The teaching load is so adjusted as to reflect the responsibility of the individual to do research.

Senator YARBOROUGH. But that upgrades the medical school. That makes it possible to have a far better medical school and teachers than they could otherwise have on those faculties.

Dr. DEMPSEY. Indeed.

The CHAIRMAN. Will the Senator yield?

Senator YARBOROUGH. I yield.

The CHAIRMAN. Did not the President's Commission, of which you are a member, headed by Dr. De Bakey, show that the best teaching goes along with research? Where you have your strongest research, as a rule, you get your best teaching. They go hand in hand.

Dr. DEMPSEY. The Commission was unanimously of the opinion that teaching and research are an indissoluble union.

Senator YARBOROUGH. In your statement, the statement is made that Public Health Service has assisted 60 counties in solving their problems of migratory workers in the field of health. Are those the only counties in which service under this health service for migratory workers has been furnished?

Dr. TERRY. That is the number of projects that we have actually assisted.

Senator YARBOROUGH. Of course, your statement points out that the migratory workers live and work in nearly a third of the Nation's counties. Since we have over 3,000 counties, including parishes in Louisiana, I assume that there are about a thousand counties in which these migratory laborers work, farm laborers. So, it seems to me, that this aid has been extended in only 60 counties. Of course, many of those counties would have a few laborers, but 60 counties barely touches the number of counties that have many farm laborers.

Dr. TERRY. This is true, sir, and I think you should bear in mind the relatively short duration of this program and the somewhat limited funds. In addition to that, one should bear in mind that it has required experimentation, so to speak, in terms of determining how this could best be done.

It also requires time for the recruitment of personnel to carry on these programs. Therefore, we have not been able, with the funds available, to get more than this underway at this time.

Senator YARBOROUGH. Dr. Terry, I am for this legislation. I have supported and cosponsored some of the other, have supported all of the public health legislation to come before this subcommittee, since I have been a member of this subcommittee, going back to 1958. I have been rather shocked lately to see the closing of the Public Health Service hospitals, Marine hospitals in the country. Do they come under your jurisdiction?

Dr. TERRY. They do, sir.

Senator YARBOROUGH. The one at Galveston, Tex., was closed. The reason given was it was too small to handle the patients. It was ordered closed and the patients transferred over to Houston. What justification is there for that action when we are trying to build up the medical profession, we are trying to build up the extent of medical care of our people, we are trying to build up public health in this country, we are trying to care for the aged. Why should those

crippled seamen—these hospitals are basically seamen's hospital, authorized by the Fifth Congress in 1798—why should they be closed in our effort to upgrade the care of our people in this country?

Dr. TERRY. Senator Yarborough, I think you are aware that the hospital at Galveston, as an example, has been inadequate for a period of many years in terms of the physical plant and general operation. Along with consideration of other hospitals, it was the question of how the best medical care could be furnished to those beneficiaries in a most economical manner. After a great deal of study of the matter, the decision was made that this could best be done by closing this hospital and providing this service through other Federal installations as well as community hospitals rather than by spending a tremendous amount of money to expand and bring this hospital into a modern plant.

Senator YARBOROUGH. Dr. Terry, is that a Public Health Service determination, or was that a Bureau of the Budget determination?

Dr. TERRY. This was a determination made by the Administration, sir.

Senator YARBOROUGH. The Public Health Service hospital as you say had been inadequate for many years. Shipping has grown greatly in the gulf coast ports. What's the nearest, if this public health service hospital is closed at Galveston, what is the nearest Marine hospital?

Dr. TERRY. New Orleans.

Senator YARBOROUGH. And the shipping in these gulf coast ports, all of them, has increased enormously?

Dr. TERRY. That is right, sir.

Senator YARBOROUGH. In postwar years. But it is not proposed that these seamen be sent to New Orleans for treatment?

Dr. TERRY. Some will be sent to New Orleans, no doubt. Others will be cared for in other Federal institutions, or if it is not feasible to move the individual to Federal institutions in the general region, they will be cared for in community hospitals.

Senator YARBOROUGH. Have the arrangements been made with the veterans hospital at Houston to take care of these sailors? Has authority been obtained? That was a recommendation, to be cared for at the veterans hospital in Houston after this hospital was closed at Galveston?

Dr. TERRY. The Veterans' Administration has agreed to this arrangement, sir.

Senator YARBOROUGH. So it is determined that since the hospital was overcrowded and did not have room to take care of all the injured and ill seamen, they just closed it? That was the determination that your official report shows, that the hospital is inadequate because there is too much business for it, it isn't big enough?

Dr. TERRY. Yes, sir; the hospital was constructed for about 79 beds and we have been running a patient census of about 130 patients there.

Senator YARBOROUGH. So having beds enough for only half, the Administration ordered closing for that half. I don't see the logic of it.

Dr. TERRY. I think it is logical to close a hospital like that if you are not going to do a better job than that, sir.

Senator YARBOROUGH. I would rather have an inadequate one than none.

Dr. TERRY. I actually think that unless that hospital were expanded into a modern, much larger physical plant, with better staffing we could not provide the quality of medical care that will be available to the beneficiaries by the other system.

Senator YARBOROUGH. I will work for that larger plant, just as I am supporting these measures that you advocate here and have those other progressive measures. I know you have advocated many progressive measures over the years. I have supported them and will continue to support them, and for a modern, progressive hospital there, too, for seamen.

Thank you.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. Just one question: What money will be authorized for the next 5 years under the migratory health provisions? No figure appears here in the discussion on section 3 of S. 510. Does that mean the original figure will be continued annually?

Dr. DEMPSEY. I believe that is true for fiscal year 1966, sir.

Senator WILLIAMS. I think you had better clarify that later if you can.

Dr. DEMPSEY. I should be glad to.

Senator WILLIAMS. I should think a new program builds increasing interest and there will be increasing applications for money under this program. Senator Yarborough suggests that very few grants have been made in very few counties, and yet many counties are covered. Will you clarify that later?

Dr. DEMPSEY. I will be glad to. I believe that since it is a new program, since it is developing, and since the yardsticks for adequately measuring it are not perfect as yet, no decision has been made beyond the immediate one as to the level to which it should grow. We will be glad to provide further information.

Senator WILLIAMS. All right, thank you.

The CHAIRMAN. Anything you gentlemen would like to add?

Dr. Sessoms?

Dr. SESSOMS. I have nothing.

The CHAIRMAN. Dr. Dempsey?

Dr. DEMPSEY. Nothing, thank you.

The CHAIRMAN. Mr. Miles?

Mr. MILES. No; thank you.

The CHAIRMAN. Dr. Terry?

Dr. TERRY. I have nothing, sir.

The CHAIRMAN. We want to thank you for this very fine testimony.

We deeply appreciate it

Dr. DEMPSEY. Thank you, sir.

The CHAIRMAN. Dr. Myron Wegman.

We are happy to have you with us, Doctor. You are from Ann Arbor, dean of the School of Public Health of the University of Michigan?

STATEMENT OF MYRON E. WEGMAN, M.D., DEAN, SCHOOL OF PUBLIC HEALTH OF THE UNIVERSITY OF MICHIGAN, AND PRESIDENT OF THE ASSOCIATION OF THE SCHOOLS OF PUBLIC HEALTH

Dr. WEGMAN. Yes, sir.

The CHAIRMAN. You are also president of the Association of Schools of Public Health.

Dr. WEGMAN. Thank you, I wanted to bring that in.

Mr. Chairman, I am here today to support aspects of both bills that you are hearing, S. 510 and 512. I have a printed statement that I would like to leave for the record, if I may.

The CHAIRMAN. All right, you may proceed in your own way, Doctor.

Dr. WEGMAN. Mr. Chairman, while I am here specifically to talk on S. 510, I would like to start for a moment by adding my support to S. 512, largely on the basis of personal experience, to add to the specific data which have been provided to you.

When I first went to Ann Arbor 4 years ago, I was told that despite the fact that the physical plant had just been practically doubled in size, my major problem would be space. I did not believe them, but I find this has been exactly true.

Right now, our school is split up into five locations, four outside of our main building. This obviously causes considerable difficulty in research. There are enormous numbers of research problems to be solved. The problem in a school of public health, or let me put it another way, the advantage of doing research of this type in a school of public health is the interaction of the natural scientists and the social scientists, and this kind of interaction is nearly impossible when we have wide physical separation. This is true, I am sure, in other institutions as well. The need for added space, as far as I am concerned, is the greatest single bottleneck that we have in advancing research in the country.

I am not going to talk further about that, Mr. Chairman, because there will be other testimony on it. I would like to turn my attention to 510. Here again, while I should like particularly to refer to schools of public health, I should like to say a word about some of the other provisions of this bill.

From the standpoint of the first section, that having to do with vaccination, I can testify from my own experience on the international front during the years that I was secretary general of the Pan American Health Organization, of the enormous need for a real vaccination program in every country, not only to protect our own citizens, but just as part of our real contribution to world improvement of health. With the speed of transportation, with the ease with which disease can move around and diseased people can move around, it becomes tremendously important for every country which is trying to do its real task before the world, to keep up its immunization. This to my mind, sir, is a national responsibility.

The migrant labor section also interests me, Mr. Chairman, because of our situation in Michigan. As you know, there were, way up at the top of the country where it gets real cold and lots of snow, and yet the migrant labor which sweeps all the way up there. It is one of our major problems and I hope this provision is extended.

Similarly, with regard to the general formula grants to the State health departments, anybody in a school of public health knows that the functioning of the State health departments and the local health departments is where health work is brought to the people, it is where our graduates go, it is where our students come from, and support of this program, through this section of the bill seems to us exceedingly important and I hope that the Congress will recognize it.

As a member of the State council of health in my State, I see this very closely. Just yesterday, we met with Governor Romney. We had a meeting of the State council of health and discussed some of the importance of the Federal-State cooperation in health work.

Now, Mr. Chairman, I would like to direct my attention specifically to some of the problems of section 314(c)(2) which has to do with the formula grants to schools of public health. I ask your indulgence to review for a moment the history of these formula grants which, as you know, are known to us as Hill-Rhodes grants. These grants were started because of the fact that the 12 schools of public health are a national resource. In our own institution, a State institution, more than 75 percent of our students are from out of State. This is paralleled in the other schools. It means, of course, that these schools are training students on a national basis and State legislatures and local funds are simply not up to the total support of what's usually one of the most expensive educational efforts of any university.

The original authorization under this act in 1958 was for \$1 million. Later, it was extended to \$2.5 million, but as you so well know, Senator Hill, it was only last year, in large part through your own recognition of the problem, that this appropriation was increased to the full amount. And it is only within the past few weeks that the actual additional sums have been received in the schools where they were sorely needed.

You know, sir, that the Second National Conference on Public Health Training, called at the direction of the Congress and held in the summer of 1963, recognized the need for increasing these grants stepwise to a total of \$5 million, doubling the allocation. I ask your permission, Mr. Chairman, to introduce into the record the relevant portions of that report dealing with this.

The CHAIRMAN. Yes, we would like to have that, Doctor. We will have that appear with your testimony.

(The report referred to follows:)

PORTION OF REPORT OF SECOND NATIONAL CONFERENCE ON PUBLIC HEALTH TRAINING

RECOMMENDATION 5

The authorization ceiling for formula grants to schools of public health be increased to at least twice the present level, and there be annual increments in appropriations adequate to reach the proposed authorization by 1970, in order to assist these schools in enriching their curriculums and increasing enrollment of federally sponsored students.

Supporting statement

The 12 schools of public health have unusual needs and limited financial resources. Neither State legislatures nor private endowments alone can keep pace with the high costs of keeping a school strong in the many and varied elements that constitute the current complex public health program. Such strength is essential if these schools are to continue their role as the primary national resource for public health training.

In recommending progressive and substantial increase in authorization and appropriations for formula grants, the conference recognized the need to compensate the schools of public health in part for the great discrepancy between instructional cost per student and tuition received by the university. Recent figures suggest that, on the average, tuition fees cover less than one-seventh the cost of basic operations and instruction. At present, well over half the students in the schools of public health are federally sponsored. The net costs to these schools on behalf of federally sponsored students exceeded \$5 million during the 1962-63 academic year.

Review of the use of formula grants to date indicated that four-fifths of the grant moneys have gone to pay salaries of personnel, mostly academic staff, but also secretarial and other supporting staff. Funds have also been used for essential materials and teaching aids. Documented planning by individual schools shows that current urgent needs are far in excess of the present authorized ceiling. Furthermore, these needs are expected to increase as enrollment grows and initial graduate study is extended beyond 1 academic year. Several programs are already of 2 years' duration, and others contemplate an increase to at least three semesters or 18 months in order to encompass sufficient instruction in the ever-widening field of public health.

A reasonable projection of needs, concentrating primarily on necessary increases in professional staff, indicates that a doubling of the present formula grant authorization of \$2.5 to \$5 million is the minimum increase required. The conference recommended annual increments in appropriations to reach the new authorization by 1970, to assure orderly growth of the schools commensurate with increased demands.

Dr. WEGMAN. There are two particular reasons why our association wishes to ask that S. 510 be amended to increase the authorization for section 314(c)(2) to the full \$5 million recommended by the Second National Conference on Public Health Training. That Conference suggested stepwise increments beginning with the year that this bill takes into consideration, but since then, two things have happened: One, there are two other institutions, two schools—two universities—which have plans for schools of public health so far advanced that by the time this bill takes effect, we are reasonably certain that these schools will be accredited and will be authorized to take part in this appropriation. As you well know, the formula which is used calls for a division of the amount and if the authorization were not increased, there would actually be a decrease to some of the existing schools. The data show that the expenditure up to now has been largely for salaries in the very largest portion. This would mean, then, an actual reduction in program if the increase were not accomplished.

Secondly, in acting on another part of the recommendations of the Second National Conference, Public Law 88-497—I hope I have that number right—called for an increase in traineeships to levels that will, by the time this bill is in effect, actually double the amount of money available for public health traineeships. The schools are prepared to accept these. Of course, not all of them, sir, will go to schools of public health. Other educational resources will be used. But it is the school of public health where they get the comprehensive training and we expect that we will be asked to take a large number of these students.

This present authorization is \$4.5 million for public health traineeships. It will go to \$7 million, \$8 million, and then \$10 million, and we simply do not have the facilities to take care of it.

I would like to point out one very important fact, Mr. Chairman, that in asking for this increase of authorization under the subsection 314(c)(2), this will not affect the overall ceiling or the total author-

ization under section 314(c). As a matter of fact, the appropriations to date have left ample room for this kind of an increase in authorization of schools of public health.

Mr. Chairman, I would like to close by emphasizing the fact that the faculties of all of our schools of public health are very well aware of the kind of assistance that has been provided by the Congress on a national basis. They recognize the confidence that has been placed in us. We know, however, that the need for additional trained public health workers in the country is not only great, but enlarging regularly and steadily, and our purpose in asking for this additional assistance is to get the resources to carry out the charge that you have given to us. Thank you, sir.

(The prepared statement of Dr. Wegman follows:)

PREPARED STATEMENT OF MYRON E. WEGMAN, M.D.

I am Dr. Myron E. Wegman, dean of the School of Public Health of the University of Michigan, and president of the Association of the Schools of Public Health, which includes the 12 accredited schools in the United States.¹ My purpose in appearing before this subcommittee is to endorse and support both of the bills before you and to outline some of the reasons our association believes the authorization under section 314(c)(2) of the Public Health Service Act, covered in S. 510, should be increased.

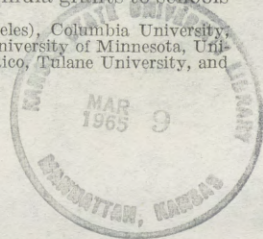
May I first address myself to S. 512 in order to express strong endorsement of the increased and more flexible support envisioned in this bill. There is no doubt whatever but that space is one of our acute bottlenecks in expanding both research and teaching activities. The 88th Congress took a significant step forward in enacting Public Law 88-129, which provides additional space for the sharply increased number of students and teaching activities in schools of public health, about which I shall have more to say later. At the same time the expansion in research, because of the advent of new techniques, new capabilities, and new personnel who bring able minds to bear on the multiplying problems, has made the obstacle of inadequate space daily a more serious one. When I first came to the University of Michigan as dean 4 years ago I was told by the faculty that one of the first problems I would have to face would be that of space. My experience has borne out the accuracy of their prediction; currently our research and teaching activities are being carried on in four other buildings besides the main structure of the school of public health. Such scattering is not only costly but it is a serious inhibition to new research projects, no matter how promising they may be. Sometimes the problem can be solved by obtaining funds for rental of nonuniversity property. This, however, has the dual disadvantage of frequent lack of physical suitability and the even greater problem of separation from the main body of school faculty and students. One of the greatest assets of university-centered research, particularly true in a multidisciplinary body like a school of public health, is the interchange which results from contact among scientists in a variety of fields, and between natural and social scientists. This is vitiated when space inadequacies necessitate separation.

The size of the current backlog of applications for support for research space is to my mind a measure of the immediacy of the need. I hope the subcommittee will approve this expansion and that the Congress will agree.

With regard to S. 510, our association is pleased that provision is being made this far in advance to assure of continuation of these vital funds for formula grants. You will have testimony from others in a better position than I to speak of the needs of State health departments. We in the schools of public health, all of which have intimate contacts with State, county, and city health departments, from which many of our students come and to which many of our graduates go, are firmly convinced of the need for more adequate support to State and local health activities. As a member of the State council of health in Michigan I know directly of the importance of this aid.

Our particular interest, of course, is in part 2 of subsection C of section 314 of the Public Health Service Act, dealing specifically with formula grants to schools

¹ University of California (Berkeley), University of California (Los Angeles), Columbia University, Harvard University, Johns Hopkins University, University of Michigan, University of Minnesota, University of North Carolina, University of Pittsburgh, University of Puerto Rico, Tulane University, and Yale University.



of public health, commonly known as Hill-Rhodes grants. Since 1958, when these grants, administered by the Public Health Service for comprehensive professional training in schools of public health, were initiated with bipartisan support and unanimous passage in both branches, they have made an enormous difference in the ability of these schools to carry out their educational functions. The original authorization was for \$1 million to be divided among the 12 schools by a formula. Subsequently, under Public Law 87-395 the authorization was raised to \$2.5 million. Only this year, however, has the appropriation reached the fully authorized limit, an action for which my fellow deans and I are eternally grateful to Senator Hill and his colleagues. My request now is that in this new legislation the authorization be increased to the full limit recommended by the Second National Conference on Public Health Training, called at the direction of the Congress in August 1963. I ask permission to insert into the record the documentation and recommendations from the report of this Conference, which deal with section 314(c)(2), formula grants to schools of public health.

I should like to recall to you the underlying rationale of the Hill-Rhodes formula grants. At the present time the 12 schools of public health are the Nation's only resource for the comprehensive, multidisciplinary training of public health workers. Other specialized institutions, including medical schools, schools of engineering, nursing schools and others, prepare professional personnel in specific fields, but it is only in schools of public health that the broad and comprehensive training leading to an accredited professional public health degree may be obtained. Six of the schools are in private universities and six in public universities but all face similar problems in terms of underwriting the cost of instruction. By its very nature, public health involves so many facets and so many different kinds of teachers that classes, except in certain core subjects, tend to be quite small. This inevitably raises the cost of instruction, thus heightening the discrepancy between tuition paid and the resources needed for operation of the school. A further complication is the difficulty of obtaining general university funds for this purpose. In our own instance, for example, approximately 75 percent of our students are from out of State, far and away the highest percentage of any school on the campus of the University of Michigan. Similar proportions are seen at the other universities with schools of public health. It is only natural, then, that State legislatures are loath to provide State tax funds to support what is essentially a national school. My predecessor, as president of this association, liked to use the analogy of the Armed Forces academies to describe our situation. In a very true sense, we are national rather than local or State schools and thus have felt it proper that a certain proportion of support should come from the national resources.

As a further index of this, more than half of the students at schools of public health today are actually sponsored by the Federal Government, through the Public Health Service, the Armed Forces, AID, and other agencies. Only 25 percent of the graduates work in the States where they were trained and most graduates work either in other States or for the Federal Government. A corollary fact is that the major employment opportunity after graduation is in governmental units. I am sure I do not have to remind the subcommittee that such posts are less well remunerated than in private industry. It thus becomes essentially impossible for schools of public health to obtain any great sum of money from voluntary contributions of graduates.

The question at immediate hand is justification for our request that the authorization be increased from the current \$2.5 million to the full \$5 million recommended by the Second National Conference on Public Health Training.

Up to this year the Hill-Rhodes formula grants have covered less than one-third of the net cost, after tuition, of training federally sponsored students. With the recently increased appropriation, the total amount for grants has gone up but costs likewise have gone up. While I do not have figures immediately available on the effect of the new appropriation (the additional amounts were actually just received within the past few weeks), I am certain that it will not carry the proportion to as much as 40 percent of the total cost.

The Second National Conference, foreseeing a substantial increase in student load to meet the Nation's acute shortage of public health personnel, recommended stepwise increase in the authorization for Hill-Rhodes grants by annual increments to a level of \$5 million by 1970.

Two important developments impel us to recommend an earlier accomplishment of the total increase. The first is the advent of new schools, two of which are actively in the process of seeking accreditation. At least one, the University of Hawaii, anticipates being ready for formal accreditation by 1966, and the other,

Loma Linda University, is at an advanced stage of development. Since the formula calls for a division of the appropriated funds among all accredited schools, addition of new schools must inevitably decrease the amount available for existing institutions. As was pointed out in the National Conference report, Hill-Rhodes grants are used chiefly for faculty and supporting salaries. Decrease in funds, by failure to increase the authorization, would thus cause serious hardship.

The other important factor is the action of the 88th Congress in passing Public Law 88-497, which sharply increased the authorization of funds for public health traineeships from a previous ceiling of 4.5 million to a level of 7 million in fiscal 1966, 8 million in fiscal 1967 and 10 million in fiscal 1968. While not all of the traineeships are for studies in schools of public health, a substantial portion will be, throwing an unexpectedly large increased load upon the schools. Expansion of teaching staff and supporting services will need to proceed much more rapidly than previously contemplated.

My colleagues on the faculties of the schools of public health of the country are, I assure you, fully cognizant of the trust which has been placed in us by the considerable support already provided by the Federal Government. There is no doubt, however, the Nation still needs more health workers of all categories. In respectfully asking for amendment to S. 510 in order to raise the authorized amount in section 314(c)(2) to \$5 million, we seek the increased support needed to carry out adequately the expanded charge we have been given.

The CHAIRMAN. The schools that we now have, even with the addition of these two other schools, they have to provide all the personnel, all the soldiers to wage these battles against the communicable diseases we have been talking about this morning, is that not right?

Dr. WEGMAN. Yes, sir.

The CHAIRMAN. Most States do not have a school of public health. So their students have to go to some other State?

Dr. WEGMAN. That is correct.

The CHAIRMAN. Our 12 schools of public health are providing the whole army for the battle in the United States?

Dr. WEGMAN. Yes, sir: for example, in our university, we have students this year from 38 States.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. What's the regular course length? How many years do they go?

Dr. WEGMAN. This varies, Senator Williams, among the schools. But the basic course, the master of public health degree, is in general one academic year, two semesters. But it is a postgraduate course. All the schools, in order to be accredited, require completion of the bachelor's degree for admission. Some have a larger proportion of physicians, dentists, veterinarians—we have a wide variety of people in the school—nurses, statisticians.

The CHAIRMAN. But they all have to come to one of your schools to get that training?

Dr. WEGMAN. Yes, sir.

The CHAIRMAN. No matter where they may come from, they are limited to these 12 schools you spoke of here today?

Dr. WEGMAN. That is right, and our enrollment has gone up just as steadily as it can. The university has asked us to suggest or estimate the extent of the expansion. We do not know how long it will go on, but the increase will be very large, we know.

Senator WILLIAMS. You expressed an interest in the migratory worker health service.

Dr. WEGMAN. Yes, sir.

Senator WILLIAMS. Have you included or developed within your public health courses anything dealing with the rural health problems that might arise in the migratory workers' situation?

Dr. WEGMAN. Yes, sir; we have done this in two important ways, one on the educational aspect, where material on this is included in the general public health course, the basic course in public health administration that every candidate for the degree must take as a required course. There is also at least one elective course directed at this for people who are particularly interested in other aspects in some of the specialized work.

One other thing which may interest you is that under contract with the Public Health Service, we have been working this past year on the development of educational materials for the migrant workers, because even though this bill directs itself at the domestic workers, many of them, particularly from the Texas area, are very inadequate in English and we are trying to develop multilingual educational materials for them in health. This project is an exceedingly interesting one that I think we are making progress with.

Senator WILLIAMS. Thank you.

The CHAIRMAN. Doctor, we certainly appreciate your presence here today and this splendid testimony you have brought us.

Thank you.

Dr. WEGMAN. Thank you, sir.

The CHAIRMAN. Dr. Charles Smith.

STATEMENT OF DR. CHARLES SMITH, DEAN, SCHOOL OF PUBLIC HEALTH OF THE UNIVERSITY OF CALIFORNIA, BERKELEY, CALIF.

The CHAIRMAN. Doctor, you are dean of the School of Public Health of the University of California at Berkeley, right?

Dr. SMITH. Yes.

The CHAIRMAN. I believe you are also Chairman of the President's Advisory Committee of Health and Medical Sciences at the University of California at Berkeley, are you not?

Dr. SMITH. Yes, sir, Mr. Chairman; that is my privilege.

I especially appreciate this opportunity to speak to you on behalf of the research facilities program administered by the National Institutes of Health. This occasion, however, also recalls our first meeting, Mr. Chairman. Then I was chairman of the American Public Health Association Lasker Awards Committee and I had the privilege of presenting to you the Lasker Award for distinguished service in public health. Your zeal in this cause is certainly evidenced with these two items of legislation that you are hearing here today.

The CHAIRMAN. May I say I was very much honored to have you make the presentation, Doctor, very much.

Dr. SMITH. Thank you.

S. 512, to continue the health facilities research program, is especially of concern to me as dean of the School of Public Health at the University of California at Berkeley as a scientist and as a member of the Surgeon General's National Advisory Health Council. I have provided the committee a written statement. In it I have outlined the urgency of this program, underscoring the ever-present and ever-mounting backlog of approved but as yet unpaid research

construction grants. Within the past few hours, and since preparing the statement, I have obtained figures for California, a State which is a prototype of the Nation. I share with Senator Murphy, whom California is now privileged to have serving on this key committee, an understandable special concern for the problems of our State and cite them only because of personal familiarity. With a population increase from slightly over 13 million people in 1956, when this program was initiated, to nearly 19 million presently, nearly a 50-percent increase, there has been a corresponding increase in student enrollment in the universities with which I am associated.

Assistance to our statewide university from this program since 1960 has been essential in doubling the capacities of our two existing facilities, adding a new dental school and a school of public health, both in Los Angeles, with additional indispensable assistance in vastly expanding the research facilities on the other campuses of the university. However, as my statement documents and the testimony of Dr. Dempsey has already underscored, the national backlog of approved but unpayable construction grants will be \$80 million, and 140 in June and by that time too, there will probably be another 140 grants apparently well underway that will double this amount.

The University of California is establishing two medical schools additionally; one in San Diego and one in Davis, Sacramento. One of the reasons for establishing one in Davis is because of the availability of the national or regional primate center, which has been one of the attractive cores in this decision.

The CHAIRMAN. That is very interesting, in view of this bill.

Dr. SMITH. They interlock, sir.

There is an entirely new campus at Irving dedicated to biological sciences and augmenting its health research and on the other campuses, next year, will result in an addition of \$9 million in construction applications for this grant.

But I wish Senator Yarborough were here to let me tell him that the University of California, like his University of Texas Medical School, by no means gets all it applies for and, indeed, in our own situation, and in my testimony that I presented here, I have described the desperate plight of my own school of public health, with overcrowded and rented space. We do not even get on the priority list to get us into the lineup for the University of California application. So the situation is really grim.

Our concern extends also to the entire State and the entire Nation. The relocation of Stanford Medical School at Palo Alto was only possible because of this program. However, its acting dean, Dean Sidney Raffle, my colleague at Stanford for 17 years, told me just 2 days ago when I was assembling information on this, that he needs another \$7 million for additional research construction. The School of Medicine at the University at Loma Linda and the College of Medicine at Los Angeles likewise require more construction and Dean Roger Egeberg, of the University of Southern California, not to be confused with the University of California at Los Angeles, a fellow member of our State board of health, told me only last night that he is preparing an application for \$2 million for a \$4 million research building. He added that two Los Angeles outstanding community hospitals, Good Samaritan and Children's, have major expansions planned, with \$7 million devoted to research facilities which are

essential to qualify them as teaching hospitals for the Los Angeles medical schools.

Dr. Victor Richards just informed me of similar expansion at the Presbyterian Medical Center and Children's Hospital in San Francisco, for similar purpose.

Your dialog with Dr. Dempsey well established the importance of these types of research resources if community hospitals are going to, one, serve as teaching hospitals, and two, provide the higher quality of medical care to patients which is essential in this setting.

In 1956, when health facilities research construction was initiated, the ratio of research construction to research grants was 1 to 3. As my statement describes, this now has dropped to 1 to 13. Thus our support for research projects and research training has vastly outstripped their housing.

The CHAIRMAN. That is quite a drop?

Dr. SMITH. It is a very important and a very crucial consideration. For the result is that there is intense rivalry for space in institutions which, like a seven-member family in a four-room house, have an acrimonious atmosphere which is disruptive of collaborative research and teamwork. I have amplified this also in my statement.

Fortunately, as you pointed out in this discussion with Dr. Dempsey, the \$400 million authorization for 5 years is not designated for payment year by year and thus will enable the Surgeon General to wipe out this backlog and enable institutions to make long-range projections now impossible. However, as my statement also amplifies, this proposal enables the Congress to exercise essential program surveillance while providing flexibility. Similarly, S. 512 farsightedly would add essential flexibility in matching ratios when regional and national research centers or programs are required in the public interest. This, too, has been brought out. One might suggest, however, some consideration by the subcommittee on the 50-50 matching requirements. I must respectfully differ a little bit from Dr. Dempsey in assurance that this 50-50 ratio is really appropriate at this time, when some institutions have already spent their dowry and our problem is precisely that. Our building was built in 1950, too early to get into this program, and now we have spent our funds and the university says, no matching, no extension.

The deans of the schools of public health, medicine, and dentistry constantly face truly tormenting decisions about allocation of space and research training space, especially as the general research support programs of NIH stimulate our programs to plan and rapidly initiate programs which in turn accelerate the need for space.

What we as deans cope with as best we can, presidents of universities face to an even greater degree. As the chairman of President Kerr's advisory committee of medical and health sciences, I sympathize with his grave plight. Like his fellow university presidents, he must establish priorities for construction of desperately needed undergraduate classrooms, libraries, dormitories, as well as research buildings. Too many times, health research comes off second best.

It is disheartening when a faculty member comes to me with an exciting idea for a research project, perhaps a new approach to a major health problem, or perhaps a new lead in a basic field, and I have to tell him not to waste his time designing that research project which, though we could readily support financially, could not carry

out because of lack of space. It is an unhappy experience to cause a brilliant investigator to think small.

This frustrating advice cannot help but quench his zeal and ambition. Indeed, in the field of health research, facilities are second only to abilities.

We have many ways of knowing the accomplishments of science through reports, papers, journals, and the press. But what is never known is the number of research projects that cannot be launched as exploration into disease for want of space. Further, there is no way to measure this loss and the penalty it imposes on human beings.

While I have concentrated this testimony on S. 512, like Dr. Wegman, I in turn would like to add most enthusiastically, though necessarily brief and unembellished, support for S. 510 which, Mr. Chairman, you also have introduced as the Community Health Service Amendments for 1965. I have no prepared statement on this and will depend on these short oral remarks. However, this perspective of 25 years on our State board of health, 20 as its president, is the basis for appreciating its implications to the health of our Nation. It will afford farsighted extension and broadening of community interest in the programs.

Only last week, at a meeting of the Berkeley branch of the Alameda County Medical Association, we were discussing the problem of why measles immunization was omitted. Now measles will be provided for and broadly, will provide for any other programs of a comparable nature which may develop. It will continue to alleviate dire needs for health needs for migratory workers, our roving national pocket of poverty. In line with this, and I only wish that Senator Williams were here to hear me testify for California, too, as Dr. Wegman did for Michigan, this is an increasingly serious problem. The very fact that the bracero program probably will be terminated or at least greatly diminished is going to necessitate a very considerable increase in the native migratory workers. The braceros were provided with health services in their program. These are absent for our native migratory workers, and real attention might well be paid to the adequacy of the amount of this appropriation for the project grants, which is the basis on which allocations are made.

The extension of section 314(c) for general public health services is essential for the grants to the States in general and for support of State and community health programs. As the dean of one of our 12 national schools of public health, I cannot let this opportunity pass without joining Dr. Wegman in urging this committee to consider the authorization for section 314(c)(2), the subsection of the Hill-Rhodes formula grant to these 12 national schools of public health.

I shall not embellish this further. Dr. Wegman has presented this and pointed out the crucial point, that is, the increase of \$2.5 to \$5 million is in line with the recommendation of the Second National Conference on Public Health Training. It in no way disturbs the overall ceiling of \$50 million for 314(c).

Mr. Chairman, S. 512 and S. 510, while lacking the dramatic categorical appeal, are foundations upon which our other vital health legislation must be built.

Thank you for this privilege of attesting this affirmance.

The CHAIRMAN. I want to thank you very much for your splendid testimony, Doctor. We appreciate it very much. I think I should

say that Senator Murphy wanted very much to be here this morning but he had an important executive committee meeting of the Public Works Committee, where he just had to be. With all our research we have not yet found a way to be in two different places at one time.

Dr. SMITH. Senator Hill, I do reiterate my deep gratification that he is on your committee, and I can assure you that I am going to go around and call on him and amplify some of the things I have outlined, only outlined in this verbal testimony.

The CHAIRMAN. We are very delighted to have Senator Murphy on this committee and I know he will be happy to have you see him and talk with him about this legislation.

Dr. SMITH. Thank you.

(The prepared statement of Dr. Smith follows:)

PREPARED STATEMENT OF CHARLES E. SMITH, M.D., DEAN OF THE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA, BERKELEY, CALIF.

Mr. Chairman and honored members of the committee, I appreciate this opportunity to speak to you on behalf of the health research facilities program administered by the National Institutes of Health. This program is of special concern to me as dean of the School of Public Health of the University of California at Berkeley, as a scientist, and as a member of the Surgeon General's National Advisory Health Council.

In my view, the health research facilities program is one that depends on the understanding and support of this committee far more than do the categorical research programs, for it lacks the strong public appeal of heart disease, cancer, arthritis, and other diseases that afflict so many of our citizens. This program depends upon your intellectual conviction of the importance of modern research facilities to scientists who are seeking the knowledge which will help us prevent, cure, or alleviate the diseases of man.

The health research facilities program was literally born with a backlog, a need, the accumulation of decades, for modern research facilities where biomedical research could be conducted and the scientists of the future trained. Every year, the total amount of these matching funds recommended by the Council for payment has been more than the annual appropriation. Right now, the backlog of recommended grants is more than \$28 million. Before the end of the fiscal year on June 30, 1965, following the two Council meetings, one in March and the other in June, it is expected that another \$50 million in recommended grants will bring the total backlog to almost \$80 million. Besides these recommended grants, institutions have formally indicated their intention to submit applications for a total of 140 construction projects that will cost in the aggregate almost \$78 million.

The proposed bill, S. 512, has distinct advantages over previous legislation. An appropriation of \$400 million in funds not designated for payment in any one of the 5 years proposed for the continuation of the program will enable the Surgeon General to wipe out the present backlog and put the program on a current basis. Institutions, knowing their applications have been recommended, but uncertain as to when funds would be available, must tie up not only matching funds, holding them in readiness for the award, but they must postpone vital research projects which cannot be started in present cramped and, in many cases, obsolete laboratories.

The present proposal provides a ceiling and enables the Congress to exercise program surveillance, but permits much more flexibility than at present within the program. The rigid ceiling first of \$30 million annually and, since fiscal 1962, of \$50 million a year prevented the program from doing much more than fill emergency needs. The type of long-range planning which characterizes the building programs of all major institutions today has been denied to this construction program. Yet, the administrators of this program are called upon daily to give advice to institutions, to help them with long-range projections when the financial ability of the program to take part in those future developments has been uncertain, indeed. The \$400 million recommended is a reasonable compromise between the already expressed needs of farsighted institutions and the prudent commitment of public funds to these projected plans and to demands which are not yet formulated. Some of these demands have been underscored by the President's Commission on Heart Disease, Cancer, and Stroke.

I know that I express the conviction of my colleagues at the University of California; of deans of schools of public health, medicine, and dentistry; State boards of health; and my fellow scientists; when I say that significant advances in health research cannot proceed without adequate facilities now lacking. It is an axiom in science that facilities rank second only to abilities.

The principle of requiring matching funds is basically a sound one as this committee recognized when it authorized the health research facilities program. The requirement of matching funds promotes local interest and commitment, as well as a sense of a responsibility for the facility itself. But matching funds for research construction are increasingly difficult to obtain in this period when the Nation has reached the conviction that education is the keystone of the Great Society.

I do not have to point out to this committee that a major national research goal of the Public Health Service, as set by the Congress, may not be of the same priority to a university medical center or other research institution. There are instances when it has been necessary for the Public Health Service to provide certain inducements and to shoulder the major costs of such construction. It is my hope that this committee will see fit to modify the requirement for 50/50 matching funds whenever and wherever regional or national research centers or research programs are required in the public interest. There are, as you know, many precedents for this type of full support. The program of regional primate research centers, of which there are now seven, is a paramount example.

I know from my own experience that the health research facilities program has not been able to keep pace with the tremendous increase in the research capability of the Nation. Fifteen years ago when I was appointed dean of the School of Public Health at the University of California, we had about \$20,000 in outside funds for research. Now we have more than \$2 million. This increase is not unusual, in fact, I would venture to say that in many medical schools the rate far exceeds the example I have cited from my own experience.

I believe I am correct in saying that the amount of NIH research grants in 1956 when the health research facilities program began was something like \$40 million. And in 1963 that amount had gone up to more than \$400 million. Now, as administrators of scientific programs, we know that for every dollar increase in the annual research budget, there should be roughly an equivalent increase in dollar value of research construction to support that expanded operation. In 1956, the ratio of health research facilities funds to NIH research grant funds was about 1 to 3. Since that time, the law governing this program has been broadened to include facilities for research training and other health related research activities, thereby vastly expanding the construction requirement to house these activities. But there has not been a concomitant increase in the health research facilities funds. The ratio of these funds to the NIH research grant and training funds which was 1 to 3 in 1956 is now about 1 to 13.

This means in fact that medical schools, hospitals, and other institutions heavily engaged in research are operating under intolerably crowded conditions. The competition for space is intense. I assure the members of this committee that, although institutional "family disputes" seldom go so far as to get into headlines, nonetheless they create an acrimonious atmosphere that disrupts productive research and teamwork. Not only is the competition for space intense among departments, but also among components of universities, among academic institutions within States, and throughout the Nation.

Not only have research project and training grants from the Federal Government and private donors contributed to the expansion of biomedical research, but also general research support grants have made it possible to plan and rapidly initiate research programs which in turn accelerate the need for space. These programs anticipate and provide for an increased number of postdoctoral fellows and graduate students whose research training cannot be carried on effectively, if at all, in present space.

When I became dean 15 years ago, we had about 70 graduate students with only 1 or 2 engaged in research training. We now have 280 full-time graduate students, 30 of them in research doctoral programs. But we are frozen in our present quarters. Not only are we overcrowded but, to make matters even worse, our rented laboratories are scattered in four different localities, a deplorable situation not unique, I assure you, north, south, east, or west.

As an administrator whose responsibilities include a vigorous, growing research program, I know only too well the problems that are created when investigators are forced to conduct their investigation in laboratories that are obsolete, make-shift, overcrowded, split up, some in this building, some in that.

Deans constantly face truly tormenting decisions about the allocation of space. But what we as deans cope with as best we can, presidents of universities face to a even greater degree. They must establish priorities for construction of desperately needed undergraduate classrooms, libraries, dormitories, as well as research buildings. Too many times research comes off "second best."

It is disheartening when a faculty member comes to me with an exciting idea for a research project, perhaps a new approach to one of the major health problems or perhaps a new lead in a basic field, and I have to tell him not to waste his time designing that research project which, though he could readily get the financial support, could not be carried out because of lack of space. It is an unhappy experience to have to caution a brilliant investigator to "think small." And the scientist who hears this frustrating advice can hardly be blamed if he abandons his idea. We have many ways of knowing what has been done in science through reports, papers, journals, and the press. But what is not known is the number of research projects that cannot be launched as exploration into disease for want of space; further, there is no way to measure this loss and the penalty it imposes upon human beings.

The CHAIRMAN. Dr. Alvin Morris, of Lexington, Ky.

We are glad to have you, Doctor. You are the dean of the College of Dentistry of the University of Kentucky?

STATEMENT OF DR. ALVIN L. MORRIS, LEXINGTON, KY., DEAN, COLLEGE OF DENTISTRY, UNIVERSITY OF KENTUCKY; ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER, AMERICAN DENTAL ASSOCIATION, AND HAL M. CHRISTENSEN, DIRECTOR, WASHINGTON OFFICE, AMERICAN DENTAL ASSOCIATION

Dr. MORRIS. Yes, Mr. Chairman.

The CHAIRMAN. We are glad to have you, Doctor. Will you tell me who the gentlemen are who are accompanying you?

Dr. MORRIS. Yes, Mr. Chairman. On my left is Bernard Conway, who is the chief legal officer of the American Dental Association, and on my right is Mr. Hal Christensen, director of the Washington office.

The CHAIRMAN. I want to say that they are both very familiar to the committee, and we are delighted that you brought them with you.

Dr. MORRIS. Thank you very much.

It is a distinct privilege, Mr. Chairman, to appear before this subcommittee to present the views of the dental profession on S. 510 and S. 512, which would extend and in some cases expand programs presently authorized under the Public Health Service Act.

I have in my prepared statement, Mr. Chairman, some comments on the seriousness of the dental disease problem in this country.

In the interest of time I shall not touch on them but ask that they appear as part of my statement.

The CHAIRMAN. That will be done.

Dr. MORRIS. Thank you, Mr. Chairman.

Programs authorized under both S. 510 and S. 512 can make sizable contributions to the effort to control and prevent dental disease. S. 510 deals among other things with support for State and local dental public health measures and S. 512 with the facilities for conducting health research, including dental research.

With respect to S. 510, we will restrict our comment to the provision for a 1-year extension of section 314(c) of the Public Health Service Act which is due to expire at the end of fiscal 1966. Section 314(c) is of particular concern to us because it authorizes the grant-in-aid

program to assist State and local dental health units that was initiated in the current fiscal year. We support this extension and would like to suggest some opportunities this "year of grace" presents to the Federal Government.

Before discussing them in detail, however, we should like to direct your attention to S. 512.

The American Dental Association and the American Association of Dental Schools are most sympathetic to the purposes of S. 512. The two points which are of special importance are those that (1) increase the ceiling under the Health Research Facilities Act from \$50 million a year to \$80 million a year, and (2) authorize a program to encourage the development of regional research centers devoted to specific major diseases.

Our major interest, quite naturally, is to judge what effect these changes will have on the future of dental research in this country. Our strong conviction is that both of them will have a beneficial and vitalizing effect and that some aspects of them are essential to further development of dental research.

For some time it has been apparent that there were more projects worthy of support under the Health Research Facilities Act than could be accommodated by the \$50 million ceiling. For several years there has been a backlog of applications that were approved but could not be funded. This has been compounded recently by the activity under the Health Professions Educational Assistance Act passed in 1963 and fully operative for the first time during this current fiscal year. As was the intent of the act, it has greatly stimulated the renovation and expansion of existing schools and the planning of new teaching facilities where local opinion deemed it necessary.

In dentistry thus far, nine dental schools have received funds under this act. In addition, 12 other applications are in one stage or another of consideration. Another 21 schools have given indication of their intention to request support in the near future. According to present information, at least five and perhaps seven new dental schools are in the planning stage at this time.

These are notable achievements and will pay real dividends in the future in terms of better health care for the American people. Everyone who worked for passage of the Health Professions Educational Assistance Act can take pride in this rapid implementation.

However, with this burgeoning activity in the construction of dental teaching facilities, there has been highlighted an accompanying and urgent need for additional research facilities money. No one needs to be an expert either in planning or in health education to recognize that it makes no sense at all to build a new school or enlarge an existing one without making adequate provision for research facilities built into the very structure of the institution. In this day and age, there is no need to defend research or explain its necessity; it is the foundation stone of all progress. Without a substantial increase in the ceiling of the Health Research Facilities Act, we will be faced with the prospect of expanding schools in a less than fully useful way or of building new schools that are less than complete when they open their doors. This should not be allowed to happen. It would have a deleterious effect on the quality of education provided to students, would retard progress in research and, in the

long run, would be extremely uneconomical since research facilities must, at some time, be added.

S. 512 proposes an increase in the ceiling from \$50 million to \$80 million, an average of \$64 million during each of the next 5 years. The associations I represent believe this would be of material benefit to the health field. We also believe \$80 million is a rockbottom minimum if we are to continue to progress in this vital area as quickly as we could and should.

There is, at the same time, an amendment which we think the subcommittee should consider and adopt. This would be to grant discretionary authority to the administrators of the Health Research Facilities Act to raise the Federal matching share to at least the level allowed in the Health Professions Educational Assistance Act, which is 66.7 percent, and preferably to the 75 percent recommended by the President's Commission on Heart Disease, Cancer, and Stroke.

One of the major benefits of increasing the allowable Federal share would be to assist schools that are not now able to realize their full research potential. Some schools have in the past, for any number of reasons, been able to mount excellent research programs. Once begun, they have been able to build their programs consistently with their own resources and continued help of the Federal Government. Not all schools, however, have been so fortunate. Others, though they possess or can acquire the academic and intellectual capability, could not make a real beginning because of lack of facilities.

Certainly, no one wants to forever preclude such institutions from beginning to build the outstanding research programs of which they are capable. Under present law, however, we are running the risk of doing so. The change in the matching formula that we recommend would go a long way toward alleviating and remedying this situation.

Addressing itself to this problem, the report of the President's Commission on Heart Disease, Cancer, and Stroke has this to say:

The present 50-percent ceiling * * * works a most severe hardship on those institutions in less economically favored parts of the country which cannot compete in raising matching moneys with the large, established research complexes. Yet these smaller and financially weaker research institutions are the very ones we must strengthen if we are to achieve a truly broad, regional expansion of our research effort * * *. There is also a lack of nonmatching authority for the construction of research facilities that are national or regional in their scope. (The President's Commission on Heart Disease, Cancer, and Stroke; report to the President on "A National Program To Conquer Heart Disease, Cancer, and Stroke, December 1964, vol. 1, p. 72.)

In making this suggestion, Mr. Chairman, we should like to emphasize that in our opinion the increased Federal percentage need not be across the board but would be granted only in selected circumstances. We would estimate that the overall average Federal participation would remain at approximately 50 percent.

There is one more major provision of S. 512 that we should like to comment on. This is the authorization of a program to encourage the development of research institutes of national and regional significance. The establishment of precisely just such institutes has been a matter of discussion in dentistry for some years. Both associations have gone before the Appropriations Committees of Congress to urge consideration of centers related to oral health where basic research and clinical studies are carried out. The chairman will remember well discussions of this proposal during hearings of the Appropriations Committee he heads.

It has been gratifying to note the number of adherents this idea has gained in the past few years. Among them is Dr. James A. Shannon, Director of the National Institutes of Health, who, in referring to such dental research institutes, said:

It is my personal conviction * * * that it is this type of approach that will break the mold of the past, broaden research in the dental sciences and provide adequate training spots for true scientists within the profession. I think this approach would have a profound impact on dental research activities in as little as 5 years. (Departments of Labor and Health, Education, and Welfare Appropriations for 1964, hearings before a subcommittee of the Committee on Appropriations for 1964, Department of Health, Education, and Welfare, pt. 3, National Institutes of Health, pp. 589-590.)

Such centers as we are discussing would be somewhat similar to the National Institute of Dental Research. The staff would consist not only of dentists or dentists with additional doctorates but also students of all those disciplines we now know to be relevant to the search for dental secrets such as biochemistry, pharmacology, crystallography, radiology, and so forth.

In this way, a large and varied number of high-caliber scientists can be attracted to a career in dentally oriented research. This approach would also make it more certain than ever that dental research would progress in a meaningfully unified fashion and not risk isolated, fragmented development. Of greatest importance would be the tremendous contributions that could be made in preventing and controlling the country's most prevalent disease.

The National Institutes of Health has done more than merely agree that this concept is viable. In late 1964, an advisory committee composed of some of the country's leading scientists was appointed by Dr. Shannon to study and discuss the feasibility of establishing dental research institutes. This committee, we understand, has all but completed its deliberations and the associations I represent have every expectation that its report will reflect acceptance and strong support for this concept.

The American Dental Association and the American Association of Dental Schools believe such oral research institutes to be precisely the kind of centers envisioned by the President in his health message and by the framers of S. 512. The adoption of this proposal would be a giant step toward implementation of this concept and for this reason we strongly urge passage of this portion of S. 512.

Parenthetically, you might be interested in the fact that the new headquarters building now being constructed in Chicago will house a vastly increased research program. This will house scientists both from the dental field and also from allied fields where research both of the clinical type and basic research will take place. While it will not be of the dimension of the institutes we are discussing here, it will nevertheless make a meaningful contribution and will gain the pride of our profession.

Finally, we should like to voice our support for section of 4 S. 512 which would create three new Assistant Secretaries for the Department of Health, Education, and Welfare. We are particularly gratified to note the desirable upgrading of the position of special assistant to the Secretary (Health and Medical Affairs) to the level of an Assistant Secretary. At the same time, we should like to make clear our conviction that this important post should always be occupied either

by a member of the health professions or by one who is intimately conversant with health matters.

The CHAIRMAN. You think it is important to get that position, do you not, Doctor?

Dr. MORRIS. Yes, we do, with all the increased activities; yes, sir.

We would like to comment very briefly on that section of S. 510 that would extend the authority under section 314(c) of the Public Health Service Act until June 30, 1967.

As we understand it, this is in accordance with the request of President Johnson who, in his recent health message said:

I have directed the Secretary of Health, Education, and Welfare to study these programs thoroughly and to recommend to me necessary legislation to increase their usefulness. Authorizations for many of these programs expire at the close of fiscal year 1966. So that a thorough review may be made, I recommend that the Congress extend the authorizations through June 30, 1965.

We agree that perhaps a review is in order, but we also believe that during this suggested review period a good deal more could be done under the existing authority of section 314(c). This is particularly true with respect to the program of grants-in-aid to assist dental public health programs at State and community levels. It was only during the current fiscal year at the initiative of the distinguished chairman of the committee that this program was begun. For this year the amount authorized is \$520,000 or about \$10,000 per State. It is recognized that this is "starter" money and we are grateful for it. In all candor, however, it must be admitted that such a sum is relatively insignificant when put next to the demonstrated need.

The CHAIRMAN. Have the different States or the dental departments of the States, received their \$10,000, do you know?

Dr. MORRIS. This is beginning to become active in some States, yes. The fact is, though, that compared to the demonstrated need, this becomes almost an insignificant sum, but we are grateful to have it started.

It is most disappointing to note that the fiscal 1966 budget provides no increase for this program, particularly in view of the strong support given by the Department of Health, Education, and Welfare before this subcommittee some two and a half years ago.

You will recall that at that time the American Dental Association documented the urgent need for this program and was supported fully by the Department of Health, Education, and Welfare. At that time, the Department's representative stated:

In our opinion, the need for increased attention to dental public health activities clearly justifies the initiation at this time of an earmarked grant for this purpose. ("Control of Dental Diseases," hearing before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, 87th Congress, 2d session, on S. 917, May 24, 1962, pp. 3-16.)

What was said then is true today. The problem grows increasingly serious and remedial action could be taken now. We hope Congress will give this matter its attention.

In the meantime, we support the 1-year extension of section 314(c) since we have every expectation that the Department of Health, Education, and Welfare will make fruitful use of the extra year made available through the "thorough review" requested by the President. We are confident the Department will give the needs of dental public health the attention they deserve and that its ultimate recommenda-

tion will reflect the favorable position previously taken before this committee.

Mr. Chairman, this completes our formal testimony. We shall be pleased to answer any questions you may have.

(The prepared statement of Dr. Morris follows:)

PREPARED STATEMENT OF DR. ALVIN L. MORRIS, OF THE AMERICAN DENTAL ASSOCIATION AND THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Mr. Chairman and members of the subcommittee, my name is Dr. Alvin L. Morris, of Lexington, Ky. I am dean of the University of Kentucky School of Dentistry and a member of the American Dental Association's Council on Dental Therapeutics. I am here today representing both the American Dental Association and the American Association of Dental Schools. Accompanying me are Mr. Bernard J. Conway, chief legal officer of the American Dental Association, and Mr. Hal M. Christensen, director of that organization's Washington office. It is a distinct privilege, Mr. Chairman, to appear before this subcommittee to present the views of the dental profession on S. 510 and S. 512, which would extend and in some cases expand programs presently authorized under the Public Health Service Act.

Before referring specifically to the provisions of S. 510 and S. 512, I would like to comment briefly on the scope and seriousness of the dental disease problem in this country.

Dental diseases are the most prevalent of all chronic diseases. Ninety-seven million Americans suffer from tooth decay; 23 million have periodontal diseases; 65,000 children under 18 have cleft lip or palate; 23,000 people develop oral cancer annually. More than half of our people over the age of 55 are without natural teeth.

Personal dental health services cost about \$2.4 billion annually, about one-sixth of the amount spent for all health services. Due to oral disease, some 85 million man-hours of industrial production are lost each year.

Every 100 inductees into the military service, on the average, require 505 fillings, 80 extractions, 25 bridges, and 20 dentures.

Only 40 percent of the people of this Nation receive dental treatment each year. Among children aged 5 to 14, nearly 42 percent from rural farms have never been to a dentist; 23 percent of the children from urban areas have never been to a dentist. Almost 60 percent of the children aged 5 to 14 years in families with annual incomes of under \$2,000 have never been to a dentist.

Programs authorized under both S. 510 and S. 512 can make sizable contributions to the effort to control and prevent dental disease. S. 510 deals among other things with support for State and local dental public health measures and S. 512 with the facilities for conducting health research, including dental research.

With respect to S. 510, we will restrict our comment to the provision for a 1-year extension of section 314(c) of the Public Health Service Act which is due to expire at the end of fiscal 1966. Section 314(c) is of particular concern to us because it authorizes the grant-in-aid program to assist State and local dental public health units that were initiated in the current fiscal year. We support this extension and would like to suggest some opportunities this "year of grace" presents to the Federal Government.

Before discussing them in detail, however, we should like to direct your attention to S. 512.

S. 512

The American Dental Association and the American Association of Dental Schools are most sympathetic to the purposes of S. 512. We believe there is an urgent need for some of its provisions. The two points which are of special importance are those that (1) increase the ceiling under the Health Research Facilities Act of \$50 million a year to \$80 million a year, and (2) authorize a program to encourage the development of regional research centers devoted to specific major diseases.

Our major interest, quite naturally, is to judge what effect these changes will have on the future of dental research in this country. Our strong conviction is that both of them will have a beneficial and vitalizing effect and that some aspects of them are essential to further development of dental research. For some time it has been apparent that there were more projects worthy of support under the Health Research Facilities Act than could be accommodated by the \$50 million

ceiling. For several years there has been a backlog of applications that were approved but could not be funded. This has been compounded recently by the activity under the Health Professions Educational Assistance Act passed in 1963 and fully operative for the first time during this current fiscal year. As was the intent of the act, it has greatly stimulated the renovation and expansion of existing schools and the planning of new teaching facilities where local opinion deemed it necessary.

In dentistry thus far, nine dental schools have received funds under this act. In addition, 12 other applications are in one stage or another of consideration. Another 21 schools have given indication of their intention to request support in the near future. According to present information, at least five and perhaps seven new dental schools are in the planning stage at this time.

These are notable achievements and will pay real dividends in the future in terms of better health care for the American people. Everyone who worked for passage of the Health Professions Educational Assistance Act can take pride in this rapid implementation.

However, with this burgeoning activity in the construction of dental teaching facilities there has been highlighted an accompanying and urgent need for additional research facilities money. No one needs to be an expert either in planning or in health education to recognize that it makes no sense at all to build a new school or enlarge an existing one without making adequate provision for research facilities built into the very structure of the institution. In this day and age, there is no need to defend research or explain its necessity; it is the foundation stone of all progress. Without a substantial increase in the ceiling of the Health Research Facilities Act, we will be faced with the prospect of expanding schools in a less than fully useful way or of building new schools that are less than complete when they open their doors. This should not be allowed to happen. It would have a deleterious effect on the quality of education provided to students, would retard progress in research and in the long run would be extremely uneconomical since research facilities must, at some time, be added.

S. 512 proposes an increase in the ceiling from \$50 to \$80 million, an average of 6 million during each of the next 5 years. The associations I represent believe this would be of material benefit to the health field. We also believe \$80 million is a rock bottom minimum if we are to continue to progress in this vital area as quickly as we could and should.

There is, at the same time, an amendment which we think the subcommittee should consider and adopt. This would be to grant discretionary authority to the administrators of the Health Research Facilities Act to raise the Federal matching share to at least the level allowed in the Health Professions Educational Assistance Act, which is 66.7 percent, and preferably to the 75 percent, recommended by the President's Commission on Heart Disease, Cancer, and Stroke.

One of the major benefits of increasing the allowable Federal share would be to assist schools that are not now able to realize their full research potential. Some schools have in the past, for any number of reasons, been able to mount excellent research programs. Once begun, they have been able to build their programs consistently with their own resources and continued help of the Federal Government. Not all schools, however, have been so fortunate. Others, though they possess or can acquire the academic and intellectual capability, could not make a real beginning because of lack of facilities. Certainly, no one wants to forever preclude such institutions from beginning to build the outstanding research programs of which they are capable. Under present law, however, we are running the risk of doing so. The change in the matching formula that we recommend would go a long way toward alleviating and remedying this situation.

Addressing itself to this problem, the report of the President's Commission on Heart Disease, Cancer, and Stroke has this to say: "The present 50-percent ceiling * * * works a most severe hardship on those institutions in less economically favored parts of the country, which cannot compete in raising matching moneys, with the large, established research complexes. Yet these smaller and financially weaker research institutions are the very ones we must strengthen if we are to achieve a truly broad, regional expansion of our research effort. * * * There is also a lack of nonmatching authority for the construction of research facilities that are national or regional in their scope."¹

In making this suggestion, Mr. Chairman, we should like to emphasize that in our opinion the increased Federal percentage need not be across the board but would be granted only in selected circumstances. We would estimate that the

¹ The President's Commission on Heart Disease, Cancer, and Stroke: "Report to the President on a National Program to Conquer Heart Disease, Cancer, and Stroke," December 1964, vol. 1, p. 72.

overall average of Federal participation would remain at approximately 50 percent.

There is one more major provision of S. 512 that we should like to comment on. This is the authorization of a program to encourage the development of research institutes of national and regional significance. The establishment of precisely just such institutes has been a matter of discussion in dentistry for some years. Both associations have gone before the Appropriations Committees of Congress to urge consideration of centers related to oral health where basic research and clinical studies are carried out. The chairman will remember well discussions of this proposal during hearings of the Appropriations Committee he heads.

It has been gratifying to note the number of adherents this idea has gained in the past few years. Among them is Dr. James A. Shannon, Director of the National Institutes of Health, who, in referring to such dental research institutes, said: "It is my personal conviction * * * that it is this type of approach that will break the mold of the past, broaden research in the dental sciences and provide adequate training spots for true scientists within the profession. I think this approach would have a profound impact on dental research activities in as little as 5 years."²

Such centers as we are discussing would be somewhat similar to the National Institute of Dental Research. The staff would consist not only of dentists or dentists with additional doctorates but also students of all those disciplines we now know to be relevant to the search for dental secrets such as biochemistry, pharmacology, crystallography, radiology, and so forth.

In this way, a large and varied number of high-caliber scientists can be attracted to a career in dentally oriented research. This approach also would make it more certain than ever that dental research would progress in a meaningfully unified fashion and not risk isolated, fragmented development. Of greatest importance would be the tremendous contributions that could be made in preventing and controlling the country's most prevalent disease.

The National Institutes of Health has done more than merely agree that this concept is viable. In late 1964, an advisory committee composed of some of the country's leading scientists was appointed by Dr. Shannon to study and discuss the feasibility of establishing dental research institutes. This committee, we understand, has all but completed its deliberations and the associations I represent have every expectation that its report will reflect acceptance and strong support for this concept.

The American Dental Association and the American Association of Dental Schools believe such oral research institutes to be precisely the kind of centers envisioned by the President in his health message and by the framers of S. 512. The adoption of this proposal would be a giant step toward implementation of this concept and for this reason, we strongly urge passage of this portion of S. 512.

Finally, we should like to voice our support for section 4 of S. 512 which would create three new Assistant Secretaries for the Department of Health, Education, and Welfare. We are particularly gratified to note the desirable upgrading of the position of Special Assistant to the Secretary (Health and Medical Affairs) to the level of an Assistant Secretary. At the same time, we should like to make clear our conviction that this important post should always be occupied either by a member of the health professions or by one who is intimately conversant with health matters.

S. 510

We would like now to comment very briefly on that section of S. 510 that would extend the authority under section 314(c) of the Public Health Service Act until June 30, 1967.

As we understand it, this is in accordance with the request of President Johnson who, in his recent health message, said: "I have directed the Secretary of Health, Education, and Welfare to study these programs thoroughly and to recommend to me necessary legislation to increase their usefulness. Authorizations for many of these programs expire at the close of fiscal year 1966. So that a thorough review may be made, I recommend that the Congress extend the authorizations through June 30, 1967."

We agree that perhaps a review is in order, but we also believe that during this suggested review period a good deal more could be done under the existing authority of section 314(c). This is particularly true with respect to the program of grants-in-aid to assist dental public health programs at State and community

² "Department of Labor and Health, Education, and Welfare Appropriations for 1964," hearings before a subcommittee of the Committee on Appropriations for 1964, Department of Health, Education, and Welfare, pt. 3, National Institutes of Health, pp. 589-590.

levels. It was only during the current fiscal year at the initiative of the distinguished chairman of the committee that this program was begun. For this year the amount authorized is \$520,000 or about \$10,000 per State. It is recognized that this is "starter" money and we are grateful for it. In all candor, however, it must be admitted that such a sum is relatively insignificant when put next to the demonstrated need.

It is most disappointing to note that the fiscal 1966 budget provides no increase for this program, particularly in view of the strong support given by the Department of Health, Education, and Welfare before this subcommittee some 2½ years ago.

You will recall that at that time, the American Dental Association documented the urgent need for this program and was supported fully by the Department of Health, Education, and Welfare. At that time, the Department's representative stated: "In our opinion, the need for increased attention to dental public health activities clearly justifies the initiation at this time of an earmarked grant for this purpose."³

What was said then is true today. The problem grows increasingly serious and remedial action could be taken now. We hope Congress will give this matter its attention.

In the meantime, we support the 1-year extension of section 314(c) since we have every expectation that the Department of Health, Education, and Welfare will make fruitful use of the extra year made available through the "thorough review" requested by the President. We are confident the Department will give the needs of dental public health the attention they deserve and that its ultimate recommendation will reflect the favorable position previously taken before this committee.

The CHAIRMAN. Mr. Christensen, do you have anything you would like to add?

Mr. CHRISTENSEN. No, sir.

The CHAIRMAN. Mr. Conway?

Mr. CONWAY. No, thank you, sir.

The CHAIRMAN. I think I should say this, when I asked who the two gentlemen were who were accompanying you, I was joking. This subcommittee has had no better friends and this legislation has no two better friends or stronger supporters than Mr. Christensen and Mr. Conway.

Dr. MORRIS. I am proud to be associated with them, sir.

The CHAIRMAN. As chairman of this subcommittee, I want to say we are very deeply grateful for the help they have given us through the years.

Dr. MORRIS. I am sure that everybody in the profession appreciates that remark, Mr. Chairman.

The CHAIRMAN. Thank you very much, gentlemen.

Dr. George Wolf, of Boston, Mass.

STATEMENT OF DR. GEORGE A. WOLF, JR., BOSTON, MASS., VICE PRESIDENT OF MEDICAL AND DENTAL AFFAIRS, TUFTS UNIVERSITY, EXECUTIVE DIRECTOR OF TUFTS NEW ENGLAND MEDICAL CENTER, AND PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY DR. ROBERT BERSON ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. WOLF. Mr. Chairman, may I request that Dr. Berson of the AAMC accompany me?

The CHAIRMAN. We shall be glad to have him. If I did not take exception to the word "old," I would say he is an old friend of the chairman's.

³ "Control of Dental Diseases," hearing before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, 87th Cong., 2d sess., on S. 917, May 24, 1962, pp. 3-16.

Dr. WOLF. May I identify myself—

The CHAIRMAN. You are president of the Association of American Medical Colleges?

Dr. WOLF. Yes, sir. I am also with Tufts University in Boston.

The CHAIRMAN. Proceed, sir.

Dr. WOLF. I would like, with your permission, to introduce the written testimony into the record and comment on it briefly orally.

The CHAIRMAN. Yes. We shall have your statement appear in the record.

Dr. WOLF. In summary, the Association of American Medical Colleges urges your favorable consideration of S. 512. I would like to describe to you briefly what this legislation means to medical schools of this country.

First, I would like to speak about the health facilities construction aspects of this legislation, because I have seen it in operation from two viewpoints: one as dean of the University of Vermont College of Medicine and in my present position. We have been recipients of grants from this group.

Second, I was formerly a member of the Health Research Facilities Construction Division Advisory Council. I have seen some interesting things during the course of this experience and would like to mention them briefly.

The figures given to you in prior testimony indicate that the approved applications greatly exceed the availability of funds. I would like to point out some of the things I have seen. I would first like to say that the Advisory Council does not approve applications easily. I think this is important to be in the record. But I would like you to visualize, as I have, a 6-foot scientist working in the basement of a 150-year-old cottage on the grounds of one of our universities, and the basement just permitted me, at my 5-foot-7-inch height, to walk through. Because of health research facilities funds, this man now has a usable laboratory.

I spoke of my experience as dean of the College of Medicine at the University of Vermont. Vermont is a very small State, as you know, and the State is supporting a medical school there at a very high rate, over \$2 per inhabitant. Up until a few years ago, there had been no new building on the Vermont medical campus for over 50 years and it was impossible to ask the State legislature to appropriate additional funds for construction, with the heavy taxload the people were already carrying. We were able, however, from a loyal alumni group, only 1,400 in number, to raise about \$800,000 and you cannot build much of a building with that. But with matching money from the health research facilities program we were able to build the building. Because of the ability of the present dean to obtain \$2 million from a private donor, and through the cooperation of several private foundations, they were finally able to complete the total \$10 million new structure, allowing them not only to improve the research program but also to increase the enrollment of medical students by 50 percent.

The CHAIRMAN. These are the people of Vermont?

Dr. WOLF. Vermont; yes.

At Tufts we have had similar examples, which I have introduced into the record, the business of taking old concrete loft buildings in downtown Boston and converting them into very highly agreeable research facilities by using private funds and taking private foundation money and matching up Health Research Facilities money. This is the kind of flexibility in the grant program which allows one to accomplish things with really very little money.

The CHAIRMAN. Massachusetts and Vermont are really serving a large part of the New England area so far as doctors are concerned?

Dr. WOLF. Yes—well, except for Dartmouth, the schools in Boston and the medical school in Burlington are the only 4-year schools in all of New England.

The point I would like to make, really, is that the health research facilities money is acting and has acted as seed money. It has attracted money from private foundations, private resources in general, as well as from State sources. I think this is extremely important.

I might say, however, that the seed could have been somewhat more fertile if the match had been 75 percent instead of 50 percent.

Now, S. 512 also speaks to another problem, and this is the national need for what might be called crash programs in research in certain areas, such as aging and dental sciences referred to just recently. It is often difficult for universities to divert their own funds, their matching funds, from other institutional construction requirements to get involved in a crash program of research, even though men qualified to do the work are on the scene. Thus it seems only reasonable that provision should be made in the law so that when a crash program to the benefit of the Nation or region is embarked upon, funds be made available to cover the entire cost of construction, rather than depending upon one institution which is serving the region to come up with the matching money.

Further, it is becoming increasingly evident that future progress in health research will occur in what Dr. Shannon has referred to as centers of excellence. It is very fortunate in this country that all of our universities and medical centers are not the same. They all have different areas of strength. It seems to me important that we capitalize on these areas where there are specific highly qualified people.

Furthermore, the matter of scientists in industry is something of some importance, it seems to me. In a city like Boston, MIT and Harvard, we at Tufts, Boston University, Boston College, et cetera, have some association or relationship with what we call the Route 128 industries. This is a road, a circular road, which goes around Boston which has many electronic industries and other highly developed industries. There is a great deal of collaboration at the engineering level. This collaboration has not occurred in medicine the way it should. We have one lone surgeon who is working out on Route 128 with an electronics company on laser and we have one lone engineer working in our hospital trying to develop a heart pump. It is an indication of what can be accomplished but it is small. Is it not possible that we have an effective relationship with industries and the universities in the area, a real center of excellence could be created which would take advantage of all the diversities of the institutions, both educational and industrial?

The contracting authority by the Public Health Service, which is requested in S. 512 is an important administrative mechanism for getting this kind of coordinated and collaborative research. The way science these days is going, it is going to become increasingly important in the future.

I would like to say one word about the organization of the Department of Health, Education, and Welfare. From the standpoint of the Association of American Medical Colleges, the activities of the Department are an extremely important part of the total medical education picture in this country. We would hope that appropriate means, as suggested, the three additional Secretaries, would be provided to accomplish our mutual goal.

The CHAIRMAN. Do you think that is important, that the position there have the prestige of an Assistant Secretary of the Department?

Dr. WOLF. We do indeed. We feel it is extremely important. This is a very broad program and very important to medical education. We feel we can speak to this.

(The prepared statement of Dr. Wolf follows:)

PREPARED STATEMENT OF DR. GEORGE A. WOLF, JR.

I am Dr. George A. Wolf, Jr., vice president for medical and dental affairs at Tufts University, and executive director of the Tufts-New England Medical Center in Boston. On this occasion I am speaking for the Association of American Medical Colleges which I have the honor of serving as president. I appreciate the opportunity of appearing before you and recognize the great contribution this committee has made to health by its past sponsorship of legislation. The Association of American Medical Colleges urges your favorable consideration of S. 512. I would like to describe to you briefly what this legislation means to medical schools of this country.

Concerning the health research facilities construction aspects of this legislation, I would like to speak to you as a former member of the Health Research Facilities Construction Division Advisory Council but also as former dean of the University of Vermont College of Medicine and in my present role. Either because of consultation or accreditation visits or project site visits for the Health Research Facilities Construction Division of the U.S. Public Health Service, I have visited most of the medical schools in this country, many hospitals and research institutes, foreign medical schools in Europe, and schools as far away as Iran.

In this age of sophisticated health research with its attendant complex instrumentation, skilled technical staff needed, and the necessity of training future generations of researchers, I can attest to the importance of physical facilities, as well as manpower, in our present and future research development. The figures given to you in prior testimony indicate that the approved applications greatly exceed the availability of construction funds, and I can assure you that the advisory council does not approve applications easily. These, however, are numbers, and I'm sure you are as concerned as I am with the people who do the research work. Visualize, as I have seen, a 6-foot scientist working in the basement of a 150-year-old cottage on the grounds of one of our best universities. The pipes just cleared my 5 feet 7 inches. Because of health research facilities funds, this man now has a usable laboratory. At the University of Vermont College of Medicine, when the people of that small State were taxing themselves over \$2 per person to support a medical school, as dean, I could not in conscience ask the legislature for construction money. The alumni, only 1,400 in number, provided \$800,000 and with health research facilities money we obtained the start on a new building.

A second phase became possible when several private foundations, attracted by the fact that we were able to build the first new building at the medical school in over 50 years, provided still more funds. Last month the present dean obtained the final \$2 million from one private donor to complete the total \$10 million new structure, allowing them not only to improve the research program but also to increase the enrollment of medical students by 50 percent.

At Tufts and the Tufts-New England Medical Center in the middle of Boston the purchase of several concrete loft buildings with private funds and with private foundation money matching health research facilities money these buildings were redone and the medical school and affiliated hospitals now have over \$3 million in research activities going on. Moreover, we have again with private foundation money, now that we have the space, revitalized all of our basic science departments and have attracted scientists to our research and teaching staffs from all over the country. In short, the health research facilities money has acted in these instances as seed money and has attracted both construction and operating funds from other sources. The seed, however, would have been much more fertile if the matching percentage authorized by law was increased from 50 to 75 percent.

S. 512 also speaks to another problem. When the national need for crash programs in research, such as aging, research in oral biology and disease, etc., is recognized, it is often difficult for a university to divert matching funds from other institutional construction needs to crash programs even though competent and useful men in the field are on the staff of the university. When the crash program is of a national or regional significance, it is only reasonable to support the construction needed fully from a regional or a national source. Thus, for the protection of ongoing total programs of medical schools, universities, and hospitals, we urge favorable consideration, giving the Public Health Service authority to pay full cost of construction when appropriate.

It is becoming increasingly evident that future progress in health research will occur in what Dr. Shannon has called centers of excellence. Fortunately, our universities and their medical schools are not all the same. Each individual faculty has much to offer with a great variety of strength varying in different institutions. The diverse skills and knowledge of faculties and others, such as scientists in industries, when focused appropriately upon a problem can produce answers which can be achieved in no other way.

In a city like Boston, for example, the relationships between universities, such as Tufts, MIT, Harvard, Boston University, Boston College, our affiliated hospitals and the so-called Route 128 industries provide an example of possible wedding of diverse talents. Although much communication between the universities and the industries goes on in the other areas in medicine, this has not been extended nearly enough. We, for example, at the Tufts-New England Medical Center have one lone surgeon working in a laboratory in an electronics company on the medical uses of laser. We also have one lone engineer working on the staff of the hospital, struggling to improve the design of the heart pump. Our dental school and a scientist from Peter Bent Brigham Hospital are working closely with groups at MIT. Massachusetts General has done excellent work on isotopes with MIT. But these are feeble gestures generated by personal friendships and mutual good will. We submit that the intellectual assets of our big cities, many of which also have one or more university medical schools and affiliated hospitals, are enormous. The potential for collaborative research in the health area has not been sufficiently exploited. We feel that the contracting authority, as proposed in S. 512, will serve to create a mechanism making collaborative research in the health field practical and desirable from the institutional standpoint. In our view this technique will supplement the granting program and increase the flexibility of the U.S. Public Health Service in attaining our mutual goals in health research.

Finally, we do not feel it appropriate for us to speak to the question of the organization of the Department of Health, Education, and Welfare. However, the health and medical activities of the Department of Health, Education, and Welfare are such an important part of this country's medical educational and research system that we hope all appropriate steps to foster its good administration will be taken.

Thank you.

The CHAIRMAN. You heard Mr. Miles testify this morning on the many new programs we have added to the Department in the last 2 or 3 years, did you?

Dr. WOLF. Yes, sir.

The CHAIRMAN. And Dr. Berson, is there anything you would like to add?

Dr. BERSON. No, nothing to add except that it is a pleasure to be here.

The CHAIRMAN. Thank you, sir.

How old is Tufts Medical School?

Dr. WOLF. It was formed in 1890.

The CHAIRMAN. Before you and I were born.

Dr. WOLF. Yes, I have to count up a bit.

May I say one more word?

The CHAIRMAN. Yes.

Dr. WOLF. Do you remember S. 1323? When I testified then you accused me of being a young dean at that time.

The CHAIRMAN. I remember it. You are still a young dean.

Dr. WOLF. What I said at the time was that the way not to stay young was to be a dean, and I was hoping that I had proved my point.

The CHAIRMAN. I want to say this, whenever you have been before this committee you have brought us some splendid, helpful testimony. We deeply appreciate it.

We appreciate your presence here, too, Dr. Berson.

Dr. WOLF. Thank you, sir.

Dr. BERSON. Thank you, Mr. Chairman.

The CHAIRMAN. Now, Dr. Hollis Ingraham of New York, commissioner of health, New York State Department of Health.

STATEMENT OF DR. HOLLIS INGRAHAM, ALBANY, N.Y., COMMISSIONER OF HEALTH, NEW YORK STATE DEPARTMENT OF HEALTH, AND MEMBER, STATE & TERRITORIAL HEALTH OFFICERS ASSOCIATION

The CHAIRMAN. Doctor, I want to say that Senator Javits is very sorry he could not be here this morning, but he had an important engagement out of the city which made it impossible for him to be here.

We are happy to have you here, sir.

Dr. INGRAHAM. In the interest of saving time, Mr. Chairman, I shall try to abridge my remarks to a certain extent. I have submitted my statement.

The CHAIRMAN. We shall have your remarks appear in full in the record.

Dr. INGRAHAM. Thank you.

I am appearing on behalf of the Association of State & Territorial Health Officers, and I have been asked to comment specifically on S. 510.

I have not had the privilege of seeing S. 512, so I can only say that the association in general is very much aware of the great value to public health that the Health Research Facilities Act has been and hope it will continue to be.

Speaking for myself and our own department, we have benefited to the extent of several million dollars of construction of research facilities in the department and are aware of the great benefit that it has been to other parts of the State as well.

But specifically on S. 510, I would like to speak to a few of the assets.

With regard to the immunization program, the association supports all the programs that are proposed. I notice that the Public Health Service representatives mentioned the desirability of including measles.

Just speaking in a small way for the upstate area of New York State, with approximately 10 million people, in 1963 we had no deaths from whooping cough; we had no deaths from diphtheria; we had 2 from tetanus; 2 from poliomyelitis; but 12 from measles, which is a further illustration of the desirability of including measles as well as the other diseases mentioned.

We also think that this amendment which would give the Surgeon General the discretion of including other diseases is highly desirable. For example, smallpox is constantly threatening us and could be far more devastating were it introduced than any other diseases mentioned in the act.

We also favor the change in the redefining of the group that is eligible from "children under five years" to "children of preschool age", since it does seem to represent a minor liberalization of eligibility. However, the association would recommend that the bill lift all restrictions as to age. There are many reasons for this.

In the first place, a child surviving beyond the preschool years does not acquire immunization simply by passing the age mark. In many cases, there is a need to reimmunize older people, and, third, this age restriction requires elaborate bookkeeping which does not help to get ineligible children vaccinated. We think our energies could be spent more profitably.

We also support the final change from "intensive community vaccination efforts" of "limited duration." This would help to develop orderly, regular, continuing programs rather than simply "short term" and hence sporadic campaigns.

With regard to the migratory workers health services, the association has consistently championed better health services for the migrant worker, who is the "stepchild" of the American labor force. We favor the extending of Federal support of services for 5 years, removing the \$3 million ceiling on this assistance.

Further, the association strongly urges that the health services now available to migrant workers be extended to include hospital care for this severely underprivileged group.

With regard to the general public health services, and special community health service projects, the association supports the provision which would extend these grants for 1 year. However, the present character of these grants is of intense concern to health officers across the Nation. Therefore, the association has named a distinguished committee from among its membership to make recommendations for eliminating features which sharply reduce the effectiveness of current grant-in-aid programs.

The members of this committee are Dr. Malcolm H. Merrill, director of public health in California; Dr. Franklin D. Yoder, director of public health in Illinois; Dr. Wilson T. Sowder, State health officer, Florida; and Dr. Joseph E. Cannon, director of health, Rhode Island.

The committee's recommendations will be announced soon.

The CHAIRMAN. Do you think we shall have those recommendations shortly, Doctor?

Dr. INGRAHAM. I was speaking to our president yesterday, and he was not sure just how quickly they will be available. We are hoping that they will be soon, but I am unable to tell you at this time, sir.

I would like to take this opportunity, if I might, for just a few moments to present in general terms the characteristics of the current grant-in-aid program that trouble my fellow State health officers across the Nation.

We do need Federal assistance. The National Planning Association predicts that current State and local expenses of \$55 billion will rise in 10 years to almost \$155 billion. State debt has almost tripled in the last decade. While State and local expenditures have exploded, revenues have almost calcified.

The Federal Government sits astride the rich yielding taxes on income and corporate profits. The States are left largely with real property taxes which many feel are already stretching reasonable limits or sales taxes which are regressive and unpopular. We deal gingerly with income taxes for fear of driving business and individuals to tax havens in other States.

Hence we must look for help to Washington where frequently a heavy price is exacted for the aid we receive.

Project grants are a case in point. A growing tendency is evident to bypass State government and make project grants directly to communities.

Some States may have invited this flanking maneuver by ignoring the massive problems of their metropolitan areas. Many of us have not. But nevertheless we pay the price of unwarranted Federal intrusion.

Let me catalog briefly what happens when Federal agencies ignore State government and deal directly on the local level.

It disrupts sound statewide planning.

It denies the State's ability to assess its own problems and to determine where additional resources can best be applied.

It introduces a divisive wedge which undercuts the State's authority.

It deals a damaging blow to genuine creative federalism.

Next I want to comment on the categorical grants which are made available to the States for earmarked purposes like heart disease, tuberculosis, venereal, and other diseases.

When the Federal Government tells a State exactly how and on what it must spend Federal health aid, strange things happen. The grant which was initiated originally to generate new enterprises—to feed the growing edge of public health—becomes, as the years pass, an expected prop for old concerns, while more urgent demands go unanswered. A State may, for example, defer a high-priority health program for which it can readily assemble a trained staff in favor of a program of lesser priority which it is ill prepared to carry on. Why? Because it can get Federal funds for the one, but not for the other.

The present array of categorical grants—which come in 15 variations—has become a fiscal jungle of competing programs, jurisdictions, and professional interests. Their ultimate purpose of promoting health sometimes seems lost in the maze of paperwork the grants generate.

I also suggest that general research conducted by State and local health agencies get more support from Washington. Public health has long been the pioneer which transformed test-tube triumphs into genuine health victories in the field—often through research in public

health techniques. But we need more liberal assistance which allows us to explore with greater initiative and enterprise.

But unfortunately, this is shrinking from year to year. Just this year in New York State, for example, it was diminished by 25 percent.

Perhaps there is an answer. President Johnson has been reported first as warm, and then cool, toward a truly brilliant proposal to return a share of the Federal Government's brimming tax revenues to the States to relieve the immense pressures on State government. I think I can speak for all my State-level colleagues in wishing that the President will warm again to this eminently sensible idea. The noted economist, Walter Heilbroner, wrote recently in the New York Times Magazine of demands on State government for health and other services. "Unless we want all these functions ultimately centered in Washington," Heilbroner said, "the States and localities must have the wherewithal to provide these services independently on a generous scale."

Of course, the Federal Government, quite properly, seeks to raise all the States to an acceptable health standard. We welcome assistance which helps us improve without stifling our initiative or denying our intelligence. But I cannot believe that the people of this Nation will be served best by having their State governments reduced to field outposts for a monolithic bureaucracy.

Therefore, in acting upon the bill presently before you and in considering subsequent recommendations by the association, I ask you to use your high powers to assure programs of Federal assistance that make excellence a possibility not only in the Nation's Capital but at all levels of our Federal system.

I should just like to add that many of the States are attempting to follow what we are preaching for the State government. In my own State of New York, for instance, in the last 10 years, county government has been greatly strengthened in contrast to the State government. In my own department, which is a relatively small one, since we do not carry on the functions of mental health or of giving State aid to the medically indigent, we nevertheless in our present budget this year provide \$42 million of aid to the State and county health departments. In the budget which is presently under consideration, I expect this will be increased to approximately \$60 million. This is given to the counties of the State in varying ratios of from 50 to 100 percent. It is given and only postaudited. The regulations under which it is given occupy approximately 25 pages which are general in outline and give these county governments great opportunity for their own initiative and for their own decisions.

Governor Rockefeller recently announced a great increase of State aid which is projected for providing for cleaning up the waters of New York State. This is a project which will require approximately \$2 billion over the next 6 to 7 years. He is requesting a bond issue of \$1 billion, which we would largely use to assist the localities. It is hoped this will be in the ratio of 30 percent State, 30 percent Federal, and 40 percent municipal expenditures.

In the event that the Federal Government is unable to come forth with the requested amounts, the Governor will recommend that the State pay up to 60 percent of the cost, with the municipalities supplying 30 percent.

I should like also to say that one Federal program with which you, Senator Hill, are very familiar, which has largely exemplified that which we are asking, is the Hill-Burton and now the Hill-Harris program. This is one in which the financing has been predominantly Federal. Nevertheless, there has been an opportunity under the general standards set forth by the Federal Government for the State to enter into statewide planning as to the construction of hospital facilities. There has been an opportunity for the localities to determine the type of construction they need within limits. Within the limits of the statewide program there has been a genuine tripartite partnership in the general program of advancing the state of health of the people. This is something we in the association would like to see furthered to a great extent, hopefully with each bearing a share of the cost, with administrative decisions, as much as can be, made on the local level, those that cannot be made locally made on the State level, and only when the State fails should the Federal Government assume the responsibilities and the decisions for carrying out programs which the localities or States have demonstrably been unable to prove the needed additions or needed corrections in steps to improve the health of the people.

In other words, what we are asking for here is exemplified, perhaps by Lincoln's statement when he said, "I go for: All share in the privileges of government who assist in bearing the burdens."

Thank you very much for the opportunity of appearing before you. I appreciate it a good deal.

(The prepared statement of Dr. Ingraham follows:)

PREPARED STATEMENT OF HOLLIS S. INGRAHAM, M.D., COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH

I am Dr. Hollis S. Ingraham, commissioner of health for the State of New York. I am here today representing the Association of State and Territorial Health Officers in connection with Senate bill 510.

While the association generally supports extension of the Federal aid program and the other amendments contained in this legislation, I want to take this opportunity to comment briefly on specific provisions of the bill.

Immunization programs

The association supports the amendment which removes the present \$11 million annual ceiling on Federal support of State and local immunization programs. Epidemics are unlikely to scale their intensity to the ceilings on funds which the Federal Government has imposed years before an outbreak. Hence, this change gives the law the flexibility to meet tomorrow's immunization needs as well as today's.

The next provision dealing with immunization extends the Federal aid program to fiscal 1970, which, of course, the association favors.

The bill also adds measles to the list of diseases for which the Federal Government will support immunization programs; e.g., diphtheria, poliomyelitis, whooping cough, and tetanus. The association supports this expansion. A simple review of the toll that measles exacts in comparison with the diseases now eligible for immunization assistance explains our position.

In 1962 the Public Health Service reported 41 deaths from diphtheria, 60 from poliomyelitis, 83 from whooping cough, and 215 from tetanus, all of which are eligible for immunization assistance. PHS reported 408 deaths from measles. In other words measles alone struck down more victims than the four other diseases combined. I might add that this innocent-sounding affliction of childhood leads to encephalitis in approximately 1 of every 1,000 cases, of which 10 to 15 percent are fatal. A third of the survivors usually suffer mental or physical impairment.

I would suggest for the future, however, rather than adding piecemeal the diseases for which support may be given, that Washington assist all immunization

programs which protect community health. In my own State, for example, we are vigorously promoting smallpox vaccination for high risk groups such as airport employees, hospital employees, and transportation employees. We get no Federal aid for this program, though I need not dwell on the fact that an outbreak of smallpox would wreak human devastation greater than diseases for which Federal immunization assistance is available.

Next, the bill redefines the age group eligible for federally aided immunization from "children under 5 years" to "children of preschool age." While I am not sure that this distinction is significant, it does seem to represent a minor liberalization of eligibility and hence has the support of the association. However, I am sure that I speak for virtually all our membership in recommending that the bill lift all restrictions with respect to age. In the first place a child surviving beyond preschool years does not acquire immunization simply by crossing a date on a calendar. The need for protection continues. Second, there is the need to reimmunize people when the protection of an earlier immunization fades. Third, this age restriction requires elaborate bookkeeping to assure Federal auditors that no vaccine has found its way into ineligible children. Our energies can certainly be spent more profitably.

Another provision of this bill would give the Surgeon General authority to help pay costs in connection with immunization against other infectious diseases not specifically mentioned in the law if and when such diseases become a major public health problem. This provision would give public health officials the flexibility meet the threats we may face in the future as well as those we fear from the past.

The final immunization provision of the bill would drop the language that limits Federal assistance to only "intensive" community vaccination efforts of "limited duration." This change, if enacted, will allow us to develop orderly, regular, continuing programs that will bring more people behind the protective shield of immunization than the intensive, short-term—and hence sporadic—campaigns now eligible for assistance.

Migratory workers health services

The association has consistently championed better health services for the migrant worker—that stepchild of the American labor force. The bill under consideration would extend Federal support of services to migratory workers for 5 years and remove the annual \$3 million ceiling on this assistance. The association favors both these provisions. Further, the association strongly urges that the health service now available for migrant workers be extended to include hospitalization care for this severely underprivileged group.

General public health services

The association generally supports the provisions of the bill extending for 1 year grants to the States for general health purposes and grants for special community health service projects. However, the present character of these grants is of intense concern to health officers across the Nation. Consequently the association has named a distinguished committee from among its membership to make recommendations for eliminating features which sharply reduce the effectiveness of current grant-in-aid programs. The members of this committee are as follows:

- Dr. Malcolm H. Merrill, director of public health, California.
- Dr. Franklin D. Yoder, director of public health, Illinois.
- Dr. Wilson T. Sowder, State health officer, Florida.
- Dr. Joseph E. Cannon, director of health, Rhode Island.

The committee's recommendations will be announced soon. However, I want to take this opportunity to present, in general terms, characteristics of the current grant-in-aid program that trouble my fellow State health officers across the Nation.

Undeniably, the States need Federal financial assistance. The National Planning Association predicts that current State and local expenses of \$55 billion will rise in 10 years to almost \$155 billion. State debt has almost tripled in the last decade. While State and local expenditures have exploded, revenues have almost calcified.

The Federal Government sits astride the rich yielding taxes on incomes and corporate profits. The States are left largely with real property taxes which many feel are already stretching reasonable limits or sales taxes which are regressive and unpopular. We deal gingerly with income taxes for fear of dringing business and individuals to tax havens in other States.

Hence we must look for help to Washington where frequently a heavy price is exacted for the aid we receive.

Project grants are a case in point. A growing tendency is evident to bypass State government and make project grants directly to communities.

Some States may have invited this flanking maneuver by ignoring the massive problems of their metropolitan areas. Many of us have not. But nevertheless we pay the price of unwarranted Federal intrusion.

Let me catalog briefly what happens when Federal agencies ignore State government and deal directly on the local level.

It disrupts sound statewide planning.

It denies the State's ability to assess its own problems and to determine where additional resources can best be applied.

It introduces a divisive wedge which undercuts the State's authority.

It deals a damaging blow to genuine creative federalism.

Next I want to comment on the categorical grants which are made available to the States for earmarked purposes like heart disease, tuberculosis, venereal, and other diseases.

When the Federal Government tells a State exactly how and on what it must spend Federal health aid strange things happen. The grant which was initiated originally to generate new enterprises—to feed the growing edge of public health—becomes, as the years pass, an expected prop for old concerns, while more urgent demands go unanswered. A State may, for example, defer a high-priority health program for which it can readily assemble a trained staff in favor of a program of lesser priority which it is ill prepared to carry on. Why? Because it can get Federal funds for the one, but not for the other.

The present array of categorical grants—which come in 15 variations—has become a fiscal jungle of competing programs, jurisdictions, and professional interests. Their ultimate purpose of promoting health sometimes seems lost in the maze of paperwork the grants generate.

I also suggest that general research conducted by State and local health agencies get more support from Washington. Public health has long been the pioneer which transformed test tube triumphs into genuine health victories in the field—often through research in public health techniques. But we need more liberal assistance which allows us to explore with greater initiative and enterprise.

Perhaps there is an answer. President Johnson has been reported first as warm and then cool toward a truly brilliant proposal to return a share of the Federal Government's brimming tax revenues to the States to relieve the immense pressures on State government. I think I can speak for all my State level colleagues in wishing that the President will warm again to this eminently sensible idea. The noted economist, Walter Heilbroner, wrote recently in the New York Times magazine of demands on State government for health and other services. "Unless we want all these functions ultimately centered in Washington," Heilbroner said, "the States and localities must have the wherewithal to provide these services independently on a generous scale."

Of course, the Federal Government, quite properly, seeks to raise all the States to an acceptable health standard. We welcome assistance which helps us improve without stifling our initiative or denying our intelligence. But I cannot believe that the people of this Nation will be served best by having their State governments reduced to field outposts for a monolithic Federal bureaucracy.

Therefore, in acting upon the bill presently before you and in considering subsequent recommendations by the association, I ask you to use your high powers to assure programs of Federal assistance that make excellence a possibility not only in the Nation's Capital but at all levels of our Federal system.

The CHAIRMAN. Senator Williams, do you have any questions?

Senator WILLIAMS. No, thank you.

The CHAIRMAN. Doctor, we appreciate very much your appearance and your very thoughtful expressions about the relationship between the Federal Government, the State government, and your local governments. I am most happy to have your thoughts on this subject. We want to thank you, sir, for this very splendid presentation. Thank you very much.

Dr. INGRAHAM. Thank you, sir.

The CHAIRMAN. Dr. William J. Dougherty, director of the Division of Preventable Diseases of the New Jersey State Department of Health.

**STATEMENT OF DR. WILLIAM J. DOUGHERTY, DIRECTOR,
DIVISION OF PREVENTABLE DISEASES, NEW JERSEY STATE
DEPARTMENT OF HEALTH, TRENTON, N.J.**

The CHAIRMAN. Doctor, you are director of the Division of Preventable Diseases of the New Jersey State Department of Health?

Dr. DOUGHERTY. Yes, sir.

Mr. Chairman, I wish to express my appreciation for the opportunity of presenting evidence of the services rendered in New Jersey under the auspices of the Migrant Health Act, pertinent observations which have resulted from practical field experience and recommendations for future action as envisioned in S. 510.

The CHAIRMAN. You should realize this—I am sure you do—that there has been no Member of the Congress of the United States who has done so much for the migratory laborer as Senator Williams of New Jersey.

Dr. DOUGHERTY. Yes, we in New Jersey are extremely proud of the effective, humanitarian work that Senator Williams has brought to this problem. You yourself have been very helpful, Senator Hill, and there are a number of members of this subcommittee—Senator Yarbrough and Senator Javits—who have also contributed, I am sure, in their sponsorship of migratory labor legislation.

I think we are agreed that migratory laborers are needed; they are indispensable to the agricultural economy of the United States.

Almost all of the working people in this country live in dignity. Many have organizations to bargain collectively for them in terms of wages and hours, safe working conditions, and for fringe benefits, such as health services, pensions, vacations, and other social improvements. The migrant workers and their families constitute an exception. They live in squalor and degradation.

The existing Migrant Health Act—Public Law 87-692—and provisions of the antipoverty program have recognized many of the needs of migrants. It is important that the Congress of the United States by its action support and improve the status of the migrant worker, give recognition to his value, and assign a dignity to his labor, for, in fact, these people serve this country by providing its sustenance. They should have benefits equivalent in all respects to workers who engage in the production of steel, automobiles, and fuel.

This act, the Migrant Health Act, was a precursor to the action envisioned in the Economic Opportunities Act.

Since it has been in operation for 2 years, it is a leader in community action programs in rural areas and a source of information and experience in the implementation of the community action programs.

I am going to skip, sir, the material which I prepared in terms of New Jersey, because it is included—

The CHAIRMAN. We shall have that appear in full in the record, though.

Dr. DOUGHERTY. Thank you.

In addition, we have included the full report of the migrant health program of New Jersey for 1964.

The work that has been done, I think, must be commended in terms of the voluntary agencies of the National Council of Churches and the Bishop's Committee which have so ably assisted the migrant health program. I must point to the fact that the dedication of our staff has contributed to the success of the activity. They have, with

patient and aggressive persuasion, won participation on the part of local communities and leaders in this activity. They have produced a quality service which has provided to the community an insight and support. We expect the expansion of rural health services as the result of this activity.

The most important point, I think, that I can make today, sir, is in behalf of hospitalization of the migrant worker. Inpatient hospital bills for migrant workers and their families submitted by 16 hospitals in New Jersey in 1964 exceeded \$47,000. The State of New Jersey, several years ago, recognized its responsibility and has helped in this area by appropriating annually approximately \$9,000. However, the pro rata share of each hospital was less than one-fifth of the total billing. This type of deficit accounts for the reluctance of hospitals to admit migrant patients who have been found in the clinics to need care and reduces the efficiency of the clinic service.

How to make up the deficit poses a terrific dilemma for the hospitals. From 50 to 60 percent of the people in New Jersey are covered by Blue Cross. The deficit cannot be charged against Blue Cross contract patients. This was ruled upon by the commissioner of banking and insurance in the State of New Jersey, who said that care of indigent patients is a responsibility of government.

In test cases, local municipal governments have been approached and have refused to pay for hospital care of migrant workers under the general assistance provisions which allow a maximum of \$10 per day against the prevailing per diem rates of \$25 to \$30 per day. The reason for many local municipalities failing to pick up this burden is the fact that in general their tax base is not sufficient for them to provide this kind of care.

Under these circumstances, the hospital has only two recourses: It can conduct a fund-raising drive, and to the extent that these are successful, the whole community meets the burden. What is more likely to happen, however, is that the hospital overcomes the deficit incurred by passing it along to paying patients who are not Blue Cross subscribers and who are not indigents. Thus, a small segment of the community, people who are already hard pressed to pay their bills because of illness, pay for the hospital care of indigent migrant workers and their families. This is inequitable and economically unsound.

Federal support for hospital care for migrants and their families would result in these costs being supported or apportioned over the total community of the United States through the payment of taxes.

Another significant problem lies in the area of subsistence needs of the people who are unemployed, who have exhausted their means, who have been abandoned in some instances, and who need shelter, food and clothing. Generally speaking, these people fall within the purview of general assistance programs. We hold that the concept of total health—physical, social, and emotional health—requires that you have food, clothing, shelter and so on, in order to be able to move forward constructively. I would therefore suggest that Federal categorical funds earmarked for assistance to seasonal workers should be available without residence requirements. The criteria for eligibility should be employment in agriculture, a demonstrated need, and lack of means to meet the need.

I must digress for a moment from the direct concern of the pending legislation to draw attention to the total disability benefits of social

security as they relate to the health and welfare of the migrant family. I recognize that this is not a question being presented to the subcommittee today. Nevertheless, these benefits contribute to the total solution of health problems of migrant citizens. It is urged that the provisions of social security be studied and/or modified to embrace these mobile seasonal workers in such a way that they, too, are protected by the total disability benefits.

Migrants are also a group who, if enrolled under social security, would perhaps be eligible for the benefits of medicare.

We have had an association with the Commonwealth of Puerto Rico and we depend upon many of their workers to support our agricultural economy. The Puerto Rican worker is frequently in jeopardy, at a disadvantage, and exploited because of his unfamiliarity with the culture on the mainland and its laws, its financial relationships and its language. It is imperative that support be given to the Commonwealth of Puerto Rico and the programs serving concentrations of Puerto Ricans in this country to improve their orientation in terms of the mainland culture and to provide them with the basic language skills which help them adjust more readily.

A committee of the American Public Health Association has evaluated services available to migrants through the Migrant Health Act. We participated by providing evidence and help in that study.

I wish to endorse the substance of this report, support its recommendations, and urge their adoption.

I would like also to say a word in behalf of the farmer. The farmer, of course, is entitled to a legitimate return from his investment and enterprise. The worker is also entitled to a legitimate wage. The farmer faces intense competition both in the fresh food market and in the processed food market. To a degree, he is caught in an economic squeeze. The farmer is pressured to improve the living conditions of the workers who work for him, and to a considerable extent, he has done so. The farmer needs help. The U.S. Government is already giving the farmer help through several programs. Since this is so, it would be consistent for the U.S. Government to provide greater support to the substantial health needs of the migrant worker.

The whole community benefits from the work of the migrant laborer. The whole community, through government, should support the services which keep him well and productive, sir.

Thank you very much.

The CHAIRMAN. Thank you, sir.

Senator Williams?

Senator WILLIAMS. Thank you, Mr. Chairman.

Doctor, I think I can say unequivocally, speaking for the residents of New Jersey, that we are proud indeed of the work you have done in most aggressively and sensitively applying the provisions of the new Migrant Health Act to our situation in that State. It is cataloged here in terms of service to the people, and that will appear in the record as broad and comprehensive service indeed.

As a matter of fact, the figures I have show that New Jersey was the leading State as beneficiary in receiving the services of the program. As other States have come in, we have fallen off a little.

We are proud indeed, and I am grateful for the ideas you have expressed here today, Dr. Dougherty, and I consider it a responsibility to follow up and see whether we can improve the program as you suggest.

Social security coverage is provided for agricultural workers, but all over the country, I observed in the field trips we took some years ago that it is a rare worker indeed who is, in fact, covered.

Dr. DOUGHERTY. They work too short a time in one place or earn too little money to be eligible for the withholding deductions.

Senator WILLIAMS. Dr. Dougherty was the star of a movie and I was one of the extras. We conducted field trips—what was the name of the tuberculin test?

Dr. DOUGHERTY. The tuberculin tine test.

Senator WILLIAMS. It made a very interesting documentary. In a matter of seconds, workers file by and get this test—it is a matter of seconds, is it not?

Dr. DOUGHERTY. Yes, sir.

Senator WILLIAMS. Very interesting.

The CHAIRMAN. I may say this, sir: So far as the field of migratory labor is concerned in the Congress, you have been our star, Senator.

Senator WILLIAMS. I may say you were the first star, Mr. Chairman. I prepared for the longest time to present myself to Senator Hill and request that we have a Migratory Labor Subcommittee, and then it took exactly seconds to get it. I remember I prepared for months, by the way, to face resistance, and there was no resistance. I am very grateful to you.

The CHAIRMAN. You have certainly done a wonderful job.

Doctor, we want to thank you for your presence and your splendid statement here today. We deeply appreciate it.

Dr. DOUGHERTY. It has been an honor to serve you.

(The prepared statement of Dr. Dougherty follows:)

PREPARED STATEMENT OF WILLIAM J. DOUGHERTY, M.D., M.P.H., DIRECTOR,
DIVISION OF PREVENTABLE DISEASES, NEW JERSEY DEPARTMENT OF HEALTH

I wish to express my appreciation for the opportunity of presenting evidence of the services rendered in New Jersey under the auspices of the Migrant Health Act (Public Law 87-692), pertinent observations which have resulted from practical field experience and recommendations for future action. As a citizen, it is an honor to be of service to the Congress of the United States.

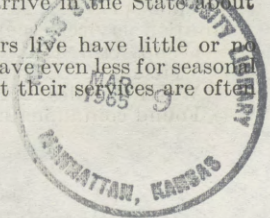
The first thing that needs to be said is that the agricultural economy of the United States needs migrant workers. Mechanization has not yet developed to the point where it can be used effectively in harvesting certain crops; human labor must be used. Efforts to recruit from permanent residents enough laborers who will work consistently for the harvesting period have not been effective. Migrant laborers are needed. They are indispensable to the agricultural economy.

Almost all of the working people in this country live in dignity. Many have organizations to bargain collectively for them in terms of wages and hours, safe working conditions, and for fringe benefits such as health services, pensions, vacations, and other social improvements. The migrant workers and their families constitute an exception. They live in squalor and degradation.

The existing Migrant Health Act (Public Law 87-692) and provisions of the antipoverty program have recognized many of the needs of migrants. It is important that the Congress of the United States, by its action, support and improve the status of the migrant worker, give recognition to his value, and assign a dignity to his labor, for, in fact, these people serve this country by providing its sustenance. They should have benefits equivalent in all respects to workers who engage in the production of steel, automobiles, and fuel.

New Jersey had about 25,000 agricultural migrant workers in 1964; somewhat less than 22,000 were housed in New Jersey. The others came in by day haul from Philadelphia or other places. Migrants begin to arrive in the State about April 1 and most leave by November 1.

In New Jersey, many areas in which migrant workers live have little or no local health services for their year-round residents; they have even less for seasonal migrants. Areas which do have health services find that their services are often



overwhelmed if they undertake to meet the health needs of seasonal workers and their families unassisted.

Because of this paradox, a group with significant health needs living temporarily in areas which are unequipped to meet these needs, the New Jersey State Health Department has for several years coordinated the provision of health services to the migrant people. It has drawn upon local health resources to the extent these were available; it has supplemented these with its own resources and funds obtained from the Public Health Service under the Migrant Health Act (Public Law 87-692).

The full report of New Jersey's migrant health program for 1964 is submitted for your information. In abstract form the program through its cooperating agencies provided:

Physician treatment services to	48 patients.
Physician clinic services	41½ hours.
Outpatient services	249 patients.
Hospital services (admissions)	113 patients.
Maternity services	61 women.
Pediatric dental examinations	412 persons.
Extractions	123 persons.
Fillings	304 persons.
Cleaning	400 persons.
Fluoride treatment	295 persons.
Dental emergency treatment	83 persons.
Clinics held	71 persons.
Persons served	2,375 persons.
Physician and nurse service	783 persons.
Physical inspection	334 persons.
Tuberculin tests	1,714 persons.
Active tuberculosis discovered	2 persons.
Oral polio vaccine I	1,535 persons.
Smallpox immunization	15 persons.
Diphtheria-tetanus toxoid	1,624 persons.
Diphtheria-pertussis-tetanus	373 persons.
Serologic tests for syphilis	1,629 persons.
Newly discovered syphilis	18 persons.
Referred for follow-up	342 persons.
To clinics	107 persons.
Public Health nursing agencies	91 persons.
Prenatal and postpartum	14 persons.
Venereal disease and dental	76 persons.
Migrant schools:	
Diphtheria-pertussis-tetanus	133 children.
Diphtheria-tetanus	179 children.
Oral polio	372 doses.
Tuberculin tests	328 persons.
Smallpox vaccine	112 persons.
Treatment of skin disease	171 persons.
Individual service in camps	1,833 persons.
Person visits	3,278.
Problem cases served	594 persons.
Camps visited	453.
Population of camps visited	5,814 persons.
Number of visits	1,285.
Medical social services	124 persons.
Problems	166.
Interviews	1,029.
Visits	265.
Health education survey	81 persons.
Farmers reached	1,000 persons.
Clinic preparation program:	
Farmers visited	40 persons.
Workers contacted	230 persons.
Time spent	12 days and nights.
Sanitation service in cooperation with Department of Labor:	
Camps visited	2,052.
Visits	7,437.
Water samples	148.
Found contaminated	26.

The following points deserve special recognition and action.

Inpatient hospital bills for migrant workers and their families submitted by 16 hospitals in New Jersey in 1964 exceeded \$47,000. The State of New Jersey recognized its responsibility to help in this area and appropriated \$9,000. However, the pro rata share to each hospital was less than one-fifth of the total billing. This type of deficit accounts for the reluctance of hospitals to admit migrant patients who have been found in clinics to need care and reduces the efficiency of clinic services.

How to make up the deficit poses a terrific dilemma for the hospitals. From 50 to 60 percent of the people in New Jersey are covered by Blue Cross. The deficit cannot be charged against Blue Cross contract patients.

In test cases, municipal governments have been approached and have refused to pay for hospital care to migrant workers under the general assistance provisions which allow a maximum of \$10 per day against the prevailing per diem hospital costs of \$25 to \$30 per day.

Under these circumstances, the hospital has only two recourses. It can conduct fund-raising drives. To the extent that these are successful, the whole community helps to meet the burden. What is more likely to happen, however, is that the hospital overcomes the deficit incurred by passing it along to paying patients who are not Blue Cross subscribers. Thus a small segment of the community, people who are already hard pressed to pay bills because of illness, pays for the hospital care of indigent migrant workers and their families. This is inequitable and unsound. Federal support for hospital care for migrants and their families would result in these costs being apportioned over the whole community through payment of taxes.

In New Jersey, migrants who have recognized needs which would make them eligible for assistance under categorical programs such as aid to dependent children, old age assistance, and aid to the blind, have been helped. The fact of recognition depends on the migrant coming into contact with a case-finding public health nurse, a health clinic, or one of the other members of the health team—the health educator, social worker, etc.—who visit migrant labor camps.

The most significant problem lies in the area of subsistence needs for people who are unemployed, who have exhausted their means, who have been abandoned in some instances, and who need shelter, food, and clothing. Generally speaking, these people fall within the purview of a general assistance program. General assistance is administered by the municipality. While some municipalities have assisted, many do not consider this group their responsibility and their tax base is not sufficient to meet these needs and those of their regular residents who are in crises. There exists a clear need for a special public assistance program for agricultural workers. For only when they can secure food, clothing, and shelter, can people begin to relate constructively in the sense of having a good physical, mental, and emotional outlook.

Federal funds should be categorically earmarked for assistance to seasonal farmworkers. This fund should be available without residence requirements. The criteria for eligibility should be employment in agriculture, demonstrated need, and lack of means to meet the need.

I must digress for a moment from the direct concern of the pending legislation to draw attention to the total disability benefits of social security, as they relate to the health and welfare of the migrant family. I recognize that this question is not being presented to the subcommittee today. Nonetheless, these benefits contribute to a total solution of the health problem of migrant citizens.

Migrant workers and their families with health problems have been observed for whom the benefits of social security have been or would have been of great value in the handling of their health problems. In general, many migrant workers are not eligible for the benefits of social security and may not be even enrolled in the system because they have worked for too short a time in any one place or have earned too little money during that time to require contributions to the social security system.

It is urged that the provisions of social security be modified to embrace these mobile, seasonal, farmworkers in such a way that they too are protected by total disability benefits. Here is a group who if enrolled would also be eligible for the benefits of medicare.

We feel that this is just and is consistent with the philosophy and purpose of social security, that every worker contribute his share to his future well-being.

The New Jersey migrant health program pioneered a working contract with the National Travelers Aid Association which has opened channels of intrastate and interstate communication and service on behalf of needy migrant workers

and their families. It renders an aggressive person-to-person referral and followup on behalf of the worker that assures continuity of service—medical, social, and financial—essential to the well-being of the migrant worker and his family. This type of service is essential to safeguard the well-being of the migrant and to assure the full return for services already rendered. This type of developmental activity is urgently needed in many areas of migrant health program activity.

The economies of the mainland United States and its neighbor, the Commonwealth of Puerto Rico, are now enmeshed in the annual migration of Puerto Rican agricultural workers into many States in this country. The Puerto Rican worker is frequently in jeopardy, at a disadvantage, and exploited because of his unfamiliarity with the culture of the mainland, its laws, its financial relationships, and its language. The migration of workers is to the economic advantage of both the Commonwealth and the mainland. If the social advantages of this interchange are to be realized and the economic advantages are to be increased, it is imperative that support be given to the Commonwealth and to programs serving concentrations of Puerto Ricans in this country to improve their orientation in the culture of the mainland and to provide them with the basic language skills that will enable them to adjust more readily.

I should like to say a word in behalf of the farmer. The farmer is, of course, entitled to a legitimate return from his investment and enterprise. The worker is also entitled to a legitimate wage. The farmer faces intense competition both in the fresh-food market and in the processed-food market. To a degree, he is caught in an economic squeeze. The farmer is also pressured to improve the living conditions of the workers who work for him, and to a considerable extent he has done so. The farmer needs help. The U.S. Government is already giving the farmer help through several programs, although to a lesser degree in New Jersey than in some other States. Since this is so, it would be consistent for the U.S. Government to provide greater support of the substantial health needs of migrant workers. The whole community benefits from the work of the migrant laborer. The whole community, through government, should support the services which will keep him well and productive.

A committee of the American Public Health Association evaluated services to migrants under the Migrant Health Act. In closing I wish to endorse the substance of this report, support its recommendations and urge their adoption.

The CHAIRMAN. At this point we welcome the statement of Senator Harrison A. Williams, Jr.

**STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A U.S.
SENATOR FROM THE STATE OF NEW JERSEY**

Mr. Chairman, I want to express my strong support for S. 510 which would extend for 5 years Federal assistance for several essential community health programs.

At this time, I particularly want to call attention to section 3 which authorizes continuance of health services for migratory workers.

In 1962 the 87th Congress enacted the pioneering Migrant Health Act. Recognizing that the leadership and assistance of the Federal Government were necessary if migrant workers and their families were to ever reach the health standards of other U.S. citizens, Congress authorized the expenditure of \$3 million annually for 3 years to stimulate State and local health programs for the benefit of migratory farmworkers.

After conducting intensive research—by means of public hearings and on-the-spot observations—the Subcommittee on Migratory Labor had strongly recommended such a program for three major reasons:

Migrant families, because of their transient lives, had far less access to health care than other Americans despite the fact that, in general, their health care needs were far greater.

Existing efforts by State, local, and voluntary groups to meet the migrants' needs had been small, uncoordinated, scattered, and only partially effective.

No county or State had been able, by itself, to cope with the problem.

To alleviate this situation, Congress authorized the Surgeon General in the U.S. Public Health Service to make grants for family health clinics and special health projects, operated by local and State authorities, to improve health services for domestic migratory farm families.

The migrant health program has now been in operation for 2 years, and after a careful study and evaluation by the American Public Health Association, certain conclusions are clear:

The achievements under the act's initial operation have been considerable. Grants have been made to family health service clinics, as well as to local projects for sanitation, nursing, nutrition, health education, dental service, social work, and immunization services. At present 55 health projects in 27 States are receiving grant assistance, although over half of these grants are for less than \$20,000, with local sources contributing all additional funds.

However, despite the progress that has been made, the APHA report strongly recommended extension of the health act for an additional 5 years with a minimum appropriation of \$10 million annually. It is my privilege today to endorse the President's recommendation contained in section 3, which will extend the life of the migrant health program for another 5 years and provide for substantial expansion of its activities.

The major conclusion of the APHA report was that the program's most "serious deficiency relates to medical care. Exclusion of payment for hospitalization and inadequacy of funds for private medical care are serious handicaps." The Public Health Association warned that these defects "severely restrict and sometimes negate the potential benefits from clinic service by preventing followup of patients referred both for emergency and rehabilitative services."

Because of the numerous gaps in the health services currently available to migratory agricultural workers, the Public Health Association called for a major emphasis to be given to "financing projects which give evidence of developing truly comprehensive health service including medical care."

Thus, it is clear that initial operation of the Migrant Health Act has merely helped establish the necessity for its continuance.

Much has been done with a small amount of money in a short 2 years. But the problem of providing decent medical services for our migrant agricultural workers is a long way from being solved. In light of our current concern for building the Great Society, our enthusiastic plans for eliminating poverty from our midst, and our fine prospects for enacting a meaningful medicare bill, the time is particularly auspicious for extending medical benefits to all needy individuals in our population. A great society includes everyone—even the often-forgotten migrant worker who toils long and late to harvest the riches of our country.

The CHAIRMAN. We will include in the record the following statement of the American Public Health Association with a covering letter from its executive director, Dr. Berwyn F. Mattison, the statement of William R. Baldwin, O.D., on behalf of the American Optometric Association, and a letter from Kenneth Williamson, associate director, American Hospital Association.

THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
Washington, D.C., January 26, 1965.

HON. LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Attached you will find a copy of the position of the APHA as it pertains to S. 510 and S. 512. It is our hope that this will be of interest to you and to your committee, and I would appreciate it being made a part of the record of your hearings on January 27.

Sincerely yours,

BERWYN F. MATTISON, M.D.,
Executive Director.

PREPARED STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association wishes to support enactment of both S. 510 and S. 512 being considered by this committee today. Each contain proposals of especial consequence to the public's health, including support for health programs and health facilities and, therefore, of particular interest to the members of the APHA. Herein follows our views on the specific proposals contained in each bill.

S. 510

We support section 2 both as it would extend and expand the Vaccination Assistance Act and remove the appropriations limitation presently applicable. This program is an outstanding example of combined local, State, and National effort to rid our Nation's people of preventable disease and disability with their resulting suffering and loss, both physical and economic. The progress during the few short years of this program's existence has, we believe, been commendable; and on that basis, together with the need for continued vigilance against poliomyelitis, diphtheria, whooping cough, and tetanus, the continuation of the authority is merited. We believe, too, that because of the problems posed by measles and, more particularly, the deleterious effects which may result from the disease such as encephalitis, brain damage, and others, and because a specific preventive agent is available, that the act should include support for measles vaccination programs.

Section 3 of S. 510 provides extension and expansion of support of health services for domestic migratory agricultural workers and their families. The APHA was pleased to have been a strong supporter of this program when it was first enacted 3 years ago. We contended, and the Congress agreed, that these citizens, whose labor is vital to important segments of our farm economy but whose necessary intercounty and interstate migrations deprive them of legal residence status, posed a truly national problem. We were in complete agreement with the premise that the Federal Government did have a distinct responsibility to aid in providing health services to these workers and their families.

The APHA has recently concluded a critical appraisal of this program. The full report of this study is available to this committee, and a copy of the summary of findings and recommendations is furnished for the record. Briefly, it was found that the program has been competently administered and that the modest amounts which have been appropriated have contributed materially to vitally needed health services and have resulted in an elevated and improved status of health among these migrants. Because of the limited funds it was impossible, however, to provide assistance that was inclusive geographically or a range of services as broad as is needed. It was specifically recommended, for example, that some funds should be available for necessary hospital care. The APHA strongly supports extension of this authority as proposed and the elimination of the ceiling on annual appropriations.

Section 4 of S. 510 would extend for 1 year the authority of sections 314(c) and 316(a) of the Public Health Service Act. We support this limited extension because within a year we expect to have comprehensive and authentic information on improved methods of providing community health services which should provide valuable documentation to this committee and to public health agencies throughout the Nation. Together with the National Health Council we are presently sponsoring the National Commission on Community Health Services, whose Chairman is the extremely well qualified Mr. Marion Folsom. The Commission, with task forces comprised of exceptionally talented and experienced health leaders, is presently in the final year of a 4-year study of community health services including their organization, adequacy, deficiencies, areas of need—all

important features of this matter. The results of this endeavor will be available in early 1966 and, it is hoped, will be of interest and of assistance to this committee. Because this body of information will soon be available, we support the 1-year extension of section 314(c) and section 316(a) as proposed in S. 510.

S. 512

The need for and the benefits of the Health Research Facilities Construction Act has long been beyond question. Continued health research is vital to an increased body of scientific data in order that we may better cope with the many and varied maladies which plague all people and continue to reduce suffering and unnecessary death. It is recognized too that special facilities are required in which health research can be performed. The APHA supports continuance of the present matched financing support program as well as the enactment of the regional or national facilities provision which is proposed as section 712.

In respect to section 4 of S. 512, the APHA is inclined to agree with the apparent rationale. The office of special assistant to the secretary for health and medical affairs is something of an administrative anomaly. It would seem to us, however, that in consideration of the importance of our Nation's health efforts, the magnitude of health responsibilities of not only the Public Health Service but of the Social Security Administration and the Vocational Rehabilitation Administration and, under this administration proposal, the number of assistant secretaries to be available, that one of the proposed assistant secretaries should be a physician. This recommendation should not be construed as a denigration of the efforts of nonphysicians who have served as special assistants for health and medical affairs. Certainly the services of Mr. Jones were of the highest quality, and the credentials of the incumbent, Dr. Dempsey, are impeccable. We do believe, however, that, as in the instances of other specialized competencies, the unique training and experience of a physician would be not only appropriate but desirable and of benefit.

Our association appreciates this opportunity to present to this committee our views on these legislative proposals.

EVALUATORY STUDY ON OPERATIONS OF THE MIGRANT HEALTH PROGRAM UNDER THE MIGRANT HEALTH ACT, DECEMBER 30, 1964, THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.

SUMMARY OF CONCLUSIONS

General

1. The Migrant Health Act (Public Law 87-692) is the first effort by Congress specifically to meet the health needs of domestic migrant agricultural workers.
2. The program under the Migrant Health Act has operated completely within congressional intent.
3. The act has permitted local groups to initiate projects to improve health services to migrants.
4. The continuation of the act will permit increasing the interstate cooperation already in evidence, and the development of greater continuity of health care for migrant agricultural workers.
5. Applications for project funds have been greater than the amounts appropriated, indicating increasing interest among health officials and others about migrant health problems and related areas of unmet need.
6. The Migrant Health Act has demonstrated that the small initial appropriation allotted to attack a large national problem is totally inadequate. Extensive field activities by both local and State personnel have demonstrated with dramatic clarity that health needs and ability to meet such needs are as a rule virtually identical with migrant and nonmigrant alike.
7. Due to delay in appropriation, the program began a year late and has not been able to demonstrate fully its potential benefit to migrant workers.
8. Program operations have broadened the public health services in many areas to include early medical care as part of the preventive services afforded migrants.
9. Through demonstrations in several projects it has become apparent that the training of personnel in migrant health work deserves additional attention in the subtleties of cross-cultural understanding and communication.
10. While it was hoped that the financial responsibility for on-going projects would gradually be assumed by local support, experience in most areas discloses that withdrawal of Federal funds would seriously undermine the program.

Benefits of program

1. The program is providing services that would not be available without the Migrant Health Act.
2. It has stimulated greatly local interest in migrants throughout the country.
3. It has resulted in marked improvement in communication among health workers, growers, and migrants.
4. It has brought into focus the need for continuity of health services in dealing with a highly mobile population.
5. It has resulted in improvement of housing, general sanitation, working and living conditions in a large number of localities.
6. It has encouraged the establishment of family health clinics or other means of providing medical care for migrants which in turn has led to better utilization of traditional public health services.
7. It has provided medical and health services not previously available in many rural areas, and in many instances has extended these services to local impoverished rural residents supported by local funds.
8. In some areas where projects did not extend coverage to other than migrant workers, local residents have requested that equivalent services be established for other local poor.

Limitations of program to migrants

1. Slightly more than 50 percent of projects established the family health service clinics which were the primary goal of Public Law 87-692.
2. Health service clinics now operate only once or twice per week and are unable to offer comprehensive medical service.
3. Inability to pay for hospitalization and private medical care often restricts or negates potential benefits from clinic service by preventing patient followup on necessary additional medical care in both emergency and rehabilitative situations.
4. Staff-patient communication especially in projects having Latin Americans in both clinical and related health activities is conspicuously ineffectual except when interpreters or bilingual health personnel are included as members of a project team.
5. Due to population fluctuation, clinic facilities are not always easily accessible, necessitating the use of available but inadequate resources within a circumscribed area.
6. The absence of any transportation in many areas prevents effective clinic use and nullifies benefits of referrals to more distant medical centers.
7. Clinics are not always held at times and places most convenient to the worker and his family.
8. All but a few clinics reveal definite understaffing of physicians, nurses, and auxiliary personnel.
9. Projects which include "studies" have been restricted by intent of the act. And yet, without this feature, certain accurate essential information cannot be gathered against which programs might be evaluated.

PREPARED STATEMENT OF WILLIAM R. BALDWIN, O.D., AMERICAN OPTOMETRIC ASSOCIATION, JANUARY 29, 1965

Mr. Chairman and members of the subcommittee, my name is William Baldwin. I am a doctor of optometry and dean of the College of Optometry at Pacific University, Forest Grove, Oreg. I am presently chairman of the Committee on Research of the American Optometric Association.

The American Optometric Association is a nonprofit professional organization representing over 13,000 practicing optometrists who provide vision care for over 60 million Americans. AOA is headquartered at 7000 Chippewa Street, St. Louis, Mo. A Washington office of the association is located at 1025 Connecticut Avenue NW.

We as an association have long been concerned with research and its importance to vision. Representatives of the National Science Foundation, American Academy for the Advancement of Science, and similar organizations whose primary concern is research and optometric researchers and scientists met in Washington in 1963 for a national conference sponsored by the American Optometric Association. One of the major concerns expressed at the conference was the need for expanded and more adequate research facilities at optometric schools and colleges.

§ S. 512 would amend the Public Health Service Act provisions for the construction of health research facilities by extending the expiration date of the provision and providing increased support for the program. It would also authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare. One of its most important sections provides for the construction and operation of specialized regional or national health research facilities.

About 46 percent of our total population or more than 83 million people depend upon some form of optometric device. Optometrists are now performing about 70 percent of the refractions which result in the application of optometric devices. Optometrists with their capacity to recognize the presence of pathological abnormalities are a first line of defense against blindness. It is apparent that the primary responsibility for the vision care needs of the Nation, including correcting the healthy eye and detecting the unhealthy, is met by the optometric profession.

Optometry's rapid growth and development has been a direct result of the increased recognition by the American people of their need for vision correction. This popular recognition of the need for vision care stems in large measure from the changes which education, industry, and technology have made in our society. Reading loads in schools and on the job are greater than ever before. Television and high-speed driving have placed new demands on vision. Stress on job safety in industry and new labor specialties have aroused considerable interest and prompted many advances in protective optometric devices and unique refractive equipment. During World War II vision training, which optometry pioneered, aided pilots in spotting an aggressor at extremely high closing speeds. Today, as the United States enters the space age, optometrists are at work solving the unknowns of light and vision in the blackness of space. Greater longevity is creating an ever larger number of aged persons within our population, a fact of great portent for our Nation's future and a challenge in the field of geriatric optometry. These are but a few examples of the changing burdens placed upon vision in this century which have been or are being met by optometry.

There is mounting evidence that research into areas of human performance involving vision can provide means for more efficient vocational, technical, and intellectual achievement. If science is to make maximum use of these human potentials all scientific disciplines which are developing competence in vision research must receive maximum encouragement and support. The opportunity for such encouragement is made available through S. 512.

Our association, the American Optometric Association, is vitally concerned by the scarcity of personnel holding advanced degrees in optometric research, especially those holding Ph. D. degrees in physiological optics. There is a vital need within the profession for teachers and researchers. There is also a rapidly increasing demand from industry and Government for qualified people educated in this field.

The American Optometric Association is now working to double the number of schools of optometry and particularly is looking for affiliation with educational institutions which have a history and climate of excellence in research. Graduate research programs are now being developed and expanded within our existing schools of optometry. S. 512 will offer optometry the opportunity to improve their ability to do vision research. Optometry has the capacity to make a significant contribution to vision research but is severely handicapped by lack of facilities.

Optometry's research objectives would more readily be achieved if this bill is approved and part of the funds authorized are utilized to assist our schools and colleges which have a record of excellence in research.

In addition, there is a need for an optometric or visual science institute under the National Institute of Health. The historical improvement in both the quantity and quality of dental research following the establishment of NIH's Dental Institute offers strong evidence that the public interest benefits from this kind of specialized research facility.

I suggest that Congress establish a National Optometric Institute as a division of the National Institutes of Health, or some other agency which would be responsible for the research needs of optometry. Such an institute would be staffed by scientists in the field of vision who would be selected not only from optometrists, but also from physiologists, biophysicists, pathologists, neuropsychiatrists, and others. I believe that if Congress will establish a National Optometric Institute, it will result in improvement of the vision care of our entire population.

A profession like optometry, through its official organization, should make recommendations about its own needs and along with representatives from fields

such as physics, psychology, ophthalmology, illuminating engineering, and others, a statement of the needs for research in vision could be formulated.

Institutional grants avoid the tremendous effort and expense of screening individual grants at the national level. A unit like the school of optometry can provide the necessary coordination of efforts of individual researchers to create an integrated program within the school. Interdepartmental and intercollege units, like the institute for research in vision at the Ohio State University, can bridge the gaps between the various departments concerned with vision. The coordination between different schools can be provided through national associations and societies.

One of the most serious problems is how to deal with the smaller college and with independent units such as the Optometric Center of New York City. There is a large undeveloped potential for effective research in these small institutions.

Dental research suffered until the founding of the National Dental Institute under the National Institutes of Health. Since then, dental research has progressed at a rapid rate, resulting in the improvement of dental care.

State-supported universities and colleges and privately supported professional schools cannot provide the necessary funds for the research essential to a healthy mixture of research and teaching. State support and student fees are needed for teaching effort and Federal support is needed for research.

There is a great need for facilities to research in optometric procedures and to develop new and improved optometric devices and equipment. There is also need for increased communication of research to teachers of optometry and to practitioners. This increase in communication can be achieved through seminars, publications, and institutes.

Today optometric research suffers from a shortage of manpower, money, and facilities. S. 512 can break this vicious circle if part of the money made available is allotted to optometric research. If our institutions are provided with the facilities, they can attract men into research and young people into the profession.

At the present time State-supported universities and colleges, and privately supported professional schools cannot provide the necessary funds for the research essential to a healthy mixture of research and training.

We urge your committee during its deliberations to give positive consideration to the contribution that optometry can make toward the solution of the problems of our Nation by improving the vision of our entire population of all ages.

Specifically, we strongly urge that S. 512 when reported by your committee have a legislative history which clearly indicated that Congress intends that part of the funds be made available for optometric research.

In conclusion, Mr. Chairman, your committee will perform a public service by approving S. 512. Our schools and colleges of optometry can perform a vital service to our Nation's health through increased vision research. We as a profession stand ready to help improve the vision care of America if given the opportunity. We need only to be recognized by Congress.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., January 28, 1965.

Hon. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: We are pleased to note that you have introduced S. 512 in the Senate of the United States to amend the Public Health Service Act, providing for construction of health research facilities by extending the expiration date thereof and providing increased support for the program to authorize additional Assistant Secretaries in the Department of Health, Education, and Welfare, and for other purposes.

As we interpret the provisions of this bill, it would do the following:

1. Extend the health research facilities construction grants program for another 5 years but at an increased level of spending to provide research facilities and for related purposes. Grants may not exceed 50 percent of the construction cost.

This program has been very effective over the past years in promoting research in general and research potentialities of many hospitals in particular. We are heartily in favor of this extension.

2. S. 512 would add a new section, 712, to the Public Health Service Act authorizing the Surgeon General to construct and, if necessary, pay up to 100 percent of the construction cost of "facilities of particular value or significance for the Nation or region thereof." As we understand it, this section restores a

provision previously in the Public Health Service Act but which, for some reason, was later removed. We feel that this provision would make possible the construction of certain specialized research facilities of value to the Nation as a whole but which because of their specialized nature could not be even partially financed with private funds. For the same reasons, such centers might be impossible to operate even in part with local funds; and the authorization for the Surgeon General to operate such research facilities is a logical corollary provision. We feel that these provisions constitute desirable additions to the Nation's research program.

3. Section 3 of S. 512 amends section 301 of the Public Health Service Act to authorize the Surgeon General, with the approval of the Secretary of the Department of Health, Education, and Welfare, to enter into contracts for research in accordance with and subject to the provisions of law applicable to contracts entered into by the military departments under title 10, United States Code, sections 2253 and 2254.

We understand that this amendment provides a firm statutory base for a program which has heretofore been authorized from year to year in appropriation language and thereby subject to point of order. We feel that this is a desirable provision in that it would remove such of the uncertainty from an ongoing and valuable means of conducting research.

4. Section 4 would provide for three additional Assistant Secretaries of the Department of Health, Education, and Welfare. It would also abolish the position of Special Assistant to the Secretary (Health and Medical Affairs) and provide that the incumbent immediately prior to the enactment of this legislation may act as one of the three additional Assistant Secretaries until the office can be filled by appointments in the manner provided by this section.

We question only the vagueness of this section as it relates to health and medical affairs. We feel it imperative that one of the three Assistant Secretaries be competent in and responsible for health and medical affairs in the Department.

We appreciate the opportunity of expressing our views on this bill and request that they be made a part of the record.

Sincerely,

KENNETH WILLIAMSON,
Associate Director.

The CHAIRMAN. The subcommittee will now stand in recess.
(Whereupon, at 12:35 p.m. the subcommittee recessed, subject]to
the call of the Chair.)

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